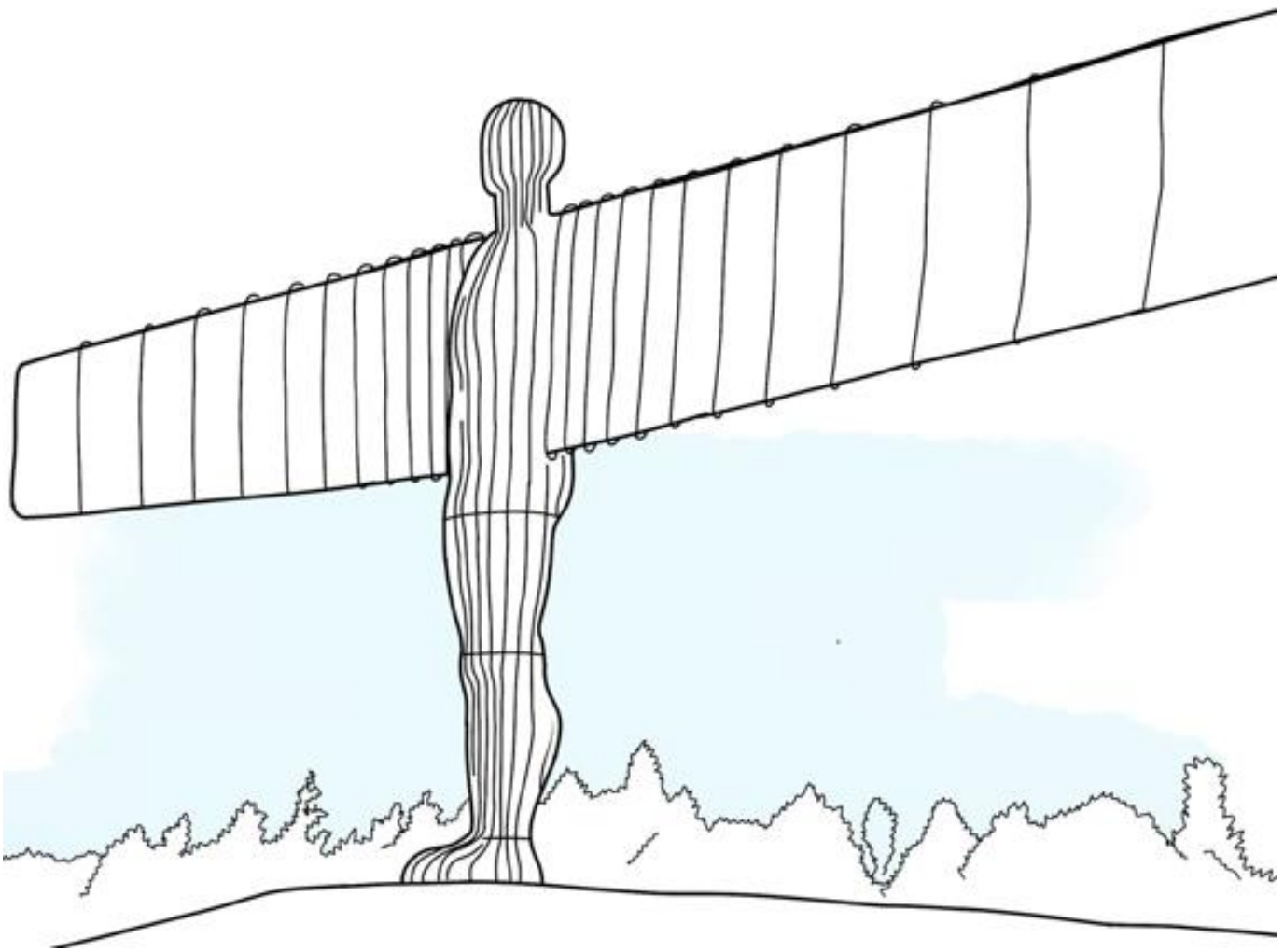
NHS
Gateshead Health
NHS Foundation Trust



Quality Account

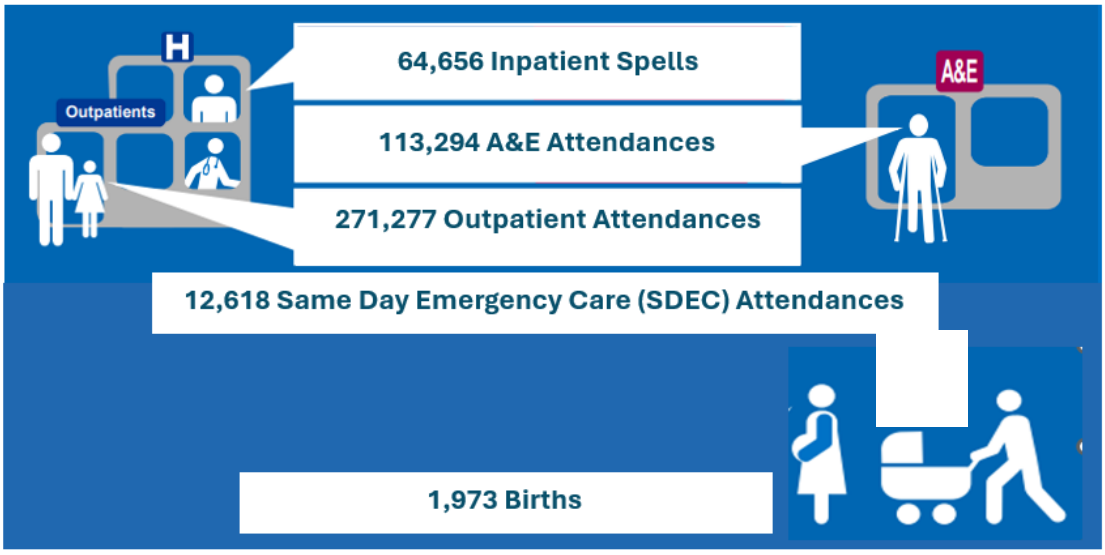
Gateshead Health NHS Foundation Trust 2024/25

Gateshead Health NHS Foundation Trust at a glance…

Local Population
Over 200,000

Employ around
4,500 staff

Inspected and rated
Good with
Outstanding for Caring
Care Quality Commission



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Part 1

Quality Account – Chief Executive's Statement

Statement on Quality from the Chief Executive

As Chief Executive of Gateshead Health NHS Foundation Trust, it is my great privilege to present our Quality Account for 2024/25. This report offers us a moment of reflection - an opportunity to consider the progress we've made, the challenges we've faced, and the ambitions we hold for our future. I am proud to say that, despite the well-documented pressures on the NHS, our teams have remained committed, resilient, and wholly focused on delivering safe, effective, and compassionate care for the communities we serve.

This past year has brought some remarkable milestones for our Trust. Most notably, we were honoured to be shortlisted for the prestigious Health Service Journal Trust of the Year award. This national recognition stands as testament to the relentless hard work of our staff across every department, from point of care clinicians to our estates and facilities teams, corporate staff and Trust volunteers. Their commitment to quality, innovation and patient-centred care has set Gateshead Health apart on a national stage.

We have also made significant improvements in how we support patients through their care journey. Our focus on patient flow, especially safe and timely discharge, has been a key priority. By working closely with our Local Authority and Social Care partners, we've streamlined processes and improved communication, which means more patients are able to return home when they are ready, reducing unnecessary time spent in hospital. These changes are more than just operational - they represent a genuine improvement in the experience of our patients and their families.

We have taken further steps to strengthen our culture of safety. In line with the NHS's national approach to patient safety, we have begun the rollout of the Patient Safety Incident Response Framework (PSIRF), supported by the implementation of a new incident reporting system. These developments enable us to learn more effectively from incidents and crucially, to embed that learning across the organisation. Alongside this, we've continued to foster a culture where staff feel empowered to raise concerns. Our Freedom to Speak Up programme has expanded, with increased visibility of our Guardian and a renewed emphasis on psychological safety in the workplace. Staff voices are critical to patient safety, and we remain determined to create an environment where every colleague feels confident to speak up and be heard.

We are clear about our long-term strategic vision. At the heart of our ambition is the intent to be recognised as an outstanding District General Hospital. We believe that outstanding care should be available locally, close to home, and that DGHs have a vital role to play in providing high-quality, comprehensive, and sustainable care. This ambition runs through every decision we make; from the way we invest in clinical services and staff development to how we engage with our partners and community. It is a commitment to excellence that touches every aspect of our work.

One of the most exciting developments this year has been the opening of our new Community Diagnostic Centre (CDC) at the Metrocentre, in partnership with Newcastle Hospitals NHS Foundation Trust. This state-of-the-art facility is designed to make diagnostic services more accessible and convenient for patients, helping to reduce waiting times and improve early detection and treatment of a wide range of conditions. By locating the CDC in a well-connected and familiar public setting, we are removing barriers to care and bringing essential services closer to where people live and work.

We are also proud that our ambition to establish Gateshead Health as the Northern Centre of Excellence for Women's Health is coming to fruition. This bold vision builds on our reputation for delivering excellent Maternity and Gynaecology services and reflects our commitment to addressing long-standing inequalities in women's health outcomes. Alongside our system partners, we are investing in research, infrastructure and clinical leadership to create a centre that not only delivers high-quality care but also shapes the future of women's health in our region and beyond.

Despite these successes, we cannot ignore the wider context in which we operate. The NHS continues to face immense financial and operational pressure. Nationally, almost half of all NHS trusts are forecasting a deficit this year, and Gateshead, like many, is required to balance the ongoing cost constraints with rising demand for services. The financial challenge is not just about numbers - it has real implications for how we staff services, invest in infrastructure and continue to innovate. It is also about how we make sure that Gateshead Health is sustainable as an organisation for the future.

Securing sustainable services means that we will need to think differently about how we all work together. Whilst this can seem challenging, I believe it is a real platform for innovation and new ways of working. It will be important to attract and retain the best people to work with us here at Gateshead as we reform and change to meet the many demands and needs of our ever-changing population and workforce. We know that staff wellbeing is central to delivering high-quality care, and we have further focussed on our wellbeing support, leadership development and flexible working options to retain and attract talented people.

We also acknowledge the impact of societal issues such as the cost-of-living crisis, which is not only affecting our staff but also the people we care for. More patients are presenting with complex needs rooted in poverty, housing insecurity and mental health issues. Health inequalities are widening, and as a Trust we are determined to work in partnership with local services to address these challenges, reduce barriers to care and better meet the needs of the most vulnerable in our communities.

Looking to the year ahead, our priorities remain clear. We will continue to put patients at the heart of every decision we make. We will focus on reducing waiting times and improving access to care, while also deepening our collaboration with partners across the system. We are also committed to sustainability, both in terms of environmental responsibility and the long-term sustainability of our services. This includes reducing our carbon footprint, reviewing our estate and embracing digital transformation to enhance patient care.

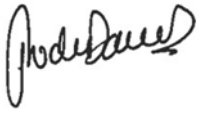
None of this would be possible without our incredible staff. Their compassion, professionalism and resilience are the driving forces behind everything we achieve. I want to take this opportunity to thank every member of our Gateshead Health family for their dedication to our patients and to one another.

We move forward with purpose, with pride in what we've achieved and with a deep sense of responsibility for the future. Our commitment to quality will remain unwavering as we continue to deliver care that is not only clinically led, but also delivered with dignity, kindness and respect.

I can confirm, in accordance with my statutory duty, that to the best of my knowledge, the information provided in this Quality Account is accurate.

Thank you for taking the time to read our Quality Account.

Signed



Date: 25 June 2025

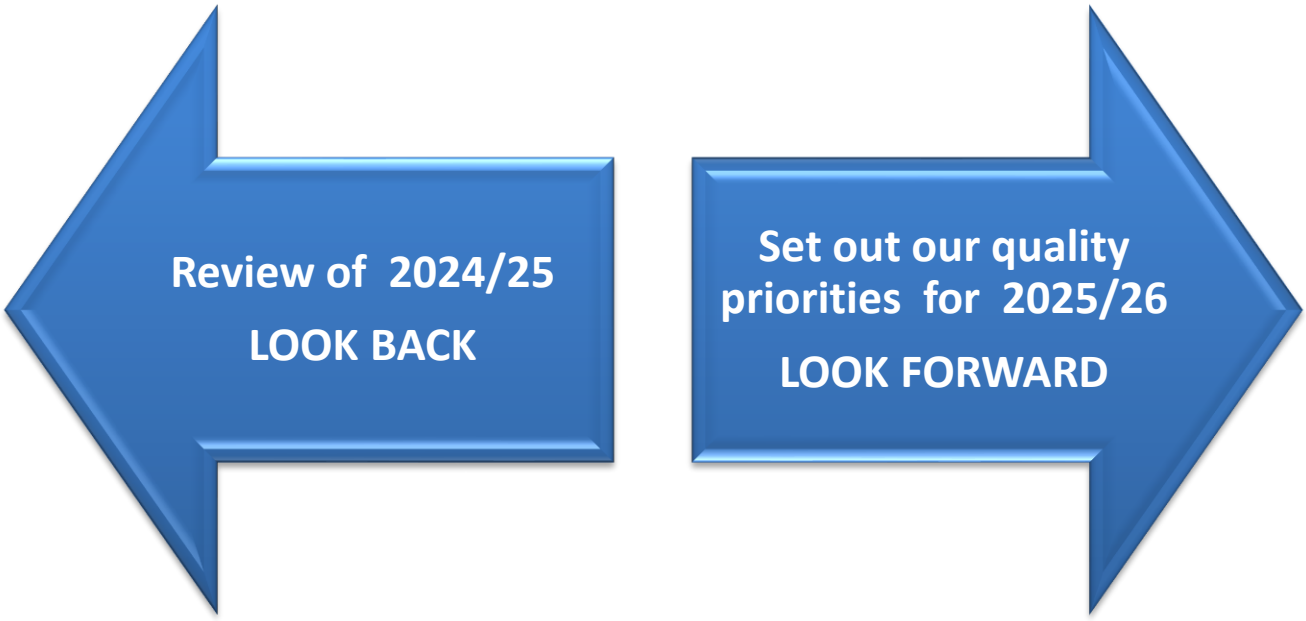
Trudie Davies
Chief Executive

What is a Quality Account?

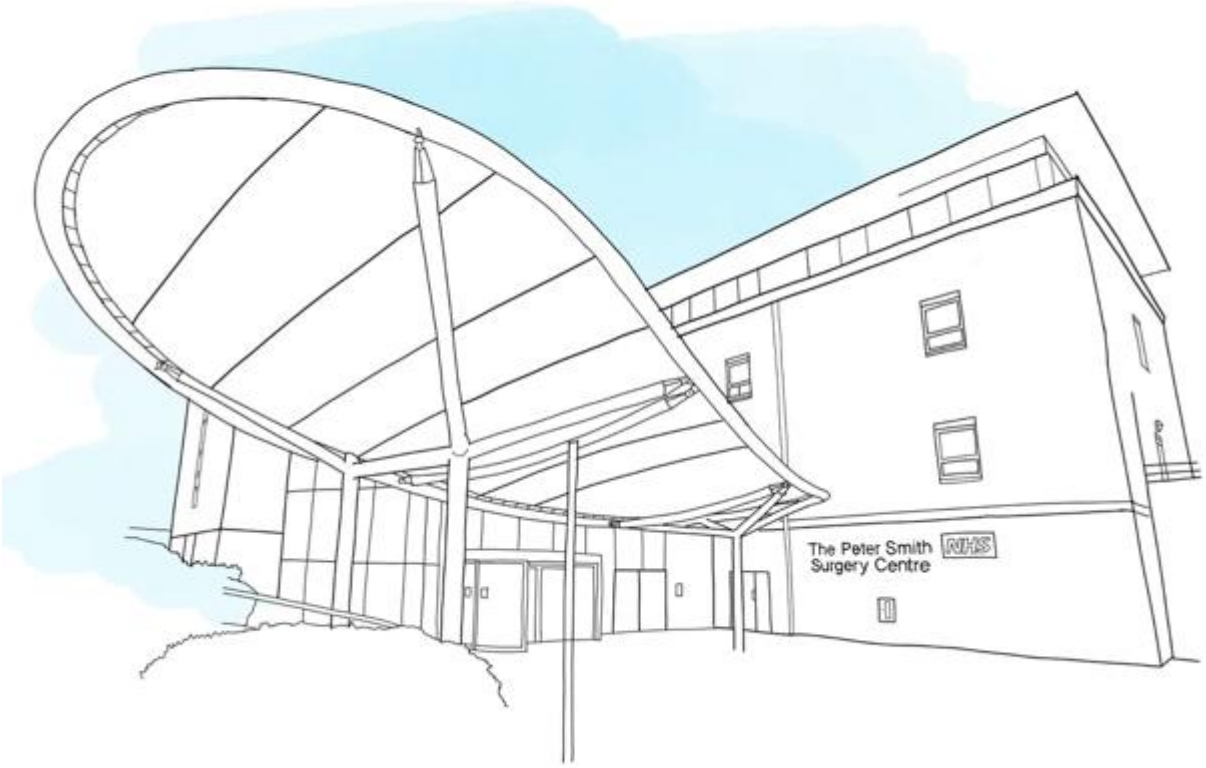
The NHS is required to be open and transparent about the quality of services provided to the public. As part of this process all NHS hospitals are required to publish a Quality Account (The Health Act 2009). Staff at the Trust can use the Quality Account to assess the quality of the care we provide. 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 2024/25.
- Outline the quality priorities and objectives we set ourselves going forward for 2025/26.



Part 2
Quality Priorities



2. Priorities for Improvement

2.1 Reporting back on our progress in 2024/25

In our 2023/24 Quality Account we identified 12 quality priorities that we would focus on. This section presents the progress we have made against these.

PATIENT EXPERIENCE:

Priority 1: We will reduce the waiting times for patients

- What did we say we would do?
- We will reduce the waiting time for people needing an elective operation so that no patient will wait more than 52 weeks.
- We will reduce the waiting time for people in our emergency department (ED).
- We will achieve 62 days' time to first treatment for patients with cancer for no less than 70% of patients.

- Did we achieve this?
- There were 0 patients waiting greater than 52 weeks for their treatment by end of March.
- 1.2% of patients spent >12 hours in ED in March. This is a 6.8% improvement versus the previous 11-month average, that peaked at 15.8%.
- We have consistently achieved over 70% throughout 24/25 for patients waiting 62 days for treatment on a cancer pathway.

- How we achieved it:
- Working closely with clinical colleagues, increased our throughput in outpatient clinics and theatres to reduce the waiting times for patients.
- Improved on our productivity metrics to enable more patients to receive treatment.
- Established elective care transformation programmes to focus on improving our elective pathways.
- A change to using 12-hour time in the ED took place in February 2025. This change allows the flow of patients from ED in time order, creating a standard process to admit patients, instead of using the 12-hour decision to admit where patients were admitted out of sequence. The process still allows for clinical priority of patients should this be required. The urgent and emergency care dashboard was amended to display the new times and patient flow meetings were amended to ensure both oversight and governance. Since the change, the number of patients waiting over 12 hours from arrival into the ED has significantly decreased, March 2025 having 71 patients (0.72%), over 12 hours compared to March 2024 and 362 patients (3.63%). This improvement continues into April and plans are progressing to reduce from 12 hours in department on phased basis down to 10 hours.
- Partly because of the work described about 12-hour time in department and wider pieces of work to improve flow and reduce long waits in the ED, the performance against the 4-hour standard has started to improve, with Q4 of 2024/25 reaching 73.14% against a target of 78%, up from both Q2, 71.53% and Q3 68.78%.

- Worked with key stakeholders across the Trust and external NHS organisations to identify barriers and overcome challenges to decrease the length of wait for patients on a cancer pathway.

- Appointed a new Associate Medical Director for Cancer Services to lead the cancer improvement agenda.

Evidence of achievement:

- Reduction in the number of patients waiting over 52 weeks for treatment.
- Reduction in the number of patients waiting in the ED.
- Consistent achievement of the 62 day cancer standard.

Next steps:

- Refresh our elective care transformation programme to further reduce the length of time our patients wait for treatment with an ambition to return to constitutional standards over a phased period of time.
- A review of the model of care across Urgent and Emergency Care is underway with plans progressing to improve performance to reach at the 78%.
- Establish a clinically led Cancer Board to continue to improve cancer waiting times and quality of care across all standards.

Priority 2: We will work with our teams to improve the experiences of people with a learning disability or neurodiversity

What did we say we would do?

- Raise awareness of learning disabilities and neurodiversity to improve the healthcare outcomes and reduce health inequalities for this group of patients.

Did we achieve this?

- Partially in relation to learning disability awareness.

How we achieved it:

- Learning disability awareness training is now mandatory within the trust through ESR e-learning and is also available face to face on request. There are now two learning disability specialist nurses within the trust to improve the experiences of access to healthcare by providing specialist support and implementing reasonable adjustments.

Evidence of achievement:

- 66% of employees have now completed the learning disability awareness training.
- Quality check of the learning disability acute specialist service highlighting the importance of having input compared to no input.

Next steps:

- Continue to implement changes recommended by the quality check of the service including the referral process, access to our service and proactive approach in ensuring all patients

with a learning disability have access to our service. Continue to encourage all members of staff to complete the learning disability mandatory training.

Priority 3: We will strengthen the use of the Carer's passports within the Trust

➢ What did we say we would do?

- Ensure that carers who wish to use a carer's passport can access the information relating to passports.

➢ Did we achieve this?

- Yes.

➢ How we achieved it:

- A "mini audit" was conducted in August 2024 regarding the current carer's passport and its usage across the organisation. The results showed that it was being used by most areas but not to its full extent. Work was started in November 2024 to revamp the carers passport.
- A new carers leaflet was produced to give to carers when a carer's passport is issued.
- Also, a new audit form was produced to enable the team to collect information on carers passport usage, and a carers feedback form to give to carers when a patient is discharged.
- The new proposed documentation was taken to the November 2024 and March 2025 Nursing and Midwifery Professional Forum, and meetings were held with the Matrons to provide the Business Units with the updates and to share the information of the relaunch of the carer's passports with their teams. News on the relaunch and changes were shared with the Comms team.

➢ Evidence of achievement:

- All wards have a 'Yellow Box' which contains all the resources and up to date information to give to carers. The Patient Experience Team have disseminated these and provided the relevant information to teams.

➢ Next steps:

- Collection of audit and feedback forms on a monthly basis to ensure monitoring and support quality improvements of the carer's passport.

STAFF EXPERIENCE:

Priority 4: We will improve the way we listen, act upon and learn from concerns

➢ What did we say we would do?

- Develop a network of freedom to speak up (FTSU) champions across a diverse range of staff groups.
- Develop and share the FTSU vision and strategy across the Trust

➢ Did we achieve this?

- Partially – we have completed training of 30 FTSU champions across a diverse range of staff groups. The FTSU Strategy has been delayed due to the Trust strategy being under review. The FTSU Strategy will have a section / chapter in the new Trust Strategy. Liaising with leads on the Trust strategy project.

➢ How we achieved it:

- We undertook advertising the FTSU Champion role, volunteers went through an interview process and were then appointed. They undertook training of role and responsibilities and now support as active FTSU Champions with ongoing meetings to share information and continued development.

➢ Evidence of achievement:

- New posters now circulated throughout Trust with all FTSU Champions advertised for support.

➢ Next steps:

- FTSU Strategy will be developed in partnership with the Trust strategy.
- To continue to embed the FTSU Champions across the Trust to support the FTSU Work.

Priority 5: We will implement the culture programme

➢ What did we say we would do?

- We will introduce a zero-tolerance campaign as part of the culture programme.

➢ Did we achieve this?

- Yes.

➢ How we achieved it:

- Subgroup set up to look at projects to support zero tolerance of bad behaviours in the workplace and ensure ICORE values are adhered to.

- We successfully achieved several projects within this group including signing of the Sexual Safety Charter and development of the sexual safety policy, alongside education and training for sexual safety and active bystander training.
- There was also a similar format followed for racial discrimination with already having signed Anti-Racism Charter we made changes to the Bullying and Harassment policy in with zero tolerance and support for the staff raising concerns as well as training and education of over 800 managers for show racism the red card and a program of bystander training.
- There has also been a zero tolerance poster champaign and a zero-tolerance intranet page to support staff to be able to get help, guidance and advice well as wellbeing information.
- Development of roadmap for raising concerns to make it easier for staff to be able to gain support not only from the FTSUG but from all key areas.

Evidence of achievement:

- Policies
- Posters
- Staff survey metrics to be monitored over subsequent years
- FTSU data analysis to see if staff
- Roadmap Document.

Next steps:

- Zero tolerance workstream will now continue to be developed and monitored as business as usual.
- Culture Board Program is being reviewed in line with Trusts other governance process review and will have a key function in continuing improvements with culture work across the Trust and improving experience for both staff and patients.

Priority 6: We will increase staff engagement

What did we say we would do?

- We will review the structure of the organisation and the governance arrangements to ensure that the clinical voice is input at the correct levels through the organisation.

Did we achieve this?

- Yes.

How we achieved it:

- A consultation to review the organisational structure took place, ensuring that all had an opportunity to share their views and ensure that clinical colleagues were consulted with to shape the restructure.
- Alongside this, the Clinical Strategy Group plays a clear role in consulting on decisions the Trust needs to make to ensure that the clinical voice is heard and involved in decision making.

Evidence of achievement:

- Changes to the structures are now taking shape following on from the consultation, such as Medicine and Community aligning, and AHP's falling within Clinical Support and Screening Services.

- Next steps:
- As with any corporate restructuring, this takes time to embed as teams work closely together who may not have previously, next steps will be to embed the new structures and support teams to work together effectively.

PATIENT SAFETY:

Priority 7: We will focus on safe staffing, including reducing the movement of staff between clinical areas

- What did we say we would do?
- We will use approved tools for all clinical areas in line with national requirements, making sure we are assessing staffing appropriately e.g. Birthrate plus, safer nursing care tool (SNCT), mental health optimal staffing tool (MHOST) etc.
- As vacancies in ward areas are filled, we will implement a system to monitor and record the level of movement between wards and departments.
- We will look for opportunities to adapt the workforce to the requirements of the patients.

- Did we achieve this?
- Yes.

- How we achieved it:
- We continue to use SNCT, MHOST, Emergency Department SNCT bi-annually as per National Guidance. This has been recently completed throughout the month of January. The community nursing safer staffing tool (CNSST) was paused by the national team to undergo a review period. This has now been re-launched and the organisation is planning to roll out the data collection at the beginning of May 2025.
- Monthly meetings in place to review, vacancies, vacancy control forms and update TRAC system. Rotational nurses are managed by the clinical lead for e-rostering for timely rotation. Internal transfer policy under review. SafeCare live system is used to monitor nurse staffing re-deployments to manage shift by shift safe staffing levels.
- Nurse staffing establishments are reviewed using acuity and dependency metrics from evidenced based tools such as SNCT, MHOST etc, within a triangulated approach to recommend a safe and appropriate skill mix, presented to the Chief Nurse and Trust Board for assurance.
- Education delivered to all areas involved in the biannual data collections on using the evidence-based tools, training concludes with a short test that demonstrates understanding of the care descriptors. Daily communication with department managers throughout the data collection period and senior nurses conduct weekly visits to areas for validation of the data collection. Completed data sets discussed in a collective group to evaluate and discuss data, and professional discussion.
- Vacancies are discussed and authorised within the service line, with additional discussion and authorisation with the Chief Matrons, and Deputy Chief Nurse. Internal transfer policy is being reviewed and to flow through the Nursing and Midwifery Workforce Group for ratification. Training for registered staff on the SafeCare live system for actioning redeployments.

- Effective and efficient bespoke rostering training provided for staff working within patient facing services. Utilisation of SafeCare live to actively redeploy staff to ensure staff are with the right areas at the right time with the right skills to meet the acuity and dependency demands of the patients. Roll out of team-based rostering to 50% of ward-based areas to enhance patient experience and autonomy of staff.

Evidence of achievement:

- Data collections, presentations and board papers
- Meeting minutes

Next steps:

- Present the findings throughout the year, continue with subsequent data collections including finance to amend budgets to match patient needs and ward structures
- Continue with governance over recruitment where applicable advertising internally first. Review and evaluate staff and patient feedback as well as sickness absence and retention figures, adapt according to lessons learned.
- Utilisation of systems to monitor the deployment of the right staff in the right place at the right with the right skills.

Priority 8: We will implement our Patient Safety Incident Response Plan (PSIRP)

What did we say we would do?

- We will develop the six identified workstreams (falls, pressure damage, digital, maternity, infection control and medicines management).

Did we achieve this?

- Partially.

How we achieved it/ Evidence of achievement:

- Each of the workstreams have been developed and are currently progressing at varying levels.
- Each identified workstream has a lead and working group reviewing and working through areas of improvement raised through Inphase and our patient safety agenda, the aim of these groups is to triangulate learning from incidents and identify trends, themes and suitable actions / steps to improve.
- These groups then currently feed via cycles of work to our executive led learning panels to ensure identified learning is shared across the trust.
- Each workstream is led by a subject matter expert and feeds into our revised governance structure with information from each workstream providing assurance to our executives of work being carried out to improve and learn from the care we are delivering to our patients throughout the Trust.

Next steps:

- Further work to embed PSIRP and the identified workstreams across the trust as we build on our expertise and understanding of the patient safety agenda. Through 2025/26 we would like to expand on how we share learning throughout the trust and strengthen these workstreams to enable us to learn more widely and share themes are trends across all areas of the organisation. Further work to build on our suite of data matrix from our newly

embedded patient safety incident reporting system. We would like to expand on how we triangulate raised concerns with our quality matrix and further strength our suite of intelligence to continue to positively influence the care we deliver.

Priority 9: We will improve the safety of patients with mental ill health in the acute setting

➢ What did we say we would do?

- We will identify a programme of work to improve our management of mental ill health, not just in our older persons' mental health team, but across the Trust.
- Engage in national cultural work around mental health.

➢ Did we achieve this?

- Yes.

➢ How we achieved it:

- All Matrons and Ward Managers across the trust received training on the Mental Health Act and the importance of ensuring the safety of patients detained under this legal framework.
- Ongoing work to improve the awareness and application of treating patients under the Mental Capacity Act.
- Improved relationships between Older Persons Mental Health Team and the acute site through working together and networking to provide advice and guidance on supporting patients who present with mental illness.
- Established the Violence Reduction Group where there will be a focus on understanding the antecedents to patients' behaviours which may be violent / aggressive.
- Audit of the use of restrictive interventions including rapid tranquilisation and restraint.
- The Older Persons Mental Health Service is year 1 into a 2-year national programme called 'The Culture of Care' Programme, which is a quality improvement programme to improve the culture on mental health inpatient settings. Where relevant to the acute setting, the learning from this programme is shared.

➢ Evidence of achievement:

- Numbers of staff trained in Mental Health Act awareness training.
- Numbers of staff trained in Mental Capacity Act training.
- Case studies where patients have received a better service / outcomes because acute staff have been supported by mental health staff.

➢ Next steps:

- This work will continue to be built upon with the launch of the Mental Health, Learning Disability and Autism Strategy for the Trust which will outline the commitment from the Trust to ensure all patients receive care that is safe, appropriate, equitable and personalised to their needs.

CLINICAL EFFECTIVENESS:

Priority 10: We will undertake improvement work around the safe processing of clinical results

➢ What did we say we would do?

- Building on the workshop held in 2023 we will undertake further work to review the processes for managing all results on the ICE system.

➢ Did we achieve this?

Yes.

➢ How we achieved it:

- A Task and Finish Group was established in August 2024 assigned to the development a high-level trust policy for managing clinical results specifically for radiology, cellular pathology and endoscopy.
- The group mapped and scoped out all current specialties and MDTs who are responsible for the management of radiology red flag alerts, had discussions with key stakeholders within radiology, business intelligence team, ICE system manager and reviewed existing compliance reports for managing results.
- Progress presented to Clinical Strategy Group (CSG) in November 2024 for initial comment followed by workshop at CSG timeout in December 2024.
- Consultation took place on proposals on key changes to the existing process and the final policy was presented back to CSG in February 2025.

➢ Evidence of achievement:

- The Policy was approved at Policy Review Group and Gateshead Health Leadership Group in February and March 2025 respectively with an agreed six-month implementation period, prior to the policy going live.

➢ Next steps:

- Communication Strategy to be agreed to share the changes with the organisation including screensavers, messages in various bulletins, presentation to multiple forums and training sessions.
- Attendance at key speciality meetings to support the development of local level standard operating procedures.
- Compliance monitoring reports to be developed and agreed processes for escalating areas of non-compliance.
- Go live in September 2025.

Priority 11: Improve communication with primary care partners

➢ What did we say we would do?

- We will reduce the duplication of GP handover forms.
- Improve the efficiency and quality of discharge letters.

➢ Did we achieve this?

- Partially

How we achieved it:

- The Trust were aware of the recurring issue of duplicate GP handover forms being sent to practices, ongoing since Q3 2022/23 .
- Although the frequency of reporting by practices of these duplicates has decreased from its peak, they continued to generate a significant number of incidents, reflecting a systemic problem within the documentation and discharge communication processes, particularly affecting Queen Elizabeth Hospital. As well as increasing workloads for practice staff, these duplicate discharge summaries are a patient safety risk. This is Trust Wide issue.
- In Q3 2024/25, the Trust facilitated a two-day workshop with pharmacists, clinicians, digital and primary care colleagues to look at the potential solutions to the problem. Following the workshop a standard operating procedure for separating the prescription and the letter to help prevent multiple copies being sent. This was rolled out across the trust at the beginning of March 2025.
- Updates to the GP handover template were made to incorporate regionally agreed standards to support clearer communication with GPs.

Evidence of achievement:

- SOP in place and new process to try to eliminate the duplication.
- Business intelligence (BI) reports in place to identify where GP handovers have not been sent which allows ward to track.

Next steps:

- Track the impact of the change by reviewing the number of incidents raised by GP practices in relation to duplicate GP discharge letters.
- Track impact of the changes using BI report and target for further education.

Priority 12: Following the introduction of a suite of ward-based quality metrics, we will continue to improve the use of data to drive improvements in patient care at the front line

What did we say we would do?

- Develop the dashboard of quality metrics currently being used in ward areas to include community and other outpatient areas.

Did we achieve this?

- Yes.

How we achieved it:

- Building on our suite of metrics and dashboards our quality metrics provide us with vital oversight of the care we are delivering across all acute wards, older persons mental health and community services. We use this information to provide assurance on our care standards. The utilisation of these metrics across our professional forum also allows us to identify areas of improvement and collaboratively we are able to provide additional support where needed to address any improvement work required, we can then monitor improvements via the metrics and reassess intervention impact.

Evidence of achievement:

- The quality metrics are collated and reviewed monthly at our nursing professional forum.

Next steps:

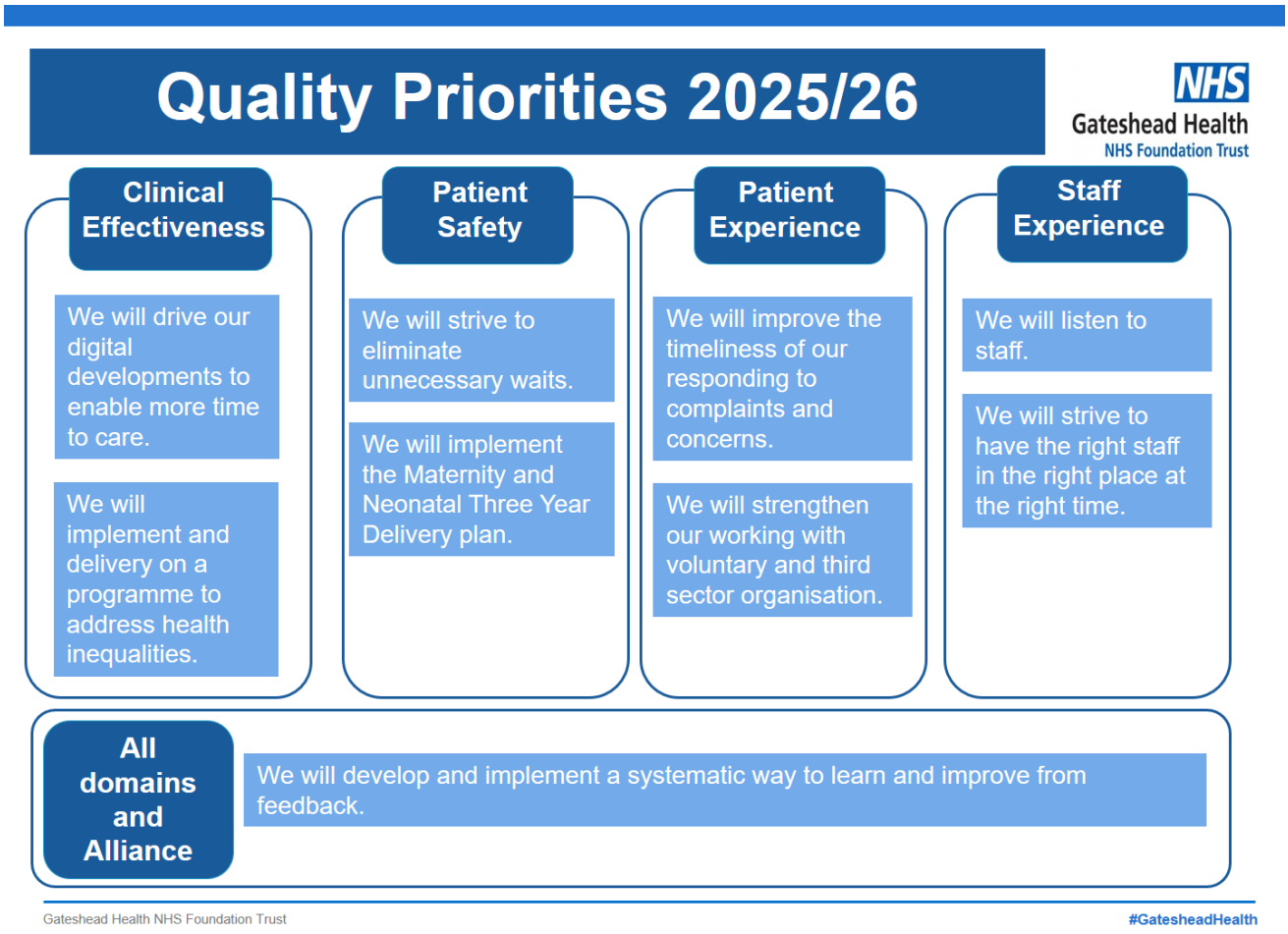
- Throughout 2025/26 we plan to further expand the quality metrics utilising these to help guide further improvements and to monitor care provision across the trust.

2.2 Our Quality Priorities for Improvement 2025/26

We have engaged with our partners and stakeholders to understand what the quality account priorities should be for 2025/26. It was agreed that we should continue to define our priorities under the four headings of:

- Patient experience
- Staff experience
- Patient safety
- Staff experience

Further to this, research, improvement and learning will flow through every part of our organisation, informing practice and enhancing outcomes. The table below shows our Quality Account Priorities for 2025/26 in summary form:



The table below shows the quality account priorities in more detail detailing how they will be measured and monitored.

PATIENT SAFETY				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will strive to eliminate unnecessary waits, to ensure patients receive timely care and experience better outcomes.	Reduce non-elective length of stay	Plan in under development and held within the Divisions	Reduce non-elective length of stay, aiming for 6.8 days by March 2026 (note some specialities are excluded such as Maternity and Older Persons Mental Health in line with National Planning Guidance)	Non-Elective LOS (total number of non-elective bed days divided by number of non-elective patients) measured via the plan monitoring reports
	Percentage of patients who are in ED for 12 hours or less (type 1 – this is Queen Elizabeth Hospital Emergency Department)	Plan in under development and held within the Divisions	Less than 0.2% of total type 1 attendances will be in the Emergency Department for more than 12 hours	% of patients who are in ED for 12 hours or less (Type 1) (number of Type 1 attendances in department for less than 12 hours divided by the total number of Type 1 attendances) measured via the plan monitoring reports
	Access to diagnostics (DM01 % monthly return patients waiting less than 6 weeks for a diagnostic)	Plan in under development and held within the Divisions	We are aiming for 99% of patients waiting less than 6 weeks for a diagnostic (on average) across the Trust by March 2026 (based on the tests that are included on a National monthly submission called the DM01. For	DM01 % patients waiting less than 6 weeks for a diagnostic (number of DM01 patients waiting under 6 weeks divided by number of DM01 patients waiting) and this is measured via the plan

			transparency these tests are: MRI, CT, non-obstetric ultrasound, colonoscopy, flexi sigmoidoscopy, gastroscopy, echocardiography, DEXA and audiology	monitoring reports
	General and Acute Bed occupancy	Plan in under development and held within the Divisions	92% across the year	General and Acute bed occupancy (number of occupied General and Acute beds divided by the number of open General and Acute beds) measured via the plan monitoring reports
	Time for diagnosis (Cancer 28-day Faster Diagnosis Standard)	Plan in under development and held within the Divisions	We are aiming to exceed the national standard that is set at 80%, and are planning a higher standard at 84% by March 2026	% of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days (number of patients diagnosed or ruled out within 28 days divided by number of patients referred) measured via the plan monitoring reports
We will implement the Maternity and Neonatal Three-Year Delivery Plan, to improve safety, equity, and the quality of care	We will implement a delivery plan based on national guidance which sets out	Benchmarking and progress towards compliance with this plan will be completed and reported quarterly	Achievement of the delivery plan.	We anticipate that a template for reporting will be forthcoming from NHS England/ICB and that this report

for women, babies and families.	how the NHS will make Maternity care safer, more personalised and more equitable, with twelve objectives identified based on four high level themes: • listening to women and families with compassion. • supporting our workforce to develop their skills and capacity, • developing and sustaining a culture of safety, and • meeting and improving standards and structures	to the council. This report will provide evidence and assurance that the Maternity service is working towards achievement of all the actions and that the service will escalate any problems or support required to enable compliance.		will be aligned with national requirements. Outcome measures will be identified for each element of the twelve priorities.
CLINICAL EFFECTIVENESS				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will drive our digital developments to enable more time to care, and therefore a better patient experience	Care planning	Review activities of daily living and develop a standardised care plan, with additional elements that can be added based on patient needs/ clinical presentation	To generate a standard of care plans across all wards, and for this to be in line with the Professional Records Standard Body (PRSB)	Care planning using the new format in place on Nervecentre on all inpatient wards.
	Record keeping/noting	A standardised approach to clinical record keeping/noting will be developed and implemented.	A standardised approach will be in place. This will be one single source of truth for acute settings.	Standardised record keeping will be in place on all inpatient wards.

		The specific clinical platform is to be confirmed.		
	Observations	Introduce onto Nervecentre two new Observations elements 1. Neuro obs, which we will do in line with NICE guidance such as post falls; and 2. MEWS Observation charts, for use in non-obstetric settings across the Trust for pregnant patients/those immediate postpartum	Standardised approach to recording specific obs e.g. neuro obs post falls, enabling better clinical oversight across the Trust.	Standardised recording of specific observations will be in place on Nervecentre on all inpatient wards.
We will implement and deliver on a programme to address health inequalities, so that all communities can access fair, high-quality care and achieve better health outcomes.	Making every contact count (MECC)	Roll out of MECC across the trust according to regional and national implementation frameworks, starting in clinical areas identified as priorities	12m implementation and roll-out	• Numbers of staff trained • Numbers of staff self-reporting delivery of MECC against baseline • Patient feedback, case studies
		Training of clinical and non-clinical staff in MECC	Improved Business as Usual where all patients, staff and visitors are offered person-centred conversations around what matters to them and their health	
		Delivery of effective MECC conversations to patients, visitors and staff		

	Health literacy	Use the NHS Standard for Creating Health Content to evaluate baseline position of patient-facing communications and make plans for improvement	A revised process for reviewing patient information leaflets, through a health literacy lens Improved Business as Usual where Trust services are easily navigable for all patients	• Number of patient information leaflets that have been reviewed through a revised health literacy process • Number of new outpatient letter templates available, that are signed off from a health literacy perspective • Reduction in the number of patients who Did Not Attend (DNA) and Were Not Brought (WNB) to appointments • Improved Access, Experience and Outcomes for patients • Improved efficiency in OPD • Patient feedback
		A quality improvement pilot project to review and redesign outpatient appointment letters	Revised outpatient letter templates will be piloted and consideration of roll out across the Trust Improved Business as Usual where Trust services are easily navigable for all patients	
	Reasonable adjustment flags	Implement a flagging system on existing clinical platforms to capture patient needs accurately	Patients will receive reasonable adjustments in care	• Number of patients with reasonable adjustment flags on clinical records • Patient feedback

		Train staff to recognise and act on individual requirements	A centralised resource hub will be in place, with access to training resources	• Number of training resources available • Staff feedback
	Equitable elective recovery	Detailed interrogation of trust data of Did Not Attend and Was Not Brought to outpatients' clinic data	We will better understand our data as well as the reasons patients miss their appointments We will work with clinical teams and communities to understand barriers and enablers to access to outpatients and design and implement solutions	• Reduction in the number of patients who Did Not Attend (DNA) and Were Not Brought (WNB) to appointments • Improved Access, Experience and Outcomes for patients • Improved efficiency in OPD • Reduction or reversal of worsening health status of patients waiting for elective procedure • Reduction in cancellation of surgery- improved efficiency of theatres • Reduction in bed days
		Strengthen the Gateshead Waiting Well offer	We will increase the number of pathways with a Waiting Well offer We will having a waiting well offer in place with specific health inequalities being targeted eg. those who live in areas of deprivation/ postcodes, lifestyle choices (including smoking)	
STAFF EXPERIENCE				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected outcome?**	**How will it be measured?**

We will listen to staff, to shape a culture where everyone feels valued, supported and able to deliver their best for patients.	We will improve communication and issues of communication moving concerns both up and down	Consistent, structured messaging through existing internal channels Empower managers to share and gather information in two-way conversations, with regular reinforcement through team briefings, CEO updates and Gateshead Health Weekly	Improved trust in leadership and greater staff engagement. Concerns are raised through the escalation routes (ie. forums) and acted on more effectively	• Staff survey results, feedback from teams briefings, volume and type of issues raised via communication routes (e.g. line managers, speaking up)
	We will develop and implement an improvement plan based on the themes that emerge from our staff survey results	Stopping incivility programme of work – encouraging politeness, respect, and tackling bullying and harassment, working closely with our staff networks, Staff Side partners and FTSU Guardian to promote a culture of civility and respect	Improved reporting of incidents which could influence staff survey results Improvement in WRES/WDES bullying and harassment metrics Reduction in grievance figures related to incivility Improvement in FTSU figures related to incivility	• Staff survey figures • Freedom To Speak Up (FTSU) quarterly figures • Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) metrics around bullying and harassment • Grievance and investigation figures
		Promoting engagement programme of work – raising awareness of Health and Wellbeing (HWB) support and	Improvement in staff survey figures related to health and well being Reduction in sickness absence	• In Month and rolling sickness absence figures • Staff survey

		helping staff stay well.		
We will strive to have the right staff in the right place at the right time, to enhance patient care and support a sustainable, high-performing workforce.	We will review our staffing models	Annual planning round Utilising the apprenticeship levy, supporting widening participation, role flexibility and redesign, different ways of working	Reduction in bank and agency usage Increase in apprenticeships for entry level roles	• Meet operational plan • Levy utilisation figures • Monitoring of workforce figures in line with planning round
PATIENT EXPERIENCE				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected outcome?**	**How will it be measured?**
We will improve the timeliness for responding to complaints and concerns, so that people feel heard, issues are resolved quickly, and trust in our services is strengthened.	We will implement a new complaints training package.	We will work with the Trust's Learning and Development team to develop a training package that aligns with PHSO Complaints Standards.	A training package will be in place. This is likely to be a one-day session.	Number of complaints investigators to successfully complete the training.
	We will review the effectiveness of our new Complaints and Concerns policy.	We will review the timeliness of completion of complaints responses in the old process and new process/policy.	There will be more complaints responded to in a timely manner and in line with Trust policy.	Number of complaints responded to in timeframe of Trust policy.

		We will evaluate the views and experiences of those who have used the Trust's new complaint process (both patients and staff).	Experiences of both patients and staff will be enhanced with the new complaints process/policy.	Feedback from patients and staff.
We will strengthen our working with voluntary and third sector organisations, to better meet the needs of our communities, support more holistic care, and help secure the long-term sustainability of our services	We are an anchor institution and will work with voluntary and third Sector Organisations	We will invite key partners to the Patient Experience Group to share insights, align priorities and build trust We will develop clear mapping of the VCS landscape in Gateshead by working with the ICB	Improved relationships and collaboration between health services and local VCS organisations Improved trust from patients and communities through a more visible, joined-up and community-driven approach	Number of VCS groups engaged in the planning and delivery of services Patient and community feedback via Healthwatch / Our Gateshead
ALL DOMAINS AND LINKS TO GREAT NORTH HEALTHCARE ALLIANCE COLLABORATIVE WORKING				
Quality Priority	**What will we do?**	**How will it be measured?**	**Expected outcome?**	**How will it be measured?**
We will develop and implement a systematic way to learn and improve from feedback, to continually enhance quality, safety and patient experience.	As an Alliance, we will work collaboratively to positively impact on patient and staff experience through Real-time patient feedback in Emergency departments	Agreed methodology across all four alliance partners, we will work with our ED department leaders and managers to understand how the patient feedback can inform continuous improvement and development of our leaders within ED.	Feedback on our approach to NHS Horizons to inform the future Modern Productive series. To have staff morale and patient satisfaction improve. Support the delivery of performance improvement. To get together as an Alliance to review the data and decide on collective action.	Staff satisfaction, patient satisfaction. Measured on the real-time patient feedback analysis and the trends
	We will develop and	We will identify and agree a	Cohort of people with lived	Number of times those with lived

	implement a strategy for how we bring in more people with lived experience to support in Trust planning and improvement.	methodology for engaging with people with lived experience to support the Trusts continuous improvement and transformation agenda.	experience who we can work with as a trust to help with codesign.	experiences are in working groups and workshops.
	We will strengthen the way we triangulate data through thematic reports which cross multiple portfolios and specialities, to demonstrate learning and improvement of services.	We will develop a continuous improvement and learning network across multiple portfolios that will identify through thematic reports what corporate improvements need to be supported with alignment to PSIRP/PSIRF.	Have a corporate improvement dashboard for transparency of a list of improvement project that align to the thematic reviews.	Through the number of active projects, closed, and through a benefits realisation approach.
	We will spread the learning from quality improvement projects across the trust e.g. the work conducted within the CDC regarding continuous improvement, daily huddles and encouraging staff to engage in collective action.	Promote QI projects and identify through the above QI and learning network how these can be spread across the organisation to create a continuous improvement culture within departments	Improved staff satisfaction better moral as staff own improvements, working towards a continuous improvement culture as business as usual	Staff survey results, number of departments we have spread learning from/to.

2.3 Statements of Assurance from the Board

During 2024/25 the Gateshead Health NHS Foundation Trust provided and/or sub-contracted 30 relevant health services. The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services. The income generated by the relevant health services reviewed in 2024/25 represents 96% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2024/25.

Participation in National Clinical Audits 2024/25

During 2024/25, 38 National Clinical Audits and five National Confidential Enquiries covered relevant health services provided by Gateshead Health NHS Foundation Trust.

During that period Gateshead Health NHS Foundation Trust participated in 95% of National Clinical Audits and 67% 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 2024/25, 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
National Audit - National Breast Cancer Audit	Yes	739 Cases submitted – no minimum requirement
National Diabetes Inpatient Safety Audit (NDISA)	Yes	5 Cases submitted – no minimum requirement
National Gestational Diabetes Mellitus Audit	Yes	402 Cases submitted – no minimum requirement
National Audit - National Pregnancy in Diabetes Audit	Yes	18 Cases submitted – no minimum requirement
National Audit - Paediatric Diabetes (NPDA)	Yes	140 Cases submitted – no minimum requirement
National Audit - Elective Surgery (PROMS)	Yes	Cases submitted - no minimum requirement Hips - 311 Knees - 403
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	12 Cases submitted – no minimum requirement
National Comparative Audit of Bedside Transfusion Practice 2024(Re-audit)	Yes	16 Cases submitted – no minimum requirement
National Comparative Audit of Blood Transfusion with NICE Quality Standard	Yes	9 Cases submitted – no minimum requirement

National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Yes	3 Cases submitted – no minimum requirement
Sentinel Stroke National Audit Programme (SSNAP)	Yes	193 Cases submitted (Not including Q4) – no minimum requirement
Care of Older People (Care in Emergency Departments)	Yes	226 Cases submitted – no minimum requirement
LeDeR	Yes	100% of Cases submitted
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	35 Cases submitted – no minimum requirement
National Audit of Cardiac Rehabilitation	Yes	486 Cases submitted – no minimum requirement
National Audit - National Chronic Obstructive Pulmonary Rehabilitation (COPD)	Yes	280 Cases submitted – no minimum requirement
National Audit - Adult Asthma (Secondary Care)	Yes	186 Cases submitted – no minimum requirement
National Audit - Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	182 (March 25 to be added) Cases submitted – no minimum requirement
National Audit - Chronic obstructive pulmonary disease (Secondary Care)	Yes	787 Cases submitted – no minimum requirement
National Audit of Care at the End of Life (NACEL)	Yes	80 Cases submitted – no minimum requirement
National Audit - Prostate Cancer	Yes	250 Cases submitted – no minimum requirement
National Audit - Neonatal Intensive and Special Care (NNAP)	Yes	100% of Cases were submitted
National Audit - Maternity and Perinatal Audit (NMPA)	Yes	100% of Cases were submitted
National Audit - National Audit of Dementia	Yes	78 Cases submitted – no minimum requirement
National Audit - National Cardiac Arrest Audit	Yes	70 Cases submitted – no minimum requirement
National Audit - National Lung Cancer Audit	Yes	213 Cases submitted – no minimum requirement
National Audit - National Heart Failure Audit	Yes	393 Cases submitted – no minimum requirement
National Audit - Oesophago-gastric cancer (NAOGC)	Yes	100 Cases submitted – no minimum requirement
National Major Trauma Registry (NMTR) / (TARN)	Yes	103 Cases submitted to date with 228 cases awaiting upload due to site downtime
National Audit - National Hip Fracture Database	Yes	318 Cases submitted – no minimum requirement
National Audit - Falls & Fragility Fractures Audit Programme (FFFAP) Inpatient Falls	Yes	19 Cases submitted – no minimum requirement
National Audit - Cardiac Rhythm Management	Yes	111 Cases submitted – no minimum requirement

National Audit - National Joint Registry (NJR)	Yes	887 Cases submitted – no minimum requirement
National Audit - National Emergency Laparotomy Audit (NELA)	Yes	176 Cases submitted – no minimum requirement
National Audit - Case Mix Programme (ICNARC)	Yes	850 Cases submitted – no minimum requirement
National Audit - Bowel Cancer (NBOCAP)	Yes	172 Cases submitted – no minimum requirement
Inflammatory Bowel Disease Audit IBD Registry	No	Benefits of the audit did not outweigh the cost to participate.
National Diabetes Footcare Audit (NDFA)	No	Due to clinical commitments at present the teams do not have the admin support to enable data submission.

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 nine national clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2024/25, and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit of Care at the End of Life

The Trust maintains high standards of end-of-life care on the acute site, as evidenced in this and previous rounds of national audit. We are able to evidence our commitment to the five priorities of care of the dying person, however this audit also highlights areas that require improvement. Many of these have been unchanged since the last round of the audit.

Case note reviews provide assurance that staff have the knowledge, skills and experience to recognise dying and this is clearly documented in case notes.

There is good evidence of the review and management of common symptoms at the end of life, but this does not reliably extend to the assessment, discussion and management of hydration and nutrition in the last days of life.

WellSky prescribing bundles support high standards of anticipatory prescribing and there is clear evidence of active decision making regarding; reviewing, starting, stopping and changing interventions as appropriate, however patients are often not involved in discussions and decisions about their care.

There is inadequate evidence that patients and those important to them have their emotional, psychological, religious, spiritual, social and practical needs assessed and supported.

Over 87% of bereaved relatives reported that they were communicated to by staff in a sensitive way and 75% felt staff behaved with compassion and had the skills to care for someone at the end of their life. Nearly 90% of surveyed staff report working in an area where there is a culture that prioritises compassion and support as fundamental in all interactions with dying patients and those important to them.

Despite consistently scoring higher than national averages in clinical care results derived from case note reviews and bereavement surveys, staff in Gateshead repeatedly report lower confidence levels than national comparators. Only 56% of staff have received training specific to end of life care in the last 3 years. Gateshead does have a comprehensive prospectus of training and education available to all staff, but end of life care training is not included in the induction programme and is only identified as priority training (not mandatory) for select staff groups.

Gateshead's specialist palliative care workforce is significantly smaller than national averages (per 100 beds) and is unable to staff the nationally recommended 7-day face-to-face service. The Trust is also yet to develop end of life volunteer service – an initiative that is now in place in one third of acute Trusts in England.

In this round of the audit, NACEL enquired about mechanisms in place within organisations to identify patients who may be from minority communities or vulnerable groups. There is scope to improve this in Gateshead.

Action Points:

- Dissemination of the headline results to patient-facing staff.
- The re-establishment of an introduction to palliative and end of life care within Trust Induction for all staff.
- Mandatory completion of level 2 or 3 training (unregistered patient-facing and registered patient-facing staff respectively).
- Clinical staff in specialist or senior roles to complete foundation and advanced palliative care training, and advanced communication skills training.
- Development of a 7-day specialist palliative are nursing service (as per 2023 pilot and business case).
- Development of an end of life volunteer workforce.
- Awareness of the vulnerability of the current out-of-hours specialist palliative care advice model (loss of which would require consideration of the expansion of the specialist palliative care consultant workforce to provide alternative OOH support).
- Consider whether Gateshead currently does enough to identify and support those from minority or vulnerable groups.

The Case Mix Programme (CMP)

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

In the past 12 months the Critical Care Unit has uploaded data on approximately 850 patients to the CMP. Data uploads (via Platform X) are being performed on an approximately weekly basis. CMP/ICNARC continue to publish Quarterly Quality Reports (QQR) for each individual critical care unit. Our most recent QQR, including data for Q3 24/25 shows good performance in all areas, with no measures showing performance worse than comparable units, and strong performance in some areas including potential mis triage to the ward, unplanned readmissions, delayed admissions and unit acquired infections in the blood. Our overall standardised mortality rate was slightly below what would have been expected (17.2% v 18.7%), and mortality for patients with a low predicted mortality was very low.

We continue to use Medicus software for data collection and this continues to be update when required. A link for lab results to be directly transferred into Medicus has come online and has significantly reduced the amount of data collection required in severity scoring. We are expecting an update of Medicus in the next month which will improve our infection data collection and simplify our data submission to the ICCQIP ICU bloodstream infection system.

Our data completeness remains excellent, with around 100% data completeness for all quality measures and very high levels of completeness for patient data. Our timeliness of data submission to ICNARC also remains excellent.

In the past month we have started contributing data to the ICNARC Cardiogenic Shock Module which is a separate data entry system focussing on patients admitted with

cardiogenic shock. We have submitted data on 6 patients so far and anticipate somewhere between 2 – 6 patients per month. We do not expect to get any performance data from this for at least a year.
In the past year we have also started submitting our ICNARC data into the North of England Critical Care Network. They have set up a centralised server collecting anonymised data from all critical care units in the Network and are using this to produce unit and network reports on a monthly basis which mirror the ICNARC Quality reports but are available much more quickly. We have been involved in the development of these reports by sense-checking the data and suggesting changes. Our ICU data clerk and Consultant lead for ICNARC are both heavily involved in the Network Data group which focusses on ICNARC data submission and quality.

Action Points:

- Continue to collect and submit data to Intensive Care National Audit and Research Centre (ICNARC)/CMP and to the Cardiogenic Shock Module.
- Continue to work with Medicus to complete update with new 'Infections' module.
- Ongoing education of ward clerks and Nursing/Medical staff regarding the correct entry of data, assisted by the ICNARC data clerk.
- Continued consideration of the ICNARC data clerk role becoming a full-time role to allow more data collection to occur e.g., quality measure data, etc.
- 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.
- Work with the Critical Care Network to ensure quality of Network reports.
- Continue to contribute to the Critical Care Network data group.

Myocardial Ischaemia National Audit Programme (MINAP)

This audit reviews the quality of care and management of patients who present with pain chest that is deemed to be cardiac in origin (Acute Coronary Syndromes). We continue to contribute to this audit on a monthly basis ensuring that the targets set within the audit are achieved. This then ensures that patients receive the most appropriate care and that this is evidence based. This enables the Trust to continue to maintain a high level of performance in patient management across key standards. This is then measured against other trusts within England and Wales and the results are then made available to us and to the public. Our aim is to continue to provide and maintain a high standard of care and more importantly, personalised care.

Action Points:

- We need to ensure consistency of input to the MINAP proformas, collaborating with the IT and the Medway system who advise of any concerns which are then reviewed. This is maintained by the Cardiology team and the value of this information can be cascaded to other members of the Cardiology team. The Cardiology Team within cardiology ward works hard to ensure smooth patient flow and appropriate placement within the hospital, thus ensuring appropriate evidenced based care. Information within the proformas is easily accessible to all and can therefore help with patient care. We will continue to participate in the annual data collection programme

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. From 2020/21 the data quality audit was extended to include ankle, elbow and shoulder cases.

Action Points:

- The Trust will continue to contribute to these audits and was awarded the Gold Quality Data Provider Award for 2024.

National Dementia Audit (NAD)

The NAD examines aspects of care received by people with dementia in England and Wales. The audit is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England/NHS Improvement and the Welsh Government as part of the National Clinical Audit Programme.

Round 6 of NAD collected date between August 2023 and January 2024. The audit was open to all general and acute hospitals in England and Wales providing acute services on more than one ward, which admits adults over the age of 65 years.

Participating hospitals were asked to complete:

Action Points:

- Prospective identification of people with dementia, or suspected dementia, admitted to the hospital for more than 24 hours from 14th August 2023 and 10th September.
- Case note audit of the first 40-80 patients (including delirium screening and assessment, pain assessment, discharge planning and discharge information)
- A survey of carer experience of the quality of care
- Annual dementia statement (ADS) from each hospital, requiring data submission of hospital level information relating to training, resources and planning care.

National Hip Fracture Database (NHFD)

The Trust continues to input data into the NHFD which records several clinical parameters for patients admitted with a fracture of either the neck or shaft of Femur.

For the year 2024 we continue to perform at a high standard being ranked third overall in the UK, and best in the Northeast of England, for attainment of Best Practice Tariff (BPT) covering several key benchmark performance areas.

We scored in the top quartile nationally for time to admission to the orthopaedic ward and prompt orthogeriatric assessment and while our overall performance rose from 87% to 89.4%.

Our main reason for failing BPT remains to get patients to theatre promptly, but this is often due to factors outside our control such as the patient being too unwell initially. Every BPT failure is discussed in the Orthopaedic SafeCare Group with learning points identified and an InPhase report completed in each instance.

Our incidence of inpatient hip fractures has risen slightly from 4.7% in 2023 to 5.3% in 2024 and each such case is reviewed as part of our participation in the National Audit of Inpatient Falls (NAIF).

Our incidence of inpatient-sustained pressure damage (in which we have been an outlier in previous years) remains low and below the national average in this area. We have an excellent orthogeriatric team who work hard to ensure all patients are reviewed within BPT criteria even over holiday periods.

Action Points:

- We will continue to discuss all hip fracture cases that fail BPT in the Orthopaedic SafeCare Meetings and complete InPhase reports. We will continue our efforts in evaluating inpatient falls and monitoring for inpatient pressure damage.

PROMS National Audit

The Trust have continued to ask patients having elective hip and knee replacement to complete health score questionnaires before surgery then three months after surgery. The difference in pre and post operative scores are compared with other trusts and data compared with the UK national average.

Action Points:

- Continue to collect and submit data to the national proms audit programme

- Continue to share our data with relevant teams within the Trust

National Cardiac Arrest Audit

The Trust continues to provide data on a monthly basis to NCAA as part of our commitment to the scheme. Any emergency / 2222 call (outside of ED & ITU) is logged by either Wd 8 staff or DART as part of their role in responding to these calls. NCAA have recently changed the dataset required for each cardiac arrest which has necessitated the adoption of the NCAA data collection form (we are working with Digital Projects Team to make this a paperless process by using CareFlow instead of paper forms). The new dataset will allow NCAA to produce higher quality data relating to local and national cardiac arrest outcomes. We continue to receive regular reports from NCAA based on the data we provide.

Action Points:

- The HCA AIM & Fluid Balance training courses were well received but poorly attended. At the moment there are no plans for the Resus team to continue, the clinical education team may pick these up.
- We have introduced What 3 words location signs in car parks to better facilitate 999 response. Defib Guardians have been identified and trained in Basic Life Support and AED usage for specific areas within the Trust where response times may be delayed.

National Paediatric Diabetes Audit

Real time data is collected and reviewed locally 3 monthly by the diabetes team and 6 monthly by the regional NENC CYP Diabetes network. Quarterly data has also been submitted to the NPDA. We have submitted data on 140 patients to the NPDA 2024-25: 135 of these patients had Type 1 diabetes (3 patients have Type 2 diabetes and 2 patients have monogenic diabetes.) 85.1% of Type 1 diabetes patients are on insulin pump therapy (81.3% are on HCL systems); 14.9% are on an intensive multiple daily injection regime; 97.8% are on CGM (continuous glucose monitoring) with alarms. The overall health care completion rate is 98.6% (100% of patients had a HbA1C; 100% had a BMI; 98.2% had their thyroid function tests; 98.6% had a blood pressure; 98.6% had a urinary albumin; 94.6% had their feet examined; 95% were recommended influenza immunisation; 95% were given sick day rules advice, 95% had their smoking status screened; 98.2% had psychology screening (42 patients required additional psychology support)). 100% new patients had thyroid screening and 100% had coeliac screening within 90 days diagnosis, 100% newly diagnosed patients had dietetic support with carbohydrate counting within 14 days diagnosis.
Median HbA1C 57mmol/mol (mean 57.6mmol/mol)
HbA1C <48mmol/mol - 12.8% (prev 2023/24 15.2%)
HbA1C <58mmol/mol – 56.8% (prev 2023/24 41.6%)
HbA1C >69mmol/mol – 7.2% (prev 2023/24 21.6%)
HbA1C >80mmol/mol – 3.2% (prev 2023/24 6.4%)
This is an ongoing and significant improvement year on year. There is no significant inequalities gaps in access to technology or health care completion rates. There is a slight difference in median HbA1C in our ethnic minority children (58.5mmol/mol compared to 56.8mmol/mol.)

Action Points:

- 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.
- Raised concerns at ICB, regional and trust senior management level re lack of dietitian on CYP diabetes MDT and through the regional CYA GIRFT consultation which took place January 2025.

- There has been significant challenges within PDSN staffing. We are working with management teams to ensure that the PDSN staffing focuses on service delivery as per the BPT and national paediatric diabetes workforce recommendations.
- We are proactively encouraging and facilitating retinal screening in all our eligible young people with diabetes. An audit of local retinal screening showed duration of diabetes to be the main risk factor for retinal abnormalities supporting the need for intensive management from diagnosis and importance of offering access to all new patients to available immunotherapy trials. This is ongoing and the new NICE HCL TA also has a retinal screening pathway and we are currently doing an audit to identify patients who require catch-up screening and have linked with the local NHS screening providers to ensure the appropriate screening can be offered going forward to those young people who have commenced HCL therapy. The recent data shows a significant increase in the uptake of retinal screening reflecting this.
- 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 implementation of the NICE HCL TA.
- To continue to deliver ward staff diabetes training to enable the staff to offer safe optimal care including use of diabetes technologies to newly diagnosed patients and known diabetes patients with a diabetes related admission or any other illness.
- 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, primay 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. We have reinstated our transition meetings jointly with the adult diabetes team and engaged with the national Seamless transition program.
- There is a need for the MDT to continue to 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. We have updated the clinical data base to reflect changes in diabetes technology and to improve the timeliness of diabetes clinic letters to patients/families and primary care.
- We continue to value the voice of children and young people and their families in service delivery and improvements and are working towards an "Investing in children membership award"
- We are continuing to work with social prescribers following the Balance It 2 pilot program supported by the Child Health and Wellbeing network/ICB to support our children and young people living with Type 2 Diabetes or at high risk of developing Type 2 Diabetes to achieve a healthier weight and lifestyle.

The reports of 20 local clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2024/25 and Gateshead Health NHS Foundation Trust intends to take actions to improve the quality of healthcare provided. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of our services:

Business Unit	Speciality	Actions identified
Nursing & Midwifery	Safeguarding Adults	Enhanced Care (EC) & Deprivation of Liberty Safeguard (DoLS) compliance audit (495) The enhanced care matrix states that patients on level 2 and 3 EC require a DoLS application to be made. To ensure understanding of what a deprivation of liberty amounts to in practice, and that staff follow the DoLS safeguards and enhanced care policy; ongoing education and training is required. The compliance had improved from 44% in the previous audit to 55% this time, however this still equates to a significant number of patients without the necessary safeguards in place and does risk illegal detention of principles of MCA and DoLS are not adhered to. The results were forwarded to Matrons for their attention, to identify areas for improvement and to feedback to ward managers. Outcomes of audit are also fed back to staff during face to face MCA training sessions. Key Message – All patients on level 2 and level 3 Enhanced Care require a DoLS application to be made. Advice and educational materials are available on the Trust intranet
Clinical Support & Screening	Radiology	Compliance with Ionising Radiation (Medical Exposure) (480) Regulations and the employers' procedures with relation to the provision of an ICE request and the justification of all examinations in relation to the mini c-arm Between 24/4/24 and 24/10/24 there were 65 procedures performed on the mini c-arm and 12 requests were not generated in advance of the procedure resulting in 81.5% compliance. The audit results will be circulated to the lead orthopaedic consultant, theatre manager and theatre RPS. A meeting has been organised to discuss the current work instructions to establish if a change in process is required to ensure compliance is 100%. This will be discussed with staff at the theatre safe care meeting in November This will be a continual audit to ensure that an appropriate radiology request has been generated prior to the mini c-arm being used. Key Message – Appropriate radiology requests need to be generated prior to the mini c-arm being used.
Surgical Services	Anaesthetics	Epidural Audit (333) Epidural patient controlled analgesia is an option for post operative pain control which can have significant benefits but also increased risk for patients. We need to ensure our

		practice is safe and meets current local and national guidelines. The audit looked to assess the current epidural practice for surgical patients. Evaluate the duration of use, complications, effectiveness and level of patient satisfaction with pain control experienced. Results highlighted limitations in current levels of documentation. Documentation needs to be improved, especially motor block observations following line removal and all patients should receive the post epidural patient information leaflet. Documentation of aseptic practice for epidural insertion always fully documented, epidural remains the gold standard for post operative pain control following major abdominal surgery and pain scores demonstrated effective pain control for 27 of the 33 patients in this audit. Discussion on presentation of the audit results at anaesthetic SafeCare highlighted ongoing issues with staff training at ward level which was resulting in patients requiring longer critical care length of stay as ward staff felt they did not have the required skills to care for patients with epidural insitu. Increased education is required. Key Message - Current policy remains fit for purpose, staffing numbers at ward level remains an issue for discharge of patients with epidural back to their base ward from critical care. Patients being nursed in individual rooms on a ward level increases risk as visibility of patients by nursing staff is reduced. Continued teaching sessions, development planned for online epidural teaching session to facilitate easier access to education for ward staff.
Clinical Support & Screening	Radiology	Radiology Practitioner Audit (467) This audit reviewed documentation audit on the documentation for all plain imaging staff to ensure training documents are signed. As part of IRMER regs it is essential that all operators have completed essential training when using the equipment. It was evident when reviewing the documentation that 20% of documents were not present. It may be that these documents are present in the staff's personal files i.e. preceptorship files. As part of learning from the audit we will ensure a re-audit is taken and a plan to also have these documents viewable on the Radiology sharepoint as well as a physical paper copy. Key Message – training documents to be visible on radiology sharepoint as well as physical paper copy.
Surgical Services	Anaesthetics	Documentation of 'Prep, Stop, Block' for regional anaesthesia procedures (457) To ascertain if documentation of "Prep, Stop, Block" is being completed in line with national SALG guidelines for regional anaesthesia procedures. All regional anaesthesia procedures were reviewed over the course of one week.

		The audit demonstrated excellent levels of compliance with all standards being met. Key Message – Good assurance and to continue the high levels of documentation.
Surgical Services	Anaesthetics	Audit of local anaesthetic doses used for local anaesthetic joint infiltration in orthopaedic surgery (442) The background for this audit stems from a recent coroner's case report into a death involving a patient who had received a dose of local anaesthetic for joint infiltration that was beyond the recommended maximum dose, resulting in local anaesthetic toxicity. The audit measured what proportion of patients received an appropriate weight-based dose of local anaesthetic during joint infiltration in elective orthopaedic surgery. Key Message - The dose of local anaesthetic given for infiltration should be accurately documented.
People & OD	Occupational Health	Audit of National infection prevention and control manual for England: 1.10 Occupational safety: prevention of exposure (including sharps injuries) 2023 and Protocol for Occupational Health management of Sharps injuries and Blood Borne Virus Exposures (420) All aspects of care and practice assessed where excellent and 100% compliance was achieved in almost all areas. In 2 of the sample of 10 audited it was not documented whether a safety sharp had been used or not, staff will be reminded to explore this when processing sharps injuries in the future. Key Message – Please document whether a safety sharp has been used or not when processing sharps injuries.
Medical Services	Care of the Elderly	Adherence to NICE guidance Regarding VTE Prophylaxis in Patients with Acute Stroke on JASRU Ward. Immobility and comorbidities are risk factors for VTE, and stroke patients are therefore at high risk. (450) VTE prophylaxis is appropriately prescribed on the whole, particularly chemoprophylaxis. However, attention should be paid to prescribing VTE prophylaxis based on the weight of the patient, as 20% (4/20) of the patients in this audit had doses administered not appropriate for their weight. Three patients were underdosed and one overdosed. Every adult had doses given to them with the assumption that they were within 50-70kg. Some adults are 49.9 kg and below while some are above 70kg. None of the patients suffered any harm. Key Message – Patient's weight should be collected accurately when prescribing VTE prophylaxis, please do not assume all adults are within a certain weight range.
Clinical Support & Screening	Radiology	IRMER Audit (462) Compliance with the Employers Procedures regarding the exclusion of pregnancy Ionising radiation used for clinical imaging and other procedures may cause harm to an unborn child (foetus);

		therefore, it is essential that the pregnancy status is determined prior to any relevant medical exposure. The Employers Procedures set out the procedure that must be followed to establish if a patient may be pregnant. 100 patients were audited: Number of examinations documenting last menstrual period (LMP) 82 = 82% compliance, Number of examinations with scanned LMP form:78 = 78% compliance CT demonstrated good levels of compliance; however, x-ray and theatres are areas identified for improvement. Key Message: Pregnancy stats should be determined prior to any exposure, LMP should be documented and a LMP form completed and scanned
Surgical Services	Maternity	Cannulation compliance documentation (delivery suite) (428) An audit to understand compliance with documenting insertion/removal of a cannula and how frequently VIP scores are being completed. 45% (9/20) had cannula inserted documented, 0% (0/20) had cannula removal documented, 0% (0/20) had VIP score documented during admission. The compliance with physically inserting cannulas/removing and VIP scoring is likely not an issue as this would appear as patient safety incidents, however documenting to evidence it is. As the audit was observing the BadgerNet documentation evidencing the compliance. Key Message: All cannula insertion and removal should be documented, VIP scores should be undertaken and documented
Surgical Services	Maternity	Emergency Lower Segment Caesarean Section Audit (69) Overall improvement in decision to delivery timings for both grades of Emergency LSCS but grade 2 still below expected targets. This maybe be due to unavoidable delays or to inaccurate documentation. Key Message - We continue to ensure grade 2 Emergency LSCS's are performed in expected time frame and ensure correct grading is documented. Re-iterated to all staff in Departmental SafeCare meeting and daily safety huddle. Additionally, staff have had refresher training in Badger to highlight appropriate location of documenting clinical findings.
Clinical Support & Screening	Endoscopy	Urgent inpatients requests for Endoscopy (429) To determine whether the JAG standard of inpatients being scoped within 48 hours is being met. It was acknowledged that there is a lot of flexibility provided by both gastroenterologists (making themselves available to scope emergencies when not scheduled to be in the endoscopy unit) and the nursing team in providing endoscopy nurses to perform ad hoc procedures when a room does not have a booked list. Key Message - The booking team and nurse co-ordinator have been effective in utilising cancelled out-patient slots. It was accepted that patients would be best helped if

		access to urgent in-patient slots were available 7 days per week in the endoscopy unit.
Surgical Services	Trauma & Orthopaedics	Review of renal function post inpatient dose of IV zolendronic acid in patients with fractured neck of femur (401) To establish if there is any deterioration in renal function in those patients who have sustained a fractured neck of femur and are given IV zolendronic acid as part of their bone protection plan. Key Message - The audit confirmed from the 50 cases reviewed there was one case of acute kidney injury following IV zolendronic infusion and in that patient, there were other causal factors. Implications for practice are that the current use of IV zolendronic can be continued.
Clinical Support & Screening	Pharmacy	Unlicensed medicines (342) To provide assurance that unlicensed medicines are being procured, supplied, prescribed, administered, and recorded according to the principals of using unlicensed medicines defined in the Medicines management policy. The unlicensed medicine tag affects the automated ordering of products stocked in the Omnicell's. It had been removed from a few unlicensed medicines stored in the Omnicell. This stopped the EPMA / Pharmacy system prompting and collating the required records the point of administration and supply A review is being carried out into the order process to manage the resupply of unlicensed medicines stored in the Omnicell and have reinstated the unlicensed tag. Key Message – need to ensure unlicensed products are marked as unlicensed on the JAC/ Wellsky pharmacy and EPMA system and added to the trust approved unlicensed list.
Clinical Support & Screening	Endoscopy	Adenoma Surveillance (273) To review the ongoing surveillance of patients requiring colonoscopy because of previous polyps according to national guidelines. Colon Capsule pilot completed – not referring into this service. Continue to follow Guidelines as doing very well 92.5% compliant. Continue monthly validation of surveillance patients. Network with regional surveillance group to share practice and to improve and standardise surveillance procedures and protocols. Key Message - 92.5 % compliant with British Society of Gastroenterologists guidelines, poor bowel preparation, polyp not retrieved. Separate bowel preparation audit required to be carried out.
Clinical Support & Screening	Endoscopy	Endoscopy Mortality & Morbidity (26) Review cause and effect- for mortality and morbidity for patients undergoing an endoscopic procedure in the department. To examine complications, readmissions and mortality following upper and lower diagnostic and therapeutic endoscopy.

		Key Message - No implications for practice. No unsafe practice. To continue to do mortality and morbidity audit
Surgical Services	Gynae Oncology	Infection prevention and control adherence audit (413) Further education and training to reinforce best practices and ensure everyone is aware of the guidelines. Training has been given, and staff are aware of personal responsibilities. Key Message - Implemented visual cues with IPC posters and reminders in the clinical area. Encouraged peer accountability where team members feel comfortable to remind and support each other. More Dannicentres have been supplied and put outside of the patient's cubicles.
Medical Services	Palliative Care	Assessing delays in patient transfer from main hospital to St Bede's Unit (383) Staff handing over to ensure that sending ward have booked transport (or to prompt this if it has not taken place) Further exploration of the transport booking system to identify any features that could be more streamlined and speed up the process (currently under review) Key Message - Dedicated St Bede's mattress supply has now been sought. Reinforcement of importance of timely handovers to staff through education session
Community Services	Memory Assessment	Audit on waiting times, access to assessments, treatment and post-diagnostic support for people with dementia in Memory Assessment Services Including a check on suitability for disease modifying drugs. (319) Audit was presented locally to consultants and other medics. The findings have also been shared with all staff within the memory hub. Key Message - Further education available for staff if required, we continue to raise awareness amongst all staff involved in assessment of documentation standards.
Surgical Services	Maternity	Audit of domestic abuse within Maternity (340) Significant improvement from previous audit around domestic abuse processes have been made. Audit findings were shared with midwives at SafeCare meeting and presented at Safeguarding Committee and Quality Governance Committee Key Message - Trust has assurance that the policy is being followed.

Participation in National Confidential Enquiries 2024/25

Enquiry	Participation	% of cases submitted
Emergency (non elective) procedures in children and young people: Anaesthetic questionnaire Transfer questionnaire Surgical questionnaire	 Yes No No	 50% (1 of 2) 0% 0 of 1) 0% (0 of 1)
Hyponatraemia	Yes	20% (1 of 5)

Learning Disability	Yes	50% (3 of 6 ongoing until October 2025)
ICU rehabilitation	Yes	100% (3 of 3)

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 at the various SafeCare meetings.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2024/2025 that were recruited during that period to participate in research approved by the Health Research Authority (HRA) was **12,192**.

Recruitment by Managing Specialty	Total
Ageing	5
Anaesthesia, Perioperative Medicine and Pain Management	20
Cancer	19
Cardiovascular Disease	1
Children	9
Critical Care	18
Dementias and Neurodegeneration	25
Dermatology	10
Diabetes	3
Gastroenterology & Hepatology	56
Gynaecological Cancers	10,997
Haematology	1
Infection	88
Metabolic and Endocrine Disorders	10
Reproductive Health and Childbirth	801
Respiratory Disorders	23
Stroke	21
Surgery	11
Trauma and Emergency Care	74
Total	**12,192**

In line with the Research Strategy, Gateshead Health NHS Foundation Trust remains a research active organisation, which ensures that our patients have access to the very latest treatments and technologies. Evidence shows clinically research active hospitals have better patient care outcomes. Our top five recruiting studies include: -

INGR1D2  INGR1D2 - INvestigating Genetic Risk for type 1 Diabetes (2)

Type 1 diabetes is a common chronic disease in childhood and is increasing in incidence. The clinical onset of type 1 diabetes is preceded by a phase where the child is well but has multiple beta-cell auto-antibodies in their blood against insulin-producing beta cells, which are present in the pancreas.

Neonates and infants who are at increased risk of developing multiple beta cell auto- antibodies and type 1 diabetes can now be identified using genetic markers. This provides an opportunity for introducing early therapies to prevent beta-cell autoimmunity and type 1 diabetes.

The objective of this study is to determine the percentage of children with genetic markers putting them at increased risk of developing type 1 diabetes, and to offer the opportunity for these children to be enrolled into phase II b primary prevention trials.

POS-ARI-ER - Perpetual Observational Study of Acute Respiratory Infections presenting via Emergency Rooms and Other Acute Hospital Care Settings

POS-ARI-ER - is a perpetual, observational study (POS), designed to provide data for clinical characterisation of acute respiratory infections (ARIs) in adults presenting to hospital settings across Europe

Every year, respiratory infections such as colds, flu, pneumonia and now, Covid-19, affect millions of people globally and are one of the main reasons for needing hospital care. New or changing viral respiratory infections also have the potential to cause large outbreaks or pandemics. Understanding respiratory infections, and the best ways to diagnose and treat them in hospital, is therefore of high public health importance.

POS-cUTI - Perpetual Observational Study on Complicated Urinary Tract Infections

POS-cUTI is an observational data collection study looking at Complicated urinary tract infections (cUTI), which are associated with significant morbidity and mortality. Due to the high frequency of UTI, they have a major impact on antibiotic use and the antibiotic resistance of prominent UTI bacteria is of recognised importance. Therefore, UTIs, and particularly cUTIs, are a target for repurposing of old and neglected drugs, new drug development and non-antibiotic therapeutic and preventive approaches.

The aim of the study is to describe the variations in current practices in treating cUTIs at study sites, the patient population they occur in and the microbiological causes of cUTI at study sites, to determine:-

- The incidence of treatment failure in patients with cUTI and identify modifiable and non-modifiable risk factors for treatment failure.
- The rate of recurrences and superinfections, and those caused by multidrug-resistant bacteria
- The mortality and its predictors in patients with cUTI
- The length of hospital stay after cUTI

Transforming Ovarian Cancer diagnostic pathways (SONATA)

The SONATA project is funded by the NHS Cancer Programme to evaluate ROMA implementation and establish the potential benefits to earlier diagnosis and benefits to the health system.

SONATA Will test the diagnostic accuracy of CA125 versus ROMA to diagnose early-stage ovarian cancer.

A woman's chances of surviving 5 years after Ovarian Cancer (OC) diagnosis drops from 90% if diagnosed at Stage 1 to 15% at Stage 4.

Currently, GPs use a blood test called CA125 and an ultrasound scan to decide whether to refer a woman to hospital for suspected ovarian cancer. CA125 misses 50% of early-stage cancers (Stage 1 & 2) and both tests cause unnecessary referrals.

Recently, a blood test called HE4 in combination with CA125 in a formula called ROMA (Risk of Malignancy Algorithm) has been developed and is being used by doctors in the US and Europe to guide referrals.

The study uses a cohort design, appropriate for diagnostic test accuracy, combining test data from NHS laboratories (Black Country Laboratory Services and the South of Tyne & Wear Clinical Pathology Service) with ovarian cancer outcome data already collected in hospital MDT databases.

Food, Pregnancy & Me

Food insecurity is when someone struggles to afford or access enough food and affects 1 in 6 people in the UK. This can affect the food they eat and their health.

During pregnancy, food is important for both mother and baby's health, however, research from the USA shows food insecure pregnant women have inadequate diets, increased risks of various pregnancy outcomes, including depression and the baby being born too early.

This increases costs for maternity services, wider health services, and society. However, little is known about food insecurity during pregnancy in the UK.

Food, Pregnancy & Me will identify food insecurity levels during pregnancy in the North East (Gateshead) and West Midlands (Coventry) and how this impacts on diet and pregnancy health; the costs to maternity services and wider healthcare.

RD Forum 2024 (RDF24)

Lucy Blackwell (Cancer Clinical Trials Officer) and Meraud Bird (Data Manager) attended the RDF24 at the Celtic Manor in Wales from the 12th -14th May.

The RDF24 welcomed more than 870 attendees from across the UK to celebrate everything research. There were a diverse range of topics to discuss such as bringing your research to life, UK site agreements, increasing diversity in research participation, strengthening research engagement and collaboration, clinical research careers, bridging the gap between delivery and governance, patient involvement and the set-up of AI research. There were also workshops, posters, panel discussions and presentations including an overview from the Health Research Authority (HRA) as well as Lord O' Shaughnessy, who gave an update on the 2023 report on Commercial Clinical Trials in the UK.

We are now one year on from the report, and he reflected on the headway that has already been made to date, including the progress of the National Costing Value Review (NCVR) and the improvement in regulatory assessment timelines. However, there is still much to do in strengthening research within the NHS.

The event was closed by Professor Helen Bevan with her presentation on how we can make large scale change and tackle the challenges that we all face in ensuring that research is at the heart of patient care.

Gateshead Quality & Patient Safety Conference 2024

Meraud Bird (Data Manager) and Bev McClelland (Research Nurse) attended the Patient Safety Conference as representatives of the Research & Development Team, Gateshead Health NHS Foundation Trust.

The theme of the research stall was "**STOP – Think Research**". Research studies are run in accordance with the study protocol. Patients taking part in research may be treated or cared for differently and this too has to be in accordance with the study protocol to ensure their safety.

Bev and Meraud were on hand to talk about how staff can find out if a patient is taking part in research and where to look and what to look out for. Their Market Place Stall came third in the stall competition, and they received a lovely crystal trophy.

Promoting Research

Medicine for Members is a series of seminars held by Gateshead Health NHS Foundation Trust. These seminars are for members of the public and staff, and cover topics related to health, public health, and healthcare.

Members are given the opportunity to learn about matters relating to their own health, the health of those around them and how their healthcare is being delivered and might be delivered in the future.

In September 2024 the Medicine for Members Event focused on Women's Health.

Conor O'Neill (Innovation Manager), Lucy Blackwell (Cancer Clinical Trials Officer) and Yvonne Marriott (Research Governance Coordinator) attended the event. The stall, promoting innovation and research in women's health, generated a lot of interest.

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

The CQUIN scheme was suspended for 2024/25.

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 2024/25.

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 announced or unannounced inspections by the CQC during 2024/25.

There were two Mental Health Act (1983) Monitoring visits during 2024/25, one on Cragside in May 2024 and one on Sunniside in July 2024.

Positive feedback was received both verbally and by way of a formal report to the Chief Executive noting areas of good practice observed and stating that improvements were noted in response to past concerns identified.

In both reports CQC shared that patients were very complimentary about the care and support being provided to them, stating that they were treated with dignity and respect by staff. They felt that they could always access support from staff if they needed help and reassurance. Patients understood their treatment plan and felt they had been included in meetings about their care and support. Patients told CQC there were a range of activities available to them. They added that they had been able to share ideas for the proposed improvement works on the outdoor areas, which they were looking forward to being completed.

Carers spoken with on Cragside praised the quality of care being provided to their loved one, stating that all staff were very good and genuinely caring. The carer added that communication with the ward was consistently good and regular updates were always provided and described the area as welcoming and comfortable for their relative and there was always flexibility with visiting times, with protected mealtimes for patients being clearly explained to the carer and their family.

During their visit to Cragside CQC saw examples of patients' religious and cultural needs being promoted on the ward. A multi-faith box had been created which contained copies of religious texts and visits to the ward from religious leaders could be arranged as and when required. Catering could also provide halal and kosher foods for patients.

Carers spoken to on Sunniside praised the staff and level of care provided to their relative. They stated that staff behaved in a professional manner and always made them feel welcome during visits, providing a "personal touch" during interactions by always checking on their wellbeing as well as providing an update on the patient's presentation. The carer added that staff had kept them up to date with the MHA status of their relative and had also provided detailed information on carer support networks to promote their wellbeing. The carer told CQC that they were kept up to date with their relative's progress, stating that the responsible clinician had been proactive in providing regular updates throughout the course of their relative's

admission. They described the ward environment as “immaculate” and felt that their relative was safe.

During their visit to Sunniside CQC reported that respect and dignity had been observed including access to facilities to promote the patients personal grooming needs. CQC wrote that on the day of the visit they saw patients having their hair cut and dried, with one patient stating that the experience had made her feel better about herself, as well as observing multiple interactions between staff and patients where reassurance was provided to the patients in a kind and compassionate manner.

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 2024/25 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient’s valid NHS Number was:	Trust %	National %
Percentage for admitted patient care*	99.9%	99.7%
Percentage for outpatient care*	99.9%	99.7%
Percentage for accident and emergency care†	99.5%	98.2%

Which included the patient’s valid General Medical Practice Code was:	Trust %	National %
Percentage for admitted patient care*	100.0%	99.4%
Percentage for outpatient care*	100.0%	99.4%
Percentage for accident and emergency care†	100.0%	99.1%

* SUS+ Data Quality Dashboard - Based on data submitted to SUS before 5.00pm on Wednesday 19th March 2025 for activity up to and including Friday 28th February 2025, for M11 2024-25

†ECDS DQ Dashboard from Friday 1st March 2024 to Saturday 22nd March 2025

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 Data Security and Protection Toolkit (DSPT) submission for 2023/24 (version 6) was submitted 28/06/2024, certificate of Standards met issued which is valid until 30 June 2025. The baseline submission for Cyber Assessment Framework (CAF) Data Security and Protection Toolkit (DSPT) 2024/25 was submitted on time on the 24/12/2024. This demonstrates the Trust is working towards its completion and the external audit of the Trust’s DSPT progress will be conducted in April 2025 with an aim to maintain the previously achieved standards met.

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission.

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

- We feel that the Trust is performing well on data quality, but we will continue to actively work on improving in all areas where we can. The performance continues to be above the national average, and the shortfall is likely to be, predominantly, those who do not have an NHS Number e.g. overseas visitors.

2.4 Learning from Deaths

During 2024/25, there were 1,191 patient deaths within Gateshead Health NHS Foundation Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 274 in the first quarter.
- 258 in the second quarter.
- 330 in the third quarter.
- 329 in the fourth quarter.

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

In early April 2025, 1,182 case record reviews and16 investigations (Mortality Council reviews) have been carried out in relation to 1,191 of the deaths included above.

In 16 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:

- 273 in the first quarter.
- 257 in the second quarter.
- 326 in the third quarter.
- 326 in the fourth quarter.

Two deaths representing 0.17% 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:

- 1 representing 0.36% for the first quarter.
- 1 representing 0.39% 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 '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.

72 case record reviews and 85 investigations were completed after 1st April 2024 which related to deaths which took place before the start of the reporting period. 0 deaths 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 'Learning from Deaths' policy. Reviewed cases are graded using the Hogan preventability score and NCEPOD overall care score following case note review.

Summary of learning/Description of Actions/Learning themes identified:

Good Practice

- Good practice was identified for reasonable adjustments made for patients with learning disabilities;
    - a mother and daughter were both in hospital at the same time, the daughter was very poorly, it was made possible for them both to be moved to the same ward in the same room, to be together at the daughter's end of life.
    - There was quick recognition of a patient's deterioration, as a result good discussions took place with the family about the treatment options available.
- Good communication with families, patient wishes respected.
- Appropriate discussions with multiple specialties.
- Valuable communication and input at end of life with palliative care team.
- Good family involvement with various specialties.
- Effective discussions around most appropriate place for care and also ceiling of care.
- Severe Mental Illness deaths, good practice identified with equal focus given to mental and physical health needs.
- Excellent timely diagnosis of issue and escalation to neighbouring trust.

Documentation

- Documentation is being recorded in multiple places and has been identified as a theme in multiple Mortality Council discussions. Care is documented on paper in the green notes, on electronic systems such as Careflow, Nervecentre. There is no consistency across the organisation. Some areas only using Nervecentre, some only using paper notes, some using both. This may adversely impact patient outcomes as the primary purpose of a patient record, whether handwritten or digital, is to support direct patient care. All records must be clear, complete, accurate, up-to-date, and legible.
- Documenting that consent has been taken from patient's, difficulties identified with recording the full discussion with the patient on the current paper form. Electronic consent recording is being explored.

Fluid Balance

- Fluid balance management – process for managing intravenous fluid not always adhered to, issues identified with volume of fluids given, undertaking blood tests, no robust way to capture/prescribe/monitor fluid. A task and finish group has been set up to look at ways to improve this.

Clinical Pathways

- Urgent endoscopies requiring theatre – look at how they are prioritised and use of emergency theatre. Standard operating procedures to be devised to set out how

emergency theatres can be accessed, this work has been done in collaboration with surgeons, endoscopy, anaesthetics and care of the elderly.

- New clinical guidelines produced for a number of clinical pathways and conditions.

Managing test results

- Issues identified with managing test results using the ICE electronic system. A task & finish group was set up to develop a trust level policy to ensure that results are managed consistently across the organisation.

Medication

- Issues identified with the management of lithium; a clinical guideline is to be produced in collaboration with all key stakeholders.

Emergency Healthcare Plans (EHCPs)

- It was identified that increasingly patients are admitted to hospital contrary to the wishes expressed within their EHCP for various reasons. The admissions are potentially avoidable, and patients are not remaining in their preferred place of care. This was shared with the EHCP improvement programme via one of the members of the Mortality Council.

Mental Capacity Assessment (MCA) 1&2/Deprivation of Liberty (DoLs)

- Following a review of historical learning disability deaths, issues were identified with the completion of MCA 1&2 and DoLs applications. However, a review of more recent cases demonstrated an improvement in this.

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. Across the remaining eight standards there are elements that have been implemented.

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 came out of the pandemic, we reviewed and changed our model of care, concentrating on patient flow especially around non-elective care. The original NHS England recommendations around seven-day hospital services are a number of years old and need to be reconsidered in light of new models of care (both locally and nationally). The priority for the Trust moving forward will be to improve the quality of care through consistent achievement of the NHS constitutional standards, reducing length of time in our Emergency Department and reducing length of in-patient stay through better use of clinical pathways including a shift to care delivered in the community. The original NHSE recommendations may need to be revised given the national shifts from digital to analogue, hospital to community and treatment to prevention and the standards redefined.

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 Trust has shown their commitment to FTSU by supporting the role as a full-time permanent position.

The FTSUG reports information on themes and trends of concerns, improvement work to support an open and honest culture and learning from concerns to the Board of Directors Bi-annually, the Quality Governance Committee and the People & OD Committee quarterly. Externally FTSUG reports to the National Guardian Office data collection for all concerns on a quarterly basis.

Our FTSUG supports the delivery of the Trust's corporate strategy and vision as captured in our ICORE values. As well as via FTSUG, staff may also raise concerns with their trade union or professional organizations' as per our FTSU Policy. There is a Roadmap which has been developed for staff to make it easier for staff to know who and where they can get support when they have concerns, they need to raise which supports the FTSU Policy. When concerns are raised via the FTSUG, the Guardian commissions an investigation with the most appropriate manager / leader 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 and is an active member of the Trust's Culture Board Program. The FTSUG now reports directly to the Chief Nurse / Deputy Chief Executive and can escalate to the Chief Executive Officer when required 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 Committee by exception when it is deemed necessary due to difficulty in reaching local resolution.

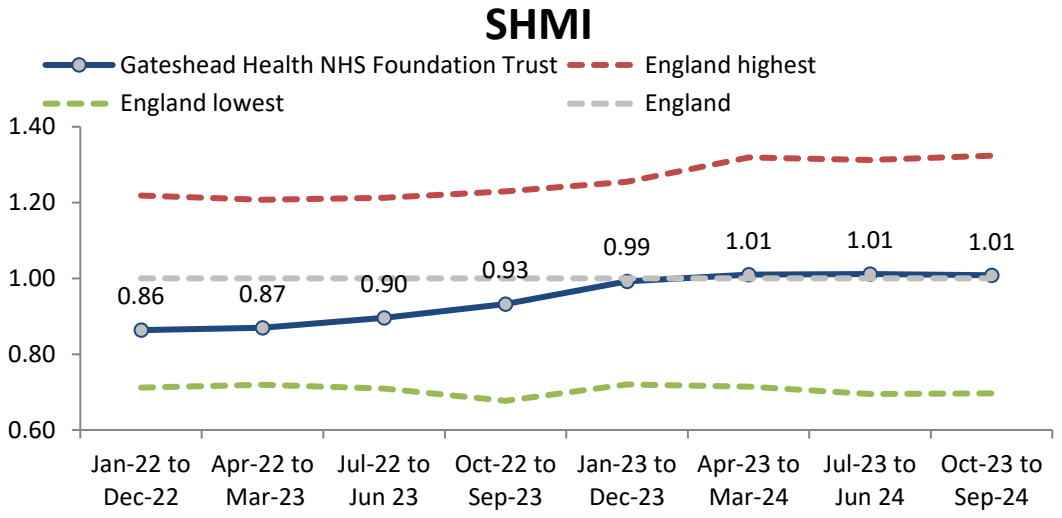
The Trust Board via the People and Organisational Development Committee receives an annual report from the Guardian of Safe Working which includes a consolidated report on rota gaps and actions taken by the Medical Workforce Group. This report is provided to the Local Negotiating Committee (LNC) by the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

The Medical Workforce Group meets monthly and reviews the developed medical workforce dashboard which summarises rota fill rates and staffing absences by service / specialty area and by business unit. The Trust Medical Staffing Team are now established and manage the medical staffing rosters on a day-to-day basis to ensure maximal roster fill rates and medical staffing cover. Gap management is proactive to ensure full rota compliance. The Associate Director for Medical Staffing has worked with colleagues in his team, finance and the leadership triumvirate in the Division of Medicine to develop a new pilot rota model starting in August 2025 for Tier 1 resident doctors. Outcome measures of the effectiveness of that pilot will include reduction in exception reporting and reduction in bank/agency spend due to rota gaps. A plan is in place to procure an e-rostering system which will further support the medical staffing team to operationalise the rota effectively with a positive impact on rota gaps and exception reporting.

2.8 Mandated Core Quality Indicators

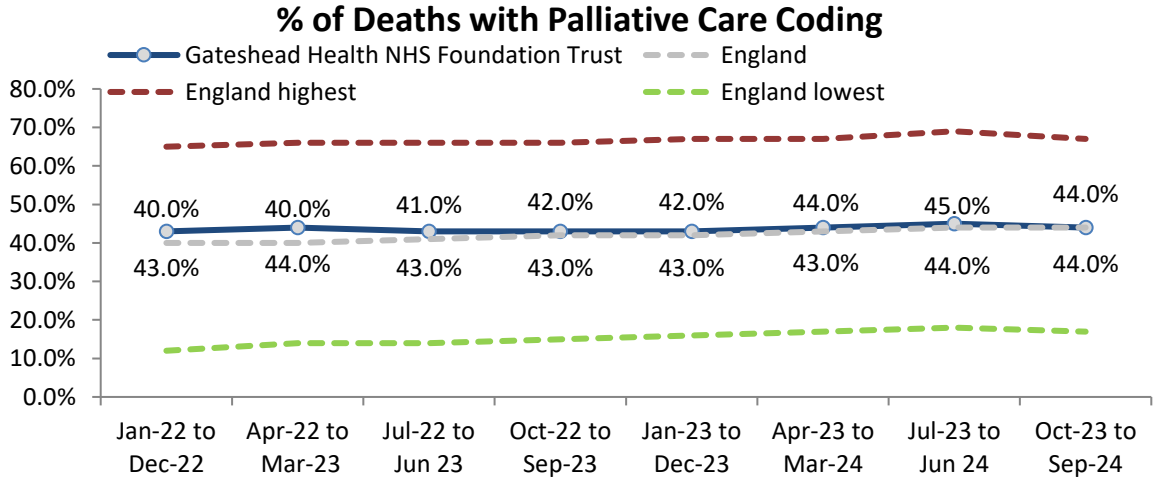
(a) SHMI (Summary Hospital-level Mortality Indicator)

SHMI	Jan-22 to Dec-22	Apr-22 to Mar-23	Jul-22 to Jun 23	Oct-22 to Sep-23	Jan-23 to Dec-23	Apr-23 to Mar-24	Jul-23 to Jun 24	Oct-23 to Sep-24
Gateshead Health NHS Foundation Trust	0.86	0.87	0.90	0.93	0.99	1.01	1.01	1.01
England highest	1.22	1.21	1.21	1.23	1.25	1.32	1.31	1.32
England lowest	0.71	0.72	0.71	0.68	0.72	0.71	0.69	0.70
Banding	3	3	2	2	2	2	2	2



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

% Deaths with palliative coding	Jan-22 to Dec-22	Apr-22 to Mar-23	Jul-22 to Jun 23	Oct-22 to Sep-23	Jan-23 to Dec-23	Apr-23 to Mar-24	Jul-23 to Jun 24	Oct-23 to Sep-24
Gateshead Health NHS Foundation Trust	43.0%	44.0%	43.0%	43.0%	43.0%	44.0%	45.0%	44.0%
England highest	65.0%	66.0%	66.0%	66.0%	67.0%	67.0%	69.0%	67.0%
England lowest	12.0%	14.0%	14.0%	15.0%	16.0%	17.0%	18.0%	17.0%
England	40.0%	40.0%	41.0%	42.0%	42.0%	43.0%	44.0%	44.0%



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 has been banded 'as expected' or 'Lower than expected'. For the latest period the SHMI is 'as expected'.
- The Trust reviews its SHMI monthly at the Mortality and Morbidity Steering Group. The model is closely monitored following recent changes to the SHMI calculation introduced in the May 2024 publication
- From May 2024 onwards, Trusts began to remove recording Same Day Emergency Care (SDEC) activity from the Admitted Patient Care dataset (APC) to the Emergency Care Data Set (ECDS) as Type 5 A&E activity. The SHMI is calculated using APC data. Removal of SDEC activity from the APC data has the potential to impact on the Trust's SHMI value resulting in an increase and therefore will continue to be closely monitored.

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 reviews cases for individual diagnosis groups where the SHMI 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.
- The Trust reviews the clinical coding for alerting diagnosis groups when required to determine whether the appropriate diagnosis was assigned and to refine the coding where appropriate.
- The Trust continues to review palliative care coding to ensure palliative care is recorded for all cases where this is appropriate. Palliative care coding is slightly higher than the national level at 2.8% of provider spells compared to 2,1% nationally in the most recent publication (April 2024). The model does not risk adjust for palliative coding.

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.

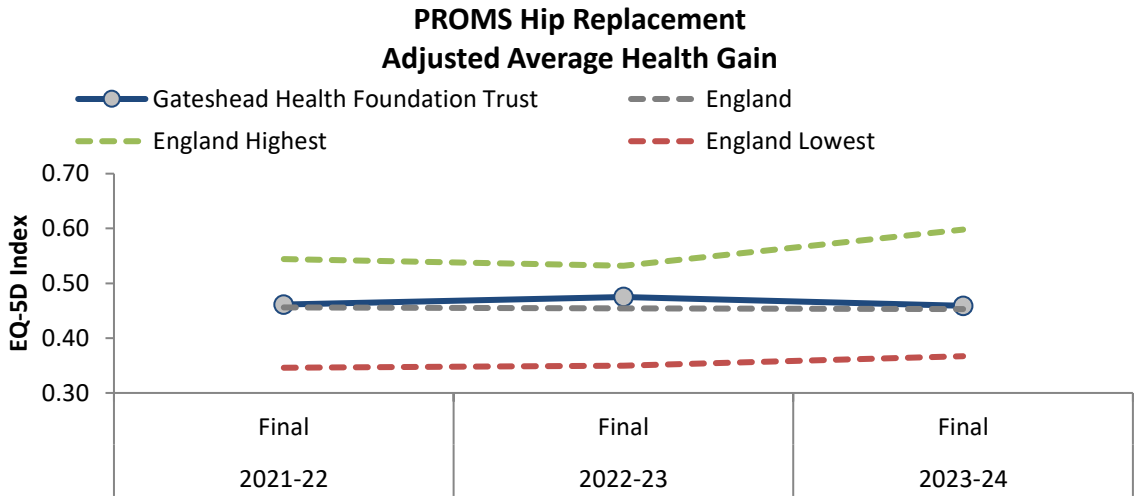
PROMs (Patient Reported Outcome Measures) for Hip Replacement and Knee Replacement:

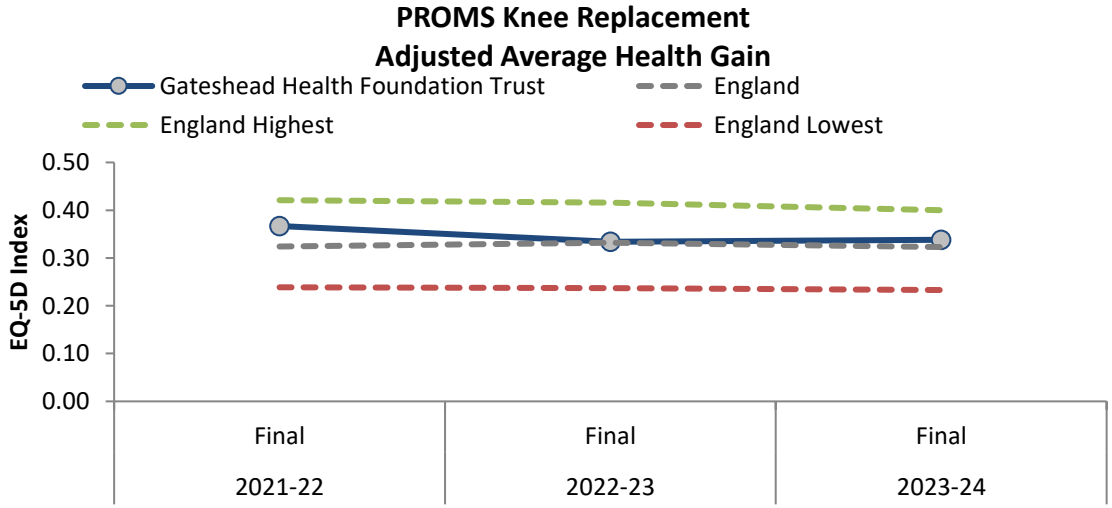
Hip Replacement Adjusted average health gain EQ-5D index	2021-22 Final	2022-23 Final	2023-24 Final
Gateshead Health Foundation Trust	0.46	0.48	0.46

England	0.46	0.45	0.45
England Highest	0.54	0.53	0.60
England Lowest	0.35	0.35	0.37

Knee Replacement Adjusted average health gain EQ-5D index	2021-22 Final	2022-23 Final	2023-24 Final
Gateshead Health Foundation Trust	0.37	0.33	0.34
England	0.32	0.33	0.32
England Highest	0.42	0.42	0.40
England Lowest	0.24	0.24	0.23

Source: https://digital.nhs.uk/data-and-information/publications/statistical/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 2023-24 remain above the national average for both hips and knees. The Trust scores are within common cause variation from the England average therefore neither statistically better nor worse.

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

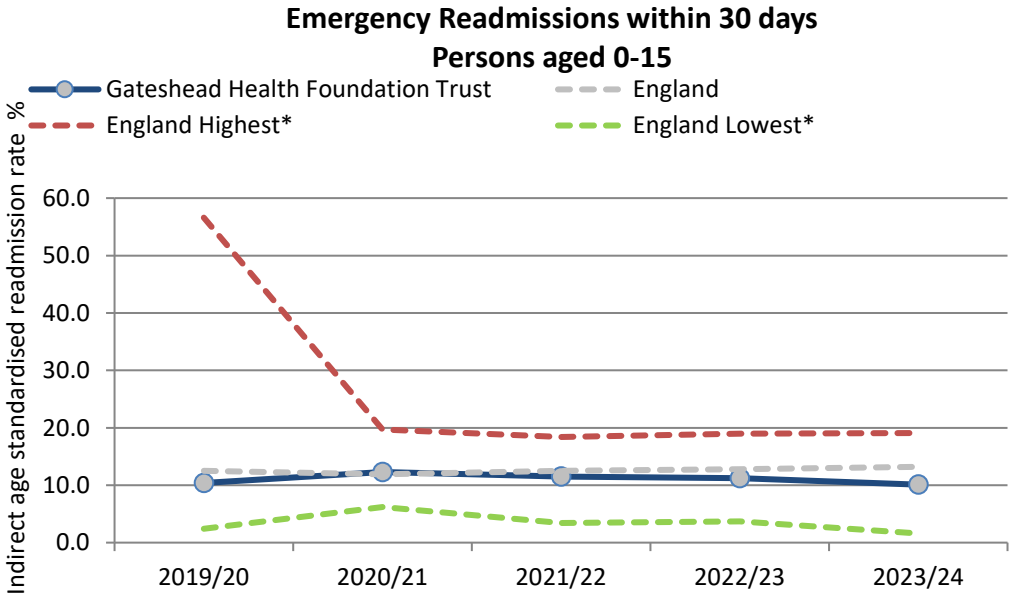
Emergency readmissions within 30 days of discharge from hospital Persons aged 0-15	2019/20	2020/21	2021/22	2022/23	2023/24
Gateshead Health Foundation Trust	10.4	12.3	11.5	11.2	10.1
Banding	B5	W	W	W	B1
England	12.5	11.9	12.5	12.8	13.2
England Highest*	56.6	19.7	18.4	19	19.1
England Lowest*	2.4	6.2	3.4	3.7	1.6

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 decreased slightly in 2023/24, remaining broadly static over the last five years, tracking 'Significantly lower' or within than the national average in each of the last five years. The readmission rate 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:

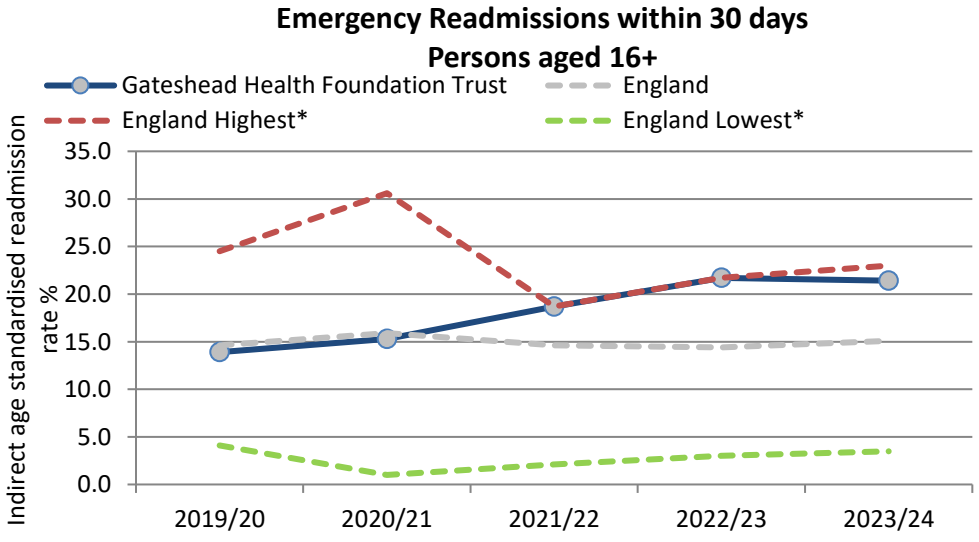
- The Trust will continue to monitor performance and undertake further investigations/actions should the rate increase.

Emergency Readmissions within 30 Days

- Aged 16 years or over

Emergency readmissions within 30 days of discharge from hospital Persons aged 16+	2019/20	2020/21	2021/22	2022/23	2023/24
Gateshead Health Foundation Trust	13.9	15.3	18.7	21.7	21.4
Banding	B5	B5	A1	A1	A1
England	14.6	15.9	14.6	14.4	15.1
England Highest*	24.5	30.6	18.7	21.7	23
England Lowest*	4.1	1	2.1	3.0	3.5

A1 = Significantly higher 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
*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 reduced from 2022/23 but remain at a similar level to the highest nationally reported positions. Scrutiny of internal data indicates that this

apparent deterioration relates to the introduction of a new Same Day Emergency Care (SDEC) facility in September 2021. Due to the way in which data was captured, an increase in readmissions was observed relating to follow up care provided in SDEC. The true shift in average readmissions is circa 6 per month – the impact on percentage readmission rate is therefore minimal, demonstrating a slight drop in the average readmission rate overtime.

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.
- Follow up by Discharge Liaison Nurses as well as voluntary sector support to ensure that patients who have been discharged can access appropriate community support and avoid readmission.
- SDEC activities are now recorded as Type 5 A&E attendances (from 1st May 2024) and a review of internal data shows that our performance will fall back in line with national best practice when 2024/25 figures are included.

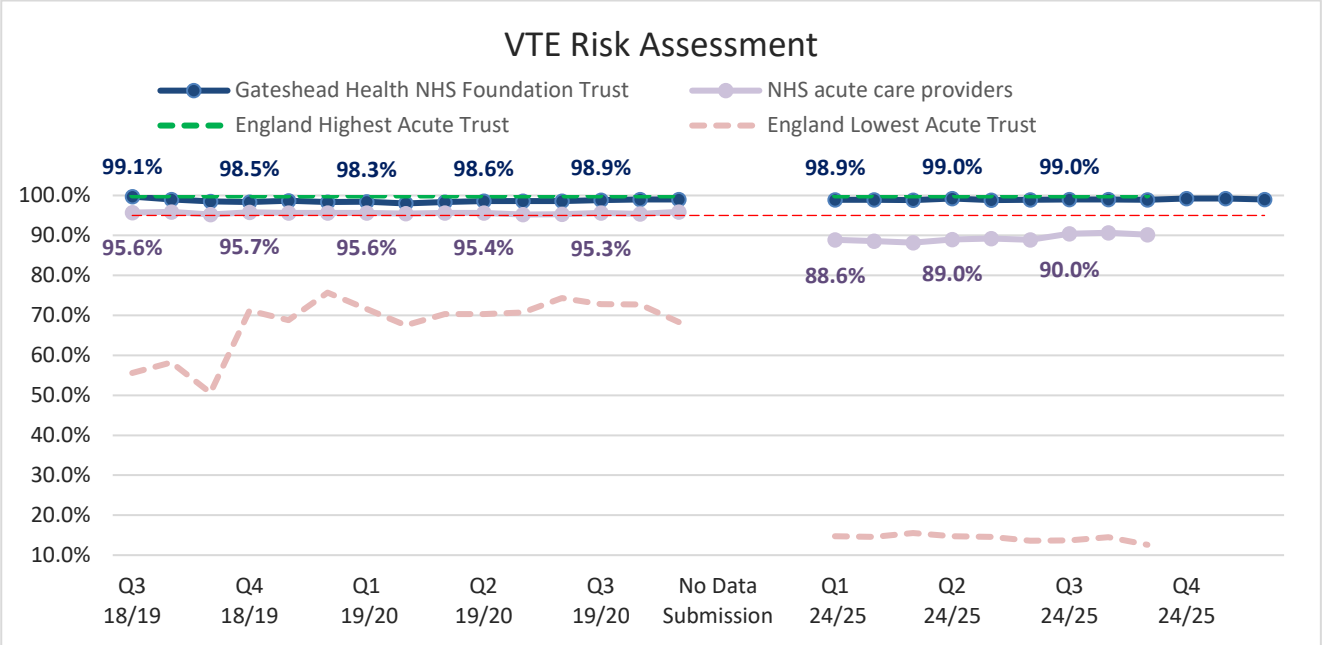
Trust's responsiveness to the personal needs of its patients

Following the merger of NHS Digital and NHS England on 1st February 2023, future presentations of the NHS Outcomes Framework indicators were to be reviewed. Annual publications which were due to be released were delayed and have to date not been forthcoming.

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

- This information is now captured by the Peoples Pulse collection please refer to Section 3.5 Focus on Staff for further information.

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



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

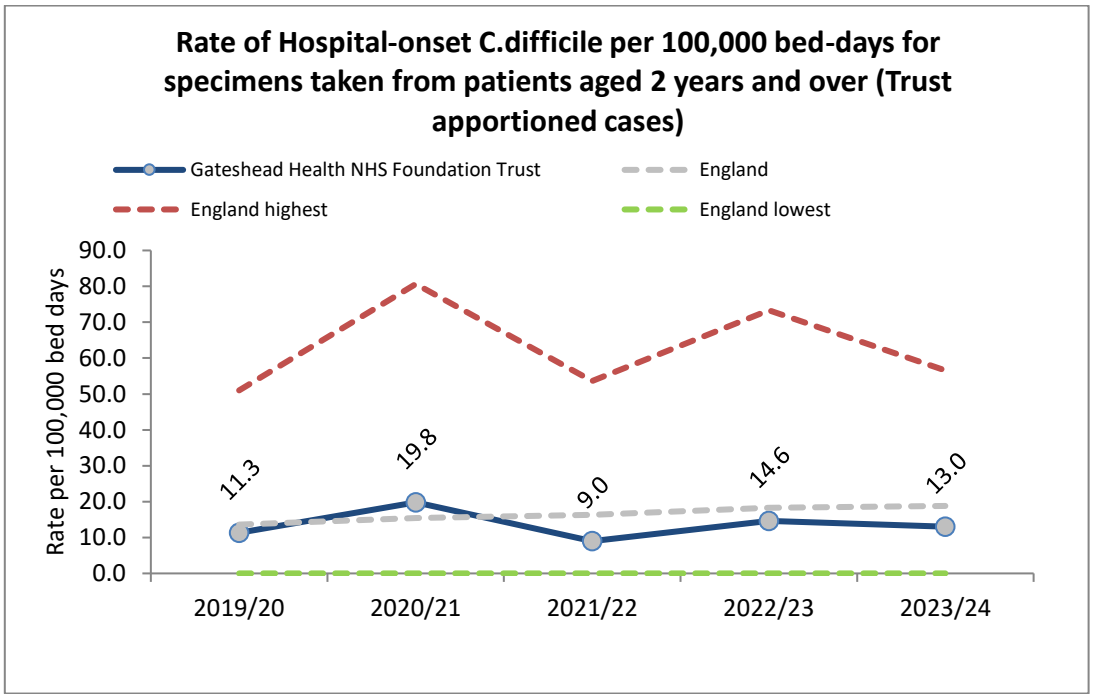
- Gateshead Health NHS Foundation Trust Compliance with DVT risk assessment has reached 95% in all areas of the hospital which use the JAC prescribing site and reassurance has been gained regarding a robust assessment in Critical Care which use a paper documentation.
- VTE Risk assessment continued to be monitored by the Trust during the suspension of the national submission. Performance continues to exceed the 95% national objective.

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

- Work on VTE will become part of the Audit & Effectiveness Group's agenda, who will be responsible for updating all guidelines and raising 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 Trust hospital acquired thrombosis data is also shared with GIRFT.

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)	2019/20	2020/21	2021/22	2022/23	2023/24
Gateshead Health NHS Foundation Trust	11.3	19.8	9.0	14.6	13.0
England highest	51.0	80.6	53.6	73.3	56.6
England lowest	0.0	0.0	0.0	0.0	0.0
England	13.6	15.4	16.3	18.3	18.8



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

- Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal, infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety across the Trust, therefore ensuring preventative measures and reducing infection is very important to the high quality of patient care we deliver.
- 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 2024/25 to minimise rates of Clostridioides difficile (C. difficile) so that it is no higher than the threshold level set by NHS England and Improvement.
- The threshold for CDI's, which is calculated by Public Health England (PHE) from November to October was increased by 37% for 2024/25 which was an increase of 14 cases.
- For 2024/25 we reported forty-eight (48) cases of healthcare associated CDI against the threshold of thirty-seven (37). Twenty-nine (29) hospital onset healthcare (HOHA), and nineteen (19) community onset healthcare associated (COHA) cases.
- The trust reported a yearly increase in CDI healthcare associated cases of 22.92% against the threshold set by PHE.

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:

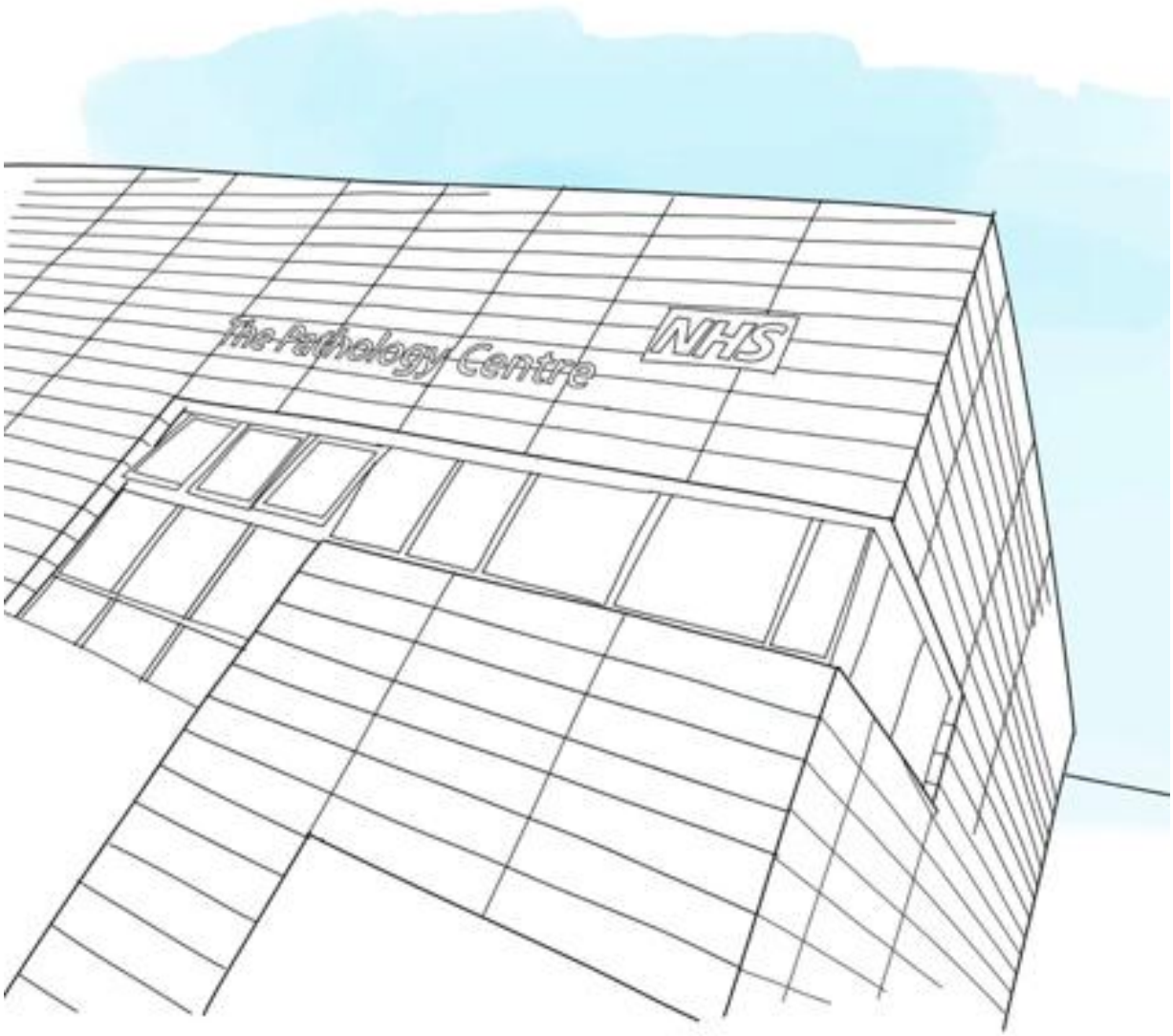
- An internal review is held for all healthcare associated CDI cases, supported by the PSIRF framework and internal safety triangulation review as necessary, where good practice and lessons learnt can be identified. The learning is then linked, if appropriate, to the key themes of sample submission, antimicrobial prescribing, documentation, patient management and human factors. The good practice and lessons learnt are then cascaded back through the internal safe care mechanisms.
- (PHE) publish thresholds for each trust on a yearly basis calculated from the previous twelve months from November to the following October for 2024/25. An action plan was devised to help with the target, these included; education and awareness around hand washing, increased audit surveillance on clinical areas, clearer definitions on cleaning terminology, clearer signage on wards, refresh of IPC intranet page and implementation of PSIRF.
- 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 can be arranged with the Clostridium difficile Ribotyping Network (CDRN) to determine if cross infection has taken place.

The number and rate of patient safety incidents per 1,000 bed days reported within the Trust.

- NHS England have paused the annual publishing of this data while they consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. This remains the same for 24/25.

Part 3

Review of Quality Performance



Review of quality performance

2024/25 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. 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	2022-23	2023-24	2024-25	Target
SHMI Period	Apr-22 to Mar-23	Apr-23 to Mar-23	Dec-23 to Nov-24	
SHMI	0.87	1.01	**1.04**	<=1
SHMI Banding	Lower than expected	As Expected	As Expected	As expected or lower than expected

SHMI - Percentage of provider spells with palliative care coding (contextual indicator)	2.2%	2.6%	2.8%	N/A
Crude mortality rate taken from CDS	1.75%	1.79%	1.77%	<1.99%
Number of calls to the CRASH team	176	134	165	N/A
Number of calls to the CRASH team that were cardiac arrests	61	51	70	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	34.7%	38.1%	42,4%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.35	0.28	0.40	N/A
Hospital Acquired Pressure Damage (grade 2 and above)	127	183	136	Year on year Reduction
Community Acquired Pressure Damage (grade 2 and above)	1470	1426	1229	N/A
Number of Patient Slips, Trips and Falls	1589	1344	1478	N/A
Rate of Falls per 1000 bed days	9.03	7.77	8.38	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm	382	464	682	N/A
Rate of Harm Falls per 1000 bed days	2.17	2.68	**3.87**	Reduction (Less than <2.25)
Harm Falls Rate Change	3.8% Increase	23.6% Increase	44.3% Increase	N/A
Ratio of Harm to No Harm Falls (i.e. what percentage of falls resulted in Harm being caused to the patient)	24.0%	34.5%	**46.1%**	Year on Year reduction

Reducing Avoidable Harm:

Reducing Avoidable Harm		2022-23	2023-24	2024-25	Target
Medication Errors	No Harm	738	671	583	N/A
	Low Harm	129	139	178	N/A
	Moderate Harm	8	2	**9**	<8
	Severe Harm	3	0	**1**	0
	Death	0	0	0	0
	Total	878	812	771	N/A
Never Events		0	1	**1**	0
Patient Incidents per 1,000 bed days		38.3	37.0	39.5	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.13	0.11	0.06	N/A

Source: Trust incident reporting systems Datix & InPhase

Infection Prevention and Control:

Infection Prevention & Control	2022-23	2023-24	2024-25	2024-25 Threshold
MRSA bacteraemia apportioned to acute trust post 48hrs	0	0	1	0
MRSA bacteraemia rate per 100,000 bed days	0	0	0.59	0
NB: **Healthcare Associated** *Clostridium difficile* Infections (CDI) post 72hr cases	40	37	48	<37
Healthcare Associated *Clostridium difficile* Infections (CDI) rate per 100,000 bed days	23.5	22.0	28.1	-

Infection Prevention & Control	2022-23	2023-24	2024-25
Hospital Onset Healthcare Associated C.difficile count	27	27	29
Hospital Onset Healthcare Associated C.difficile per 100,000 occupied overnight beds	17.37	17.32	18.65
Community Onset Healthcare Associated C.difficile count	13	10	19
Community Onset Healthcare Associated C.difficile per 100,000 occupied overnight beds	7.19	5.52	10.51

Other Indicators:

Other Indicators	2022-23	2023-24	2024-25	Target
Percentage of Cancelled Operations from FFCE's†	0.41%	0.29%	0.30%	0.80%
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	5.00%	4.21%	4.17%	Improve Year on Year
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	90.1%	91.9%	93.7%	90%
Proportion of patients who are readmitted within 28 days across the Trust*	14.06%	13.57%	5.65%	Improve year on year
Proportion of patients undergoing knee replacement who are readmitted within 30 days*	8.43% 15 patients readmitted	8.80% 25 patients readmitted	3.20% 8 patients readmitted	Improve Year on Year
	8.49%	8.74%	6.10%	

Proportion of patients undergoing hip replacement who are readmitted within 30 days*	18 patients readmitted	27 patients readmitted	13 patients readmitted	Improve Year on Year

* Figures taken from Healthcare Evaluation data (HED) and provide full financial years for 2022-23, 2023-24 and April to December 2024-25

† FFCE's refer to First Finished Consultant Episodes. A patient's treatment or care is classed as a spell of care. Within this spell can be a number of episodes. An episode refers to part of the treatment or care under a specific consultant, and should the patient be referred to another consultant, this constitutes a new episode

Safeguarding Children and Adults

- The Adult and children's safeguarding teams are committed to ensuring that effective safeguarding arrangements are in place, to prevent and protect adults, young people and children from harm or abuse. Safeguarding is firmly embedded within the organisation as being everyone's responsibility. Leads for both adults and children ensure that a think family approach is evident across the Trust.
- Both safeguarding teams have worked in partnership with key partners to address safeguarding priorities in Gateshead.
- Within the quarterly Safeguarding Group, we bring the lived experiences of service users by sharing patient stories and any learning at every meeting.
- The children and adult teams have continued to work together to further raise awareness of the 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.
- In response to what staff have told us the safeguarding children team have worked with the Gateshead Safeguarding Children Partnership and have facilitated on site level 3 safeguarding training. This has been well received, and compliance is now at 90% or above across all levels. Training has been targeted at domestic abuse, county lines, substance use in children, knife crime and sexual exploitation.
- The safeguarding children team have embedded the use Careflow and docstore to record children's safeguarding information. This allows pertinent information to be available to practitioners at the point of need.
- The Children in Care team are in the process of moving to the use of Careflow and docstore as the child's record
- The Safeguarding children team have worked with the records team to develop a process for children's records when they have been adopted, this process will provide a continuous record for the child.
- The Adults team continue to prioritise and deliver capacity training in line with Mental Capacity Act legislation.
- During the past twelve months the children and adult safeguarding teams have continued to deliver a comprehensive safeguarding service. Despite staffing pressures, the team have continued to support staff to safeguard some of the most vulnerable people in society.
- The joint adult and children Safeguarding Link Meetings have been successful and continue via MS Teams with an emphasis on promoting a "Think Family" approach to Safeguarding. This has proved to be a successful forum for education, sharing knowledge, and for staff to discuss individual safeguarding case studies.
- The adults and children's safeguarding teams continue to provide regular news bulletins within the QE Weekly providing valuable updates on current safeguarding issues and promoting training opportunities.

- The adult and children team have embedded the use of InPhase to report safeguarding concerns.
- The Adult team continue to prioritise safeguarding and prevent training, including monitoring the compliance levels to ensure staff are preventing any harm, ensuring safety by preventing abuse and neglect, sharing any learning and to ensure the health and well-being of our patients and colleagues.
- Adult safeguarding team have continued to see a steady increase in concerns during the last 12 months with the main categories being neglect, self-neglect, domestic abuse, and financial. This reflects the information shared from partner agencies. These concerns also include the community teams, where we continue to offer support and advice, and attend team meetings to share any updates or learning.
- The adult team continue to receive provider concerns in relation to care homes and domiciliary care providers. We have recently seen an increase in concerns being raised by community staff which have been escalated appropriately. We continue to liaise and share these concerns with the Local Authority, ICB and within the provider Information sharing meetings which have recently started back up again.
- The adult team continue to receive complex domestic abuse referrals, including staff members that are supported and signposted. The team continue to work with departments and partner agencies to support and safeguarding people who are at risk of harm, including domestic abuse. The team work closely with managers, security, and HR to ensure the safety and wellbeing of staff.

3.2 CLINICAL EFFECTIVENESS

Getting it Right First Time (GIRFT)

Six GIRFT visits took place throughout 2024/25.

- Pancreatic Cancer Peer Review – May 2024
- Gynaecology Gateway Review NENC ICS – September 2024
- Anaesthetic and Peri-operative Gateway Review NENC ICS – October 2024
- Diabetes in Children and Young Adults System Review NENC ICS – January 2025
- Diabetes Adults only Gateshead Review NENC ICS – January 2025
- Breast Surgery Gateway Review Northern Cancer Alliance – February 2025

The governance process for managing GIRFT visits was reviewed during the year, making this more robust and managed at Business Unit level. The outcomes of the visits were discussed within the business units and subsequent action plans developed, which will be monitored locally.

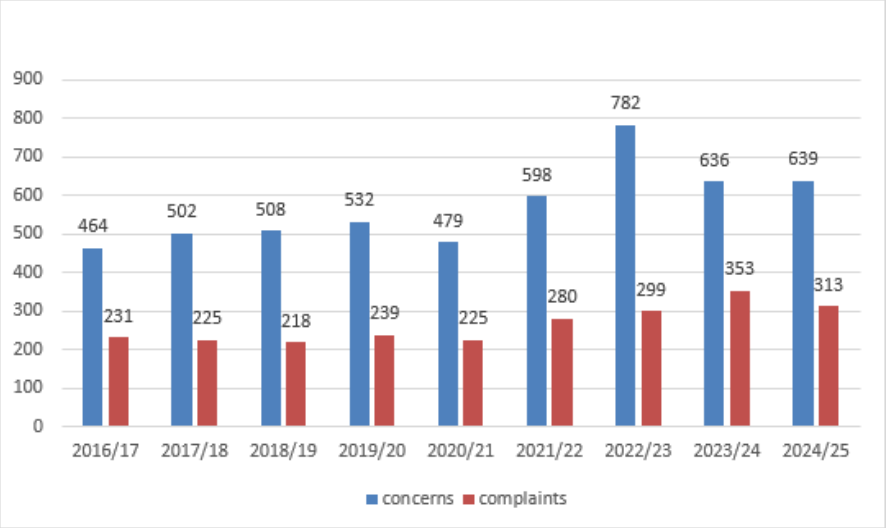
3.3 PATIENT EXPERIENCE

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 2024/25 we received a total of 313 formal complaints. Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment when inpatients or outpatients of the Trust. It also involves apologising and explaining what happened to staff or visitors who have suffered harm. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers, staff and visitors and makes sure that openness, honesty and timeliness underpins responses to such incidents. The Patient Advice and Liaison Service (PALS) offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers.

Complaints and Concerns 2016 to 2025



Complaints Performance Indicators	Total 2024/25
Complaints received	313
Acknowledged within three working days	313
Complaints closed	322
Closed within agreed timescale	158
Number of complaints upheld	280
Number of complaints partially upheld	3
Concerns received by PALS	636

Complaints Indicators	Total 2024/25
Number of closed complaints reopened	40
Number of closed complaints referred to Parliamentary & Health Service Ombudsman	13

Outcome of complaints referred to Parliamentary & Health Service Ombudsman (PHSO)	Total 2024/25
Considering whether to investigate	1
Currently investigating	2
Complaints upheld	0
Part upheld	1
Declined to be investigated	8
Agreed actions with Trust (incl as a result of learning)	1

*Number of closed complaints reopened.

In the year 2024/25 40 closed complaints were reopened. This compares to 53 in 2023/24. Reasons for reopening cases include where the complainant has additional questions/concerns following receipt of the Trust's complaint response letter.

During 2024/25 the top four main reasons to raise a formal complaint were in relation to:

- Implementation of care
- Communication, confidentiality and consent
- Access, admission and discharge
- Clinical Assessment

During 204/25 the top four main reasons to raise a concern were in relation to:

- Communication, confidentiality and consent
- Implementation of care
- Access, admission & discharge
- Car parking

As a result of complaints and concerns raised over the past year a number of initiatives have been implemented, of which a small number of examples are shared below.

In response to a complaint regarding Radiology:
The person's episode of care was report to our REALM (Radiology Errors and Learning Meeting) to ensure this was reviewed by the wider team to help overall team learning and education. It was also reported to Everlight, so they could follow their process for reviewing cases and learning lessons to improve patient outcomes wherever possible.

In response to a complaint regarding Trauma and Orthopaedics:
We discussed the importance of meaningful interaction with patients during cohorted Nursing care. In this context, cohorted care refers to assigning a staff member to remain in a bay (e.g. with four patients) where individuals are at increased risk, such as from falling, and provide supervision and engagement. This engagement can include conversations, playing games, or other suitable activities to promote safety and well-being. Concerns had been raised regarding a recent patient fall and the subsequent communication with the patient's family. In response, we developed a checklist for registered staff to use in the event of a fall. This checklist outlines all essential assessments that must be completed and has been added to each patient's nursing file. This aims to ensure that all necessary steps are followed and that communication with relatives is prompt and consistent.

In response to a complaint regarding Surgery:
As part of this complaint, we have reviewed our processes regarding making patients nil by mouth and the processes surrounding regular medications that are not classed as critical, as per national guidelines, so they can be re-started as soon as possible. This learning and reflections from this were also presented at SafeCare meetings in general surgery.

In response to a complaint regarding PeaPod:
We have identified a number of points of learning for the team including Nursing staff to complete observations regularly for patients on the Short Stay Unit. We also fed back to the team that Doctors should ask the Nursing staff for exact numbers when discussing

observations and not just use the phrase ‘normal’. We also emphasised the need for clear and comprehensive documentation to all the staff involved in care.

In response to a complaint regarding Surgery:
We identified that further education was required with a ward team on the death certificate procedure and the process linked to the issuing of death certificates. The bereavement booklet families receive from the ward has also been highlighted with the ward team, to ensure that relevant parts of the leaflet are discussed with families and that they have all the necessary information before they leave the ward.

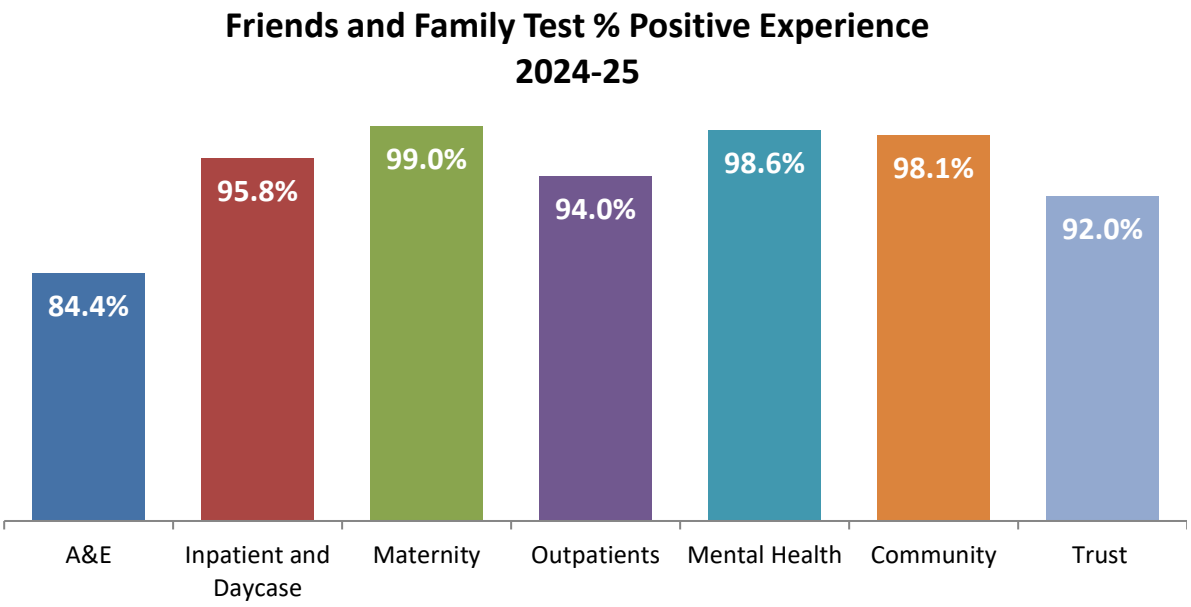
Friends & Family Test

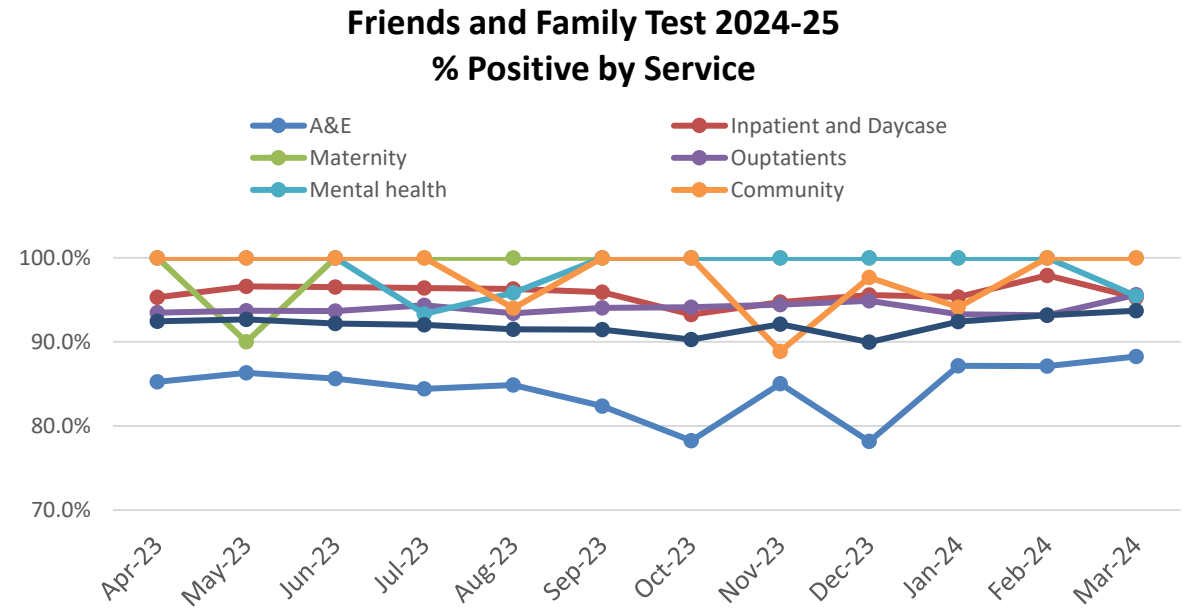
Listening to our patients and service users remains central to how we evaluate and improve the care we provide. The Friends and Family Test (FFT) continues to be one of the key tools we use to understand how patients feel about their experiences with Gateshead Health NHS Foundation Trust. It offers valuable, real-time feedback from those who use our services, helping us to celebrate what we’re doing well and identify areas where we can improve.

Over the past 12 months, we are proud to report a strong and consistent level of positive feedback across the Trust. Our overall Trustwide average for the year was 92%, reflecting the high quality of care and compassion our teams deliver every day. In particular, our Maternity services received exceptional praise, with a rate of 99%, a testament to the dedication of our Midwifery teams and their focus on personalised and safe care for women and families. Similarly, our Mental Health services scored an impressive 98.6%, and our Community Services were close behind at 98.1%, both of which highlight the importance of continuity, accessibility and compassionate engagement in these areas.

Inpatient and day case services also performed very strongly, with a positive score of 95.8%, showing that patients consistently feel well cared for and supported throughout their hospital stays. Our Emergency Department, while operating under the pressure of increasing demand, achieved a solid 84.4% rate. We recognise that A&E can be a challenging environment for patients and staff alike, and we are continuing to explore improvements in communication, waiting times and care pathways to further enhance the patient experience.

We remain committed to acting on the feedback we receive through FFT and ensuring that every voice contributes to shaping our services. Whether the response is one of gratitude or highlights an opportunity to do better, each comment matters and drives our ambition to deliver the highest possible standard of care.


Friends and Family Test % Positive Experience
2024-25
84.4%
95.8%
99.0%
94.0%
98.6%
98.1%
92.0%
A&E
Inpatient and Daycase
Maternity
Outpatients
Mental Health
Community
Trust


Friends and Family Test 2024-25
% Positive by Service
A&E
Inpatient and Daycase
Maternity
Ouptatients
Mental health
Community
100.0%
90.0%
80.0%
70.0%
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24

3.4 Good News Stories

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

Emergency medicine practitioner achieved prestigious accreditation

Gateshead Health's Advanced Clinical Practitioner (ACP) in Emergency Medicine, Andrea Swingler has worked in the Trust for nearly four years and has recently achieved the RCEM Advanced Clinical Practitioner credential from the Royal College of Emergency Medicine (RCEM)

New state-of-the-art pharmacy robot

We have taken a significant step forward in improving patient care and safety with the installation of a brand-new pharmacy robot. This cutting-edge technology, the BD 210 Rowa, marks a new chapter for the Pharmacy department, which has utilised robotic systems for over 20 years.

Top of the Charts for Maternity Care

We have been rated the top provider of maternity care in England, according to a survey of new parents.

The report ranks maternity care by Gateshead Health's team as number one across the country

Ranked top 10 in professional development in obstetrics and gynaecology

We are pleased to share that out of 163, the Queen Elizabeth Hospital, Gateshead is among the top 10 performing obstetric and gynaecology units and highly commended for professional development nationally, based on feedback from our trainee

Community Diagnostic Centre at Metrocentre welcomes its first patient

A new Community Diagnostic Centre (CDC) at the Metrocentre has welcomed its first patient as part of a £18.6 million investment to improve diagnostic services for the local community.

Pathology service earns national recognition for excellence

The South of Tyne and Wear Clinical Pathology Service (SoTW CPS), part of Gateshead Health NHS Foundation Trust, has achieved national recognition by maintaining its prestigious ISO 15189:2012 accreditation. This international standard ensures medical laboratories meet high-quality requirements for accuracy and competence, which is essential for excellent patient care

Women's health bus takes services to Gateshead communities

Health and care organisations across Gateshead, including Gateshead Council, NHS trusts, GP practices, CBC Health and the voluntary and community sector, are working together to improve women's health through a mobile service. The Newcastle Community Health Bus, affectionately named "Monty," is provided by Newcastle GP Services to bring health services directly to local communities. This service is being developed as part of the Gateshead Women's Health Hub, which supports the Government's National Women's Health Strategy by working collaboratively to improve healthcare access and outcomes for women and girls.

Improving paediatric care: collaboration with a young patient and mother

Gateshead Health NHS Foundation Trust's paediatrics department recently conducted a walk-through with patient Orin Milor and his mother, Jen. The exercise was to look at a child's surgical journey through the hospital and all the departments children coming in for surgery would visit

Gateshead Health setting the gold standard in recording data

We are excited to announce that Gateshead Health has received the Gold National Joint Registry (NJR) Quality Data Provider Award for 2024.

3.5 Focus on staff

Under our corporate strategy one of our strategic aims is *'We will be a great organisation with a highly engaged workforce'.* We recognise the importance of looking after our people and making our Trust a great place to work. It has been proven that a supportive and positive working environment for NHS colleagues has a direct impact on patient care and experience. We have placed significant focus on health and wellbeing, growing and developing our workforce and developing our culture to be the best in the NHS.

2024/25 has seen significant people-related developments here at Gateshead Health NHS Foundation Trust as a result of a combination of significant national developments, ensuring we are responsive to emerging challenges and we are taking proactive steps to introduce initiatives and strategic actions aimed at improving staff engagement, development, and well-being.

This year, the Trust have concluded a project driven by Unison's "Pay Fair for Patient Care" campaign which involved a comprehensive re-banding exercise to ensure that as a Trust our Healthcare Assistant role aligned with the national profile changes. We sought to work in partnership with key stakeholders, involving extensive negotiations and reflecting our dedication to recognizing and rewarding the invaluable contributions of our healthcare support staff.

As a People and OD team at the beginning of 2025 we successfully developed and implemented a structured pay progression system for all colleagues. This system ensures that essential criteria are in place for individuals to progress to the next pay step.

As part of the Annual Planning Cycle the Trust has taken a refreshed approach which has included moving to an agreed methodology for workforce planning, the introduction of a triangulated planning template, between Finance, Workforce and Operational and Performance teams and a clear launch and support available for managers.

The People and OD team have also been responsive in providing support and expertise to large-scale organisational change programmes, such as the establishment of the Community Diagnostic Centre, working collaboratively with Alliance partners Newcastle Upon Tyne NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust.

Over the past year, as a Trust we have also been participating in the NHS People Promise Exemplar Programme which has supported us to focus on improving staff experience and retention. During this time, we have implemented schemes such as 30-60-90-day new starter conversations, a refreshed approach to reward and recognition, retirement cafes and self-rostering pilot.

This year, we have been pleased to see a reduction in our temporary staffing spend, consistently maintaining a below the target of 2.5% of the pay bill, demonstrating a clear commitment to reducing reliance on temporary staff.

The launch of our Flexible Retirement scheme has provided staff with more options to manage their career transitions. This initiative supports our employees in achieving a better work-life balance while retaining their valuable expertise within the Trust and enabling them to share their skills and knowledge with colleagues.

We have made significant strides in our cultural work over the past 12 months emphasizing the importance of civility and zero tolerance towards any form of harassment or discrimination. The "It's not okay..." campaign reflects our proactive approach to fostering a respectful and supportive workplace culture. Additionally, we have reinforced our commitment to sexual safety through targeted training and awareness programs, ensuring a safe and respectful environment for all staff and patients. The launch of the Sexual Safety Policy and the signing of the NHS Sexual Safety in Healthcare Charter demonstrate our dedication to eradicating sexual misconduct in the workplace.

Our newly developed EDI Dashboard has been an invaluable tool to support monitoring and promoting of equality, diversity, and inclusion across the Trust. The dashboard tracks progress against strategic objectives, providing valuable insights into population comparisons, values scores by protected characteristics, and training and recruitment metrics.

During the year a thorough review has taken place of all our Trust training programs to ensure they remain relevant and aligned with our strategic goals. The intention is that this will lead to enhanced training offerings, including the introduction of new courses and the optimisation of existing ones. Our training initiatives are designed to support career progression, adapt to changes in healthcare, and promote a culture of lifelong learning.

Our commitment to continuous improvement is also reflected in the advancements made within our Library and Knowledge Services. The development of a Library Digital Plan and the integration of electronic resources into clinical systems have significantly enhanced access to information and supported evidence-based practice. The establishment of a multi-disciplinary library committee and the promotion of tailored current awareness bulletins further highlight our dedication to supporting staff development and improving patient care.

3.6 National targets and regulatory requirements

The following indicators are all governed by standard national definitions

Indicator		2022/23	2023/24	2024/25	Target	National Average / Benchmark
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		73.0%	68.8%	**69.9%**	92.0%	59.2%*
A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		73.3%	71.1%	**71.7%**	76.0%	73.9%
Cancer Faster Diagnosis Standard	Faster diagnosis standard (FDS): Maximum 28-day wait to communication of definitive cancer/not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	76.4%	77.3%	**80.0%**	75.0%	76.2%*
	Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients	98.8%	99.6%	**99.4%**	96.0%	91.0%*
	Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening	61.4%	66.5%	**74.9%**	85.0%	68.1%*
Maximum 6-week wait for diagnostic procedures		81.3%	90.9%	**85.2%**	99.0%	82.5%**

*2024-25 YTD February 2025 position

** February 2025 position

Annex 1: Feedback on our 2024/25 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 2024-25 we feel able to comment as follows:

Progress Against Quality Priorities for 2024-25

OSC expressed its thanks to all the Trust's staff and volunteers for work undertaken to deliver against the identified priorities. The Committee noted positive progress in relation to reducing waiting times for patients.

In relation to the improvement of experiences for people with a learning disability or neurodiversity, Committee noted that learning disability awareness training is now mandatory for staff, with 66% having currently completed this course. The OSC is supportive of planned work to increase this figure, with a target of 90%. The OSC queried what evidence there was to demonstrate that experiences had improved for neurodivergent patients, and it was acknowledged by the Trust that whilst stories of patients do get fed up to the Board, there is more work to be done to capture and record patient experience in this area.

The OSC was pleased to note the continued engagement of the Trust with its staff and the various mechanisms used to listen to staff, including engagement with those working on nightshifts.

Quality Priorities for 2025-26

OSC is supportive of the Trust's Quality Priorities for 2025/26, particularly the continued drive for digital developments to enable more time for care and to avoid duplication of effort. The OSC also noted the Trust's commitment to health literacy and reviewing the way that letters are written to ensure accessibility for all.

The OSC is supportive of the Trusts plans to continue to listen to staff and to encourage staff to suggest any ideas they have for continued improvement.

4.2 Northeast and North Cumbria Newcastle Gateshead Integrated Care Board

Commissioner Statement from NHS North East and North Cumbria Integrated Care Board for Gateshead Health NHS Foundation Trust Quality Account 2024/25

NHS North East and North Cumbria Integrated Care Board (NENC ICB) is committed to commissioning high quality services from Gateshead Health NHS Foundation Trust (GHFT). NENC ICB is responsible for ensuring that the healthcare needs of patients that they represent are safe, effective and that the experiences of patients are reflected and acted upon. The ICB welcomes the opportunity to review and provide comment on this 2024/25 Quality Account.

Overview

The ICB would like to thank GHFT for the openness and transparency reflected in this year's Quality Account. The ICB would like to commend all staff for their commitment and dedication demonstrated throughout these challenging times and for striving to ensure that patient care continues to be delivered to a high standard.

Achievements

The ICB would like to congratulate GHFT and its staff on the achievements made during this period. The ICB recognises the attainments detailed within the quality account, which include:

- Strengthening the use of carer's passports by developing a new carers leaflet/feedback form, a new audit form for ongoing monitoring, and distributing resources to wards.
- Implementing the zero-tolerance campaign as part of the culture programme achieving several projects, e.g., signing the sexual safety charter, amending the Bullying and Harassment policy, developing a roadmap for raising concerns.
- Increasing staff engagement by ensuring the clinical voice is heard and involved in decision making.
- Focusing on safe staffing and reducing staff movement by using approved tools to assess staffing and the SafeCare Live system to monitor staff re-deployment, and implanting vacancy authorisation processes.
- Improving the safety of patients with mental ill health in the acute setting. This was achieved, among other initiatives, by training all Matrons and Ward Managers on the Mental Health Act, improving relationships and sharing learning between the Older Persons Mental Health and the acute teams, establishing the Violence Reduction Group which focuses on understanding the antecedents of behaviours.
- Improving safe processing of clinical results by mapping responsibility for managing radiology red flags, reviewing existing compliance reports and implementing a new policy.
- Improving communication with primary care partners by reducing duplication and improving efficiency and quality of discharge letters. This was achieved by using a

second system to create the documentation, preventing duplication and clarifying communication.
- Using data to drive improvements by building on existing metrics and dashboards providing assurance on care standards and identifying areas of improvement.
- Opening the Community Diagnostic Centre in partnership with Newcastle-upon-Tyne Hospitals NHS Foundation Trust
- Undertaking 95% of National Clinical Audits, 5 National Confidential Enquiries and local clinical audits.
- GHFT Receiving the Gold National Joint Registry Quality Data Provider Award for 2024.
- Ranked third overall in the UK, and best in the North East, for Best Practice Tariff as part of the National Hip Fracture Database.
- Ranked in the top 10 for professional development in obstetrics and gynaecology and highly commended for professional development nationally, by trainees.

National recognition of the South of Tyne and Wear Clinical Pathology Service, part of GHFT, by maintaining accreditation and ensuring accuracy and competence.

Areas for Further Development
The ICB recognises the additional work required which has been identified within the quality account. In particular, the work to:

- Reduce waiting times for treatment (<52 weeks) and in the Emergency Department (ED). Achievements, include increasing throughput in outpatient clinics and theatres, improving elective pathways.
- Improve the experiences of people with a learning disability (LD)/neurodiversity. Partially achieved with the implementation of mandatory LD awareness training and provision of two LD specialist nurses.
- Improve the way the Trust listens, acts upon and learns from concerns. Partially achieved with the training of new freedom to speak up champions, however the strategy was delayed.
- Implement Patient Safety Incident Response Plan (PSIRP). Six workstreams are progressing with further work required to embed workstreams and PSIRP.

Future Priorities
The ICB is fully supportive of the identified Quality Priorities for 2025/26 which include:

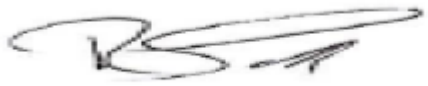
- Striving to eliminate unnecessary waits by reducing non-elective stays and percentage of 12 hours waits in ED and improving access to diagnostics.
- Implementing the Maternity and Neonatal Three-Year Delivery Plan by listening to women and families, supporting the workforce to develop skills/capacity, developing/sustaining a culture of safety, and meeting/improving standards and structures.
- Driving digital developments enabling more time to care and providing better patient experience by standardising care plans and clinical record keeping and expanding observation elements on Nervecentre.
- Implementing a programme to address health inequalities, e.g., roll out of Making Every Contact Count, evaluate baseline of patient-facing communications and identifying improvements, improving access, experience and outcomes for patients.
- Listening to staff by improving two-way communication and implementing a plan based on themes from the staff survey.

- Ensuring the right staff are in the right place at the right time, to enhance patient care and meet strategic aims and intentions by reviewing different ways of working.
- Improving the timeliness responding to complaints and concerns by reviewing the effectiveness of the new Complaints and Concerns Policy and implementing a new training package.
- Strengthen working with voluntary and third sector organisations by inviting key partners to the Patient Experience Group to share insights, align priorities and build trust. Work with the ICB to map the Voluntary Care Sector landscape in Gateshead.
- Implement systematic learning and improve from feedback by working collaboratively to positively impact patient/staff experience, bring more people with lived experience to support planning and improvement, strengthen triangulation of data to improve services and share learning.

The ICB can confirm that to the best of their ability the information provided within the annual Quality Account is an accurate and fair reflection of GHFT's performance for 2024/25. It is clearly presented in the required format, contains information that accurately represents the Trust's quality profile and aspirations for the forthcoming year.

NENC ICB remains committed to working in partnership with GHFT to assure the quality of commissioned services in 2025/26.

Yours sincerely,



Richard Scott
Director of Nursing (North)
NHS North East and North Cumbria Integrated Care Board

4.3 Gateshead Healthwatch

Gateshead Health NHS Foundation Trust
Annual Quality Account 2024/25
Response from Healthwatch Gateshead - 5th June 2025

Thank you for sharing the draft quality account for our comment and Healthwatch Gateshead would like to take this opportunity to thank your team for all their hard work.

Healthwatch Gateshead welcomes this year's Quality Account. It shows that Gateshead Health NHS Foundation Trust (GHFT) is staying focused and making progress toward its goals. We're pleased to see that you are regularly reviewing how resources are used to ensure they're effective. We also support your ongoing commitment to providing outstanding and compassionate care to patients and the wider community.

Our comments on the progress made in 2024/25:

- **Waiting Times (Priority 1):**

Efforts to cut elective waits and long Accident and Emergency delays are clear and well tracked. It's good to see cancer treatment targets being met. Still, it would help to include more patient feedback.

- **Learning Disability and Neurodiversity (Priority 2):**

Mandatory training and support from specialist nurses are positive steps, but only 66% of staff have completed the training. It's unclear what's being done to improve this or if staff can apply the training in practice. There's also little information on how professionals communicate with patients or use their feedback to improve services.

- **Carers Passport (Priority 3):**

The new resources and audit approach look solid.

- **Staff Concerns & Culture (Priorities 4 & 5):**

It's great to see the Freedom to Speak Up rollout progressing well. However, the report lacks the staff perspective—it doesn't explore why some may have felt unable to raise concerns in the past. It also misses details on staff support, such as regular supervision, reflective practice, and overall wellbeing. We'd appreciate more information on these areas.

- **Staff Engagement (Priority 6):**

The restructure seems well thought out.

- **Safe Staffing (Priority 7):**

This section is well-written and informative. However, including feedback from staff and patients on whether they noticed any changes from the new tools would help show their impact on the continuity of care.

- **Patient Safety Incident Response (Priority 8):**

The structure—workstreams, panels, and leads—is clear. However, there's little detail on how changes like the Patient Safety Incident Response Plan will lead to real improvements. More examples or case studies would have helped show learning in action.

We're concerned that only 56% of staff received proper training in end-of-life care, according to the National Audit. This is a critical gap that needs urgent attention.

It's also worrying that nearly half of patients didn't have a mental capacity assessment. These should be done early to ensure care is legally and ethically sound, and to help reduce readmissions.

In elderly care, under- or over-medication is a serious risk—especially for immobile patients. Staff need proper equipment to weigh patients accurately. Incorrect dosing can harm patients and cause moral distress for staff.

- **Mental Health in Acute Settings (Priority 9):**

Lots of good work on training and joint working.

- **Clinical Results (Priority 10):**

The policy work is thorough. Will there be a feedback loop from staff using the new process to help improve it?

- **Communication with Primary Care (Priority 11):**

The discharge letter issue is well explained, and the fix sounds structured.

- **Ward-Based Quality Metrics (Priority 12):**

The metrics are being used well to guide improvements. However, more information on whether do staff find them useful and if patients are shown the results would be welcomed.

Our comments on the Priorities for 2025/26 – Looking Ahead:
The priorities are broad-ranging and well structured, with clear monitoring indicators. However, we feel there are areas to consider for future focus:

- **Complaints Handling:**

It's great to see a commitment to improvement. However, it would be helpful to understand what specific processes will be put in place to ensure patients receive feedback about any changes made because of their complaints.

- **Health Inequalities:**

Some initiatives are still marked as "wording to be confirmed," which suggests internal discussions are ongoing. It would be useful to know how community groups or service users will be involved in shaping these actions.

- **Digital Transformation:**

There's clearly a lot of technical planning happening. To build trust and understanding, we'd welcome a plain-English explanation of what these changes will mean for patients.

We welcome the 2025/26 priorities and the strong focus on patient experience. We also encourage the Trust to keep improving how it listens to families and carers. Working with partners like Healthwatch can help capture the views of patients, families, carers, and the wider community. Patients tell us that what matters most is a joined-up approach to their care and support.

We understand that the NHS is going through a period of major change. Trusts are under pressure to cut costs in some areas, and the upcoming NHS 10-year plan is expected to bring big shifts—moving more services into the community, focusing on prevention, and making greater use of technology. To meet these changes, the Trust will need to work closely with all partners to make sure residents continue to receive the high-quality care they deserve and expect. Healthwatch Gateshead is keen to continue to work with you to make this happen.

We'd like to thank everyone at GHFT for their ongoing dedication to providing safe, high-quality services to our communities. We look forward to continuing our partnership with GHFT over the next year.

4.4 Council of Governors

Council of Governors feedback on the Quality Account 2024/25

The Council of Governors had the opportunity to partake in a consultation workshop on the development of the Quality Account and quality priorities on 6th March 2025. In addition, the completed draft of the Quality Account was shared with all Governors as part of the consultation process. We have used our knowledge of the Trust gained through attendance at meetings and other engagement opportunities during 2024/25 to determine whether the content of the document presents a fair reflection of the achievements, challenges, risks and

opportunities experienced during the year, as well as whether the quality priorities for 2025/26 are focussed on what we feel are the key areas.

Overall, we feel the draft Quality Report is concise and informative, and bears testament to the commitment of all staff at Gateshead Health, to provide excellent healthcare to the people of Gateshead and further afield who use our services. All staff also strive to enhance patient care despite the challenges of the future.

We like the introductory section at a glance and think it is interesting and helpful for those who don't read the whole document, and we feel the Chief Executive Statement is well balanced celebrating what has been achieved and recognising what is still to be done in a very difficult context.

We also shared a number of specific points for consideration:

- Inclusion of a detailed description of the Alliance;
- Inclusion of a brief description of the 15 Steps Challenge and PLACE. Readers and indeed staff may not be aware of what these two initiatives are;
- Consider the mentioning the Great North Health Care Alliance within the glossary section;
- Ensure the document is shared widely across the organisation particularly headline sections, the Chief Executive Statement as well as the agreed targets for next year.

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:

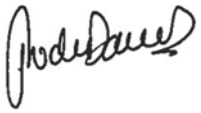
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2024 to March 2025
    - papers relating to quality reported to the board over the period April 2024 to March 2025
    - feedback from Northeast and North Cumbria Newcastle Gateshead Integrated Care Board dated - 20/05/2025
    - feedback from governors dated - 14/05/2025
    - feedback from local Healthwatch organisations dated – 05/06/2025
    - feedback from Overview and Scrutiny Committee dated – 13/06/2025
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – not yet published
    - the 2024 national patient survey – March 2025
    - the 2024 national staff survey – March 2025
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated – 23/06/2025
    - 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: 25 June 2025 Chair: 

Date: 25 June 2025 Chief Executive: 

Glossary of Terms

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.

Council of Governors
Our Council of Governors represent our staff, stakeholders and our local communities in the running of the Foundation Trust, under the terms of the Trust's constitution. The Council of Governors' statutory duty includes the appointment and removal of the Chairman and Non-Executive Directors, the appointment of the Trust's auditors and the approval of changes to the constitution of the Trust. They also hold to account the Trust Board for its management of the Trust. The Council of Governors are involved in a number of initiatives within the organisation, including 15 steps challenge visits and PLACE visits.

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.

Integrated Care Board (ICB)
A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System (ICS) area.

Integrated Care System (ICS)
Integrated care systems are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

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.

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.

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.