

**Gateshead Health NHS Foundation Trust**

**Quality Account  
2010/2011**

# 1 Statement from the Chief Executive

As an introduction to our Quality Account for 2010/11, I am proud to report that we have built on the foundation of previous years and consistently achieved our national and local standards, meeting Monitor's regulatory requirements and achieving unconditional registration with the Care Quality Commission in the process.

This would not be possible without our dedicated staff and their commitment to provide the highest possible standards of care. Our priorities for improvement are driven by the Board and staff are actively focused on quality and patient safety, challenging practice and exploring new ways of working. This is reflected in the initiatives implemented in the past.

In addition to continuing the themes of previous years (for example, further reductions in the rate of Healthcare Associated Infections; our MRSA rates now reflecting a 90% reduction over three years), 2010/11 has seen many independent acknowledgements of our focus on the quality of the services we deliver for our patients:

Both our breast and bowel screening services have undergone successful quality assurance visits. The breast unit has received an extremely positive and complimentary report which highlights that the unit provides an excellent patient focused service with a high regard for quality, meeting all of the breast service related target standards. It was also commended on the proactive work that is done to achieve consistently high quality service delivery. The South of Tyne Bowel Cancer Screening Service hosted at our Trust also received excellent feedback on the overall performance and centre management. The recommendations made within the action plan included further work to include patient experience and consideration of new processes and technologies.

We are also delighted that we were placed 2<sup>nd</sup> for the whole of England in our recent Cancer Patient Experience Survey, which measured patients' experience of services whilst being treated in hospital.

In addition, we have seen further improvements in our Mortality Rates with a RAMI score of 82 at the year end (100 representing the national average).

All of the above provides assurance to our patients and their carers of our commitment to providing the highest standards of care

The Trust remains firmly committed to delivering even higher levels of patient safety and clinical quality and this is reflected in our priorities for 2011/12 which are:

## **Clinical Effectiveness**

- Reducing mortality
- Improving care for patients who have suffered a stroke

## **Patient Safety**

- Reducing harm from pressure damage
- Improve the quality and timeliness of patient discharge information to General Practitioners
- Further develop the Medicines Safety Programme

## **Patient Experience**

- Increase the number of patients reporting a positive experience

In writing this report we have consulted widely with our staff, governors and members, local stakeholders and most importantly taking into account the views of our patients.

I can confirm to the best of my knowledge the information contained within the Quality Accounts is accurate.

A handwritten signature in black ink, enclosed within a hand-drawn oval. The signature appears to be 'Ian Renwick'.




**Signed: Ian Renwick, Chief Executive**

**Date: 18 May 2011**

## 2 Priorities for Improvement

### 2.1 Reporting back on our progress in 2010/11

In our 2009/10 Quality Account we identified 6 quality improvement priorities that we would focus on over the year. This section focuses on the progress we have made against these.

<b>Key</b>
 <b>We achieved our aims</b>
 <b>We partially achieved our aims or significantly improved our processes to enable future improvement</b>
 <b>We did not achieve our aims</b>

#### Priority 1: Reduce avoidable hospital mortality



The Hospital Standardised Mortality Ratio (HSMR) compares the expected rate of death in a hospital with the actual rate of death and allows us to assess the Trusts performance on a range of clinical conditions, such as patients with conditions that most commonly result in death for example, heart attacks and strokes.

If the Trust has a HSMR of 100, this means that the number of patients who died is exactly as predicted. A HSMR above 100 means that more patients died than would be expected, and one below 100 means that fewer than expected died. The calculation takes into account factors such as age, sex, diagnosis and presence of other diseases. Using this we can also compare our performance with other Trusts locally and nationally.

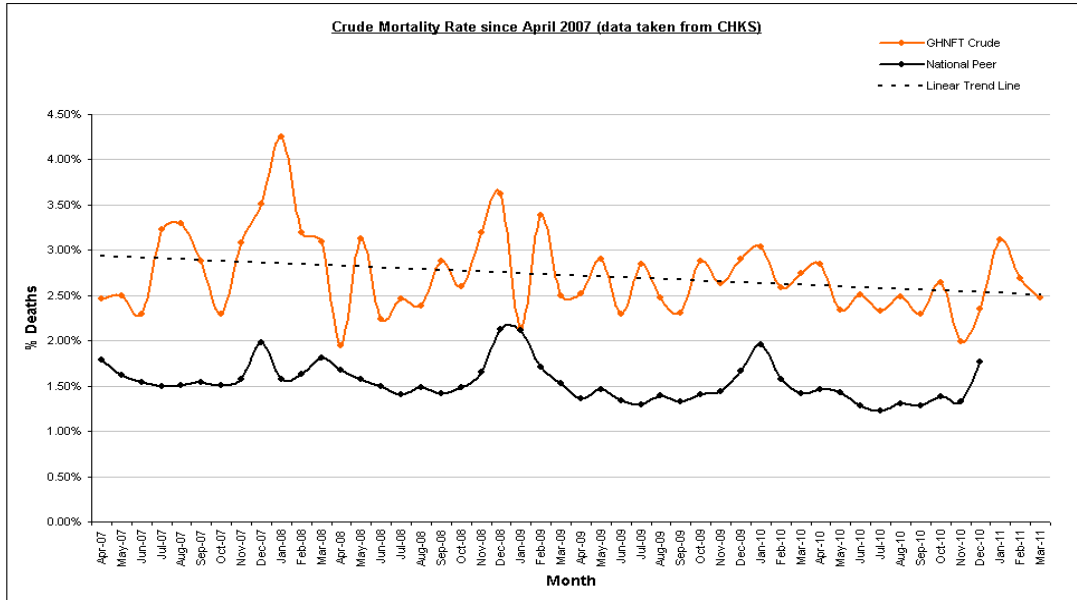
Like many others, the Trust uses an independent organisation called CHKS to monitor its Hospital Standardised Mortality Ratio. The CHKS version of the HSMR is known as RAMI (Risk Adjusted Mortality Index).

Crude mortality rate is a measure of the number of deaths which does not include an adjustment for risk factors as in the RAMI.

## What did we say we would do?

Achieve a year on year reduction in avoidable mortality utilising CHKS Crude Mortality Rate and Risk Adjusted Mortality Index (RAMI).

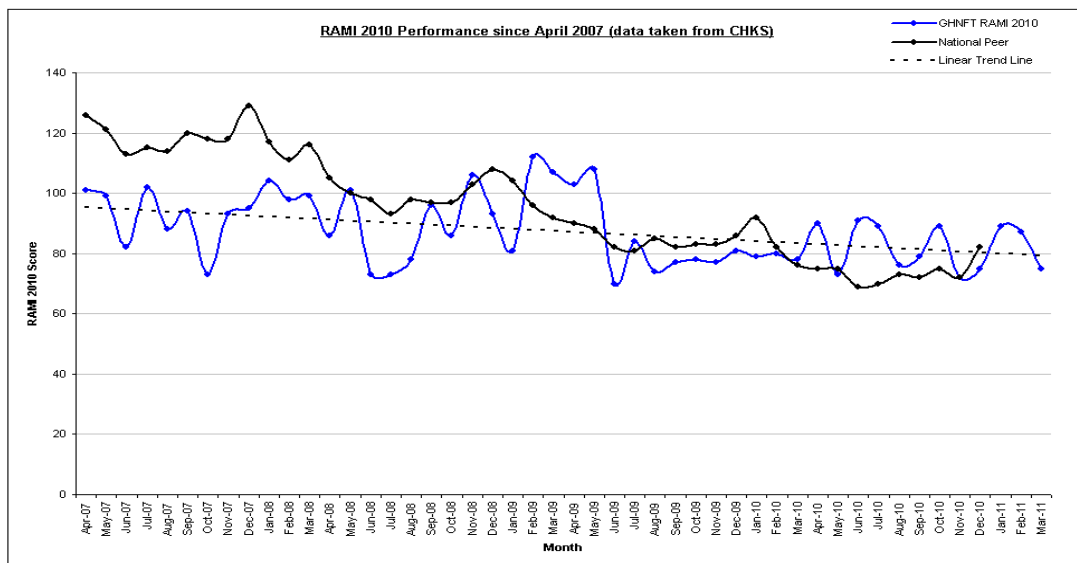
## What did we achieve?



As can be seen in the chart above, despite the fluctuations in the data the overall trend from April 2007 to March 2011 is one of a downward trend. The Trust crude mortality rate lies approximately 1 to 1.2% above that of the national average.

Whilst the Trust crude rate seems high in comparison to the national average, it does not take into account risk factors, such as cohorts of patients, co-morbidities, age etc. In order to assess mortality at GHNFT with risk adjustment, the use of the RAMI 2010 score from CHKS will enable this and is displayed in the following chart.

As can be seen from the chart below the Risk Adjusted Mortality Index (RAMI) score also shows a declining trend from April 2007. The RAMI score for April 2007 to March 2008 was 94, whereas the year to date figure for April 2010 to March 2011 is 82, representing a fall of 12 points. It is clear to see in the chart how the national average has fallen during this time and the latest picture has GHNFT being slightly above the average for 2010/11. It is to be noted however that the national data is only available up to December 2010.



Our efforts have continued to focus on our streams of work aimed to reduce avoidable patient harm and complications.

We have built on our existing work related to improving the care of the Deteriorating Patient. We developed four key areas of work to examine the quality of care of our patients at various points in their care pathway.

This involved

- An in-depth analysis of patients identified through the Global Trigger Tool audits
- A review of patients readmitted to the Critical Care Unit during their hospital stay.
- A review of relevant patients reported through the incident reporting system.
- A review of patients whose condition resulted in a call to the Cardiac Arrest Team.

Our work showed that patients' vital signs, for example blood pressure, temperature, pulse, rate of breathing, was not always recorded in a timely manner. On occasion the EWS scores, a score calculated from the vital signs, that shows signs that

the patient's condition is becoming worse, were not acted upon soon enough and indicated that we needed to improve our response processes.

As a result of this we have redesigned the Early Warning Score chart to help improve compliance with monitoring patients. It uses a colour coded system to prompt staff on when and how to respond to problems and facilitates earlier involvement of senior medical staff.

We have also reviewed and strengthened our programme of education and training for staff in recognising and caring for the deteriorating patient.

Another important piece of work has been improving care to prevent patients from developing deep vein thrombosis (DVT) and pulmonary embolism (PE) a condition recognised as causing avoidable deaths.

Deep vein thrombosis (DVT) is a blood clot in one of the deep veins in the body. Blood clots that develop in a vein are also known as venous thrombosis. DVT may lead to

complications such as pulmonary embolism. This is when a piece of blood clot breaks off into the bloodstream and blocks one of the blood vessels in the lungs.

People in hospital can be at risk of DVT because they may be unwell and inactive for long periods of time. DVT can happen at any time during a stay in hospital or in the weeks after leaving hospital.

DVT and pulmonary embolism together are known as venous thromboembolism (VTE).

We have concentrated on ensuring that patients are assessed for the risk of VTE on admission and that those at risk are given the appropriate treatment to prevent them from developing such complications. We have achieved the target set by the Department of Health of risk assessing over 90% of our patients for risk of Venous Thromboembolism (VTE) on admission to our hospital.

We have also developed information for our patients that advises them on how to help prevent VTE.

Our initiative of clinical teams undertaking reviews of patients who have died is helping us to identify where care has been good as well as areas where we need to improve. This initiative has recently been recognised by our Strategic Health Authority, at their Patient Safety Summit in March 2011 when the Trust was presented with a Patient Safety Award.



We have continued to review patient care through the Global Trigger Tool. This has allowed our clinical teams to identify events through triggers which may have caused or have potential to cause varying levels of harm and to introduce changes to improve patient care.

Reducing avoidable deaths will remain a priority for us in 2011/12 and section 2.2 sets out our proposed plans.

## Priority 2: Further reduce our Healthcare Associated Infection Rates

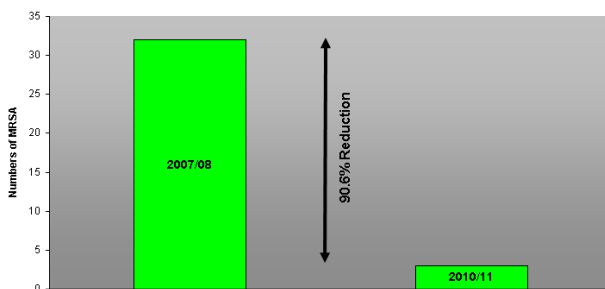


Ensuring that the health of our patients is not comprised by healthcare associated infections is a key priority for us. Our significant improvements in reducing MRSA Bacteraemia and Clostridium Difficile are shown below.

What did we say we would do?	What did we achieve?	
Reduce the number of MRSA bacteraemia from 8 in 2009/10 to 5 in 2010/11	We reduced the number of MRSA to 3	
Reduce the number of Clostridium Difficile from 105 in 2009/10 to 90 in 2010/11	We reduced the number of Clostridium Difficile to 48	

We are very pleased with this achievement and will continue to work hard to reduce all avoidable infections.

We have reduced infections of MRSA bacteraemia occurring after 48 hours of admission by over 60% in 2010/11. This means that over the last four years we have made a reduction of 90%.



Joint working across Gateshead with the primary care trust team has proved beneficial and this approach will continue for 2011/12.

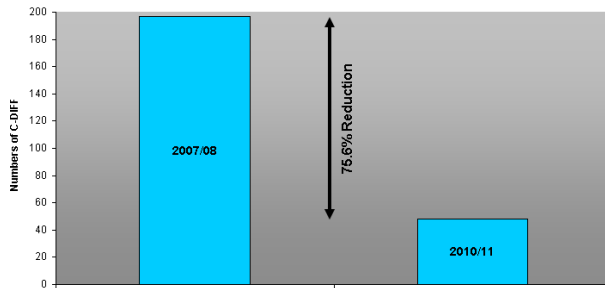
We have continued to use a form of investigation called Root Cause Analysis for all cases of MRSA to identify any lessons that could be learnt. This is a technique that helps us to understand why the infection may have occurred in the first place. This learning is then shared with staff across the hospital to inform our practice and help prevent further infections.

We will continue to sustain this good practice and aim to eliminate these largely preventable infections.

We have implemented a screening test for patients admitted for both planned procedures and emergency admissions to detect MRSA carried in the nose or on the skin. This has allowed us to treat patients carrying MRSA, to reduce the risk of them getting ill themselves from MRSA or giving MRSA to other patients.

We have reduced our Clostridium Difficile infection in 2010/11 by over

50% and over the past 4 years by 75%.



We have had an intensive program of work that has included ensuring patients who are suspected or have been diagnosed with infective diarrhoea are placed in a side room to prevent the spread of infection.

We have had a consistent approach to ensuring strict hand hygiene at the point of the patient's care. We have also continued to maintain high levels of environmental cleanliness.

### Priority 3: Improve medication safety







The Trust has an approved strategy to improve medication safety across the organisation based on the fourth report from the Patient Safety Observatory – “Safety in doses: medication safety incidents in the NHS”. The strategy comprises seven key themes:-

1. Increase reporting and learning from medication incidents
2. Implement National Patient Safety Agency safer medication practice recommendations
3. Improve staff skills and competence
4. Minimise dosing errors
5. Ensure medicines are not omitted
6. Ensure the correct medicines are given to the right patient
7. Document patient’s medicine allergy status



For 2010/11 we chose to concentrate on themes 2, 3, 5 and 7 as these were priority areas highlighted through incident reporting and National Health Service Litigation Authority (NHSLA) requirements. We had also undertaken a significant amount of work in relation to theme 1 in the previous year.

#### What did we say we would do?


##### Theme 2 - Implement NPSA safer medication practice recommendations

What did we say we would do?	Did we achieve this?
To ensure actions are progressed to new NPSA alerts issued involving medicines.	
To engage with North East Strategic Health Authority Anticoagulant Group as part of Safer Care North East initiative.	 Unfortunately this regional initiative did not go ahead
To demonstrate implementation of the care bundle, incorporating the 4 elements described in the ‘Safer Use of Intravenous Gentamicin for Neonates’.	
To implement needle free devices Trust wide to ensure completely closed system of IV drug delivery.	

Theme 3 - Improve staff skills and competence

What did we say we would do?	Did we achieve this?
To progress the second e-learning module which will be focussed on drug administration.	 <p>We underestimated the challenges of developing customised e-learning. However we are progressing with a more simplistic approach called 'Authentic World'</p>
Overhaul and consolidate all trust drug policies into clearer themed documents to support safe prescribing, supply and administration of medicines.	 <p>Whilst we have not completed this piece of work, due to service pressures, we have developed a framework that will consolidate the current 31 drug policies into five key documents that will provide practitioners with a comprehensive and user friendly set of guidance on medicines management. The five themes are :</p> <ul style="list-style-type: none"> <li>• Overview of the Ordering, Storage, Prescribing &amp; Administration of Medicines</li> <li>• Supply Of Medicines</li> <li>• Administration Of Medicines</li> <li>• Prescribing of Medicines</li> <li>• Controlled Drugs</li> </ul>

Theme 5 - Ensure medicines are not omitted

What did we say we would do?	Did we achieve this?
Develop and implement a programme of work that will focus on ensuring medicines are not omitted.	

As omitted or delayed medication has been identified by the National Reporting and Learning System as the second largest cause of medication incident, this theme was the main issue targeted for improvement in the 2010/11 programme of work. An intensive audit followed almost 100 patients

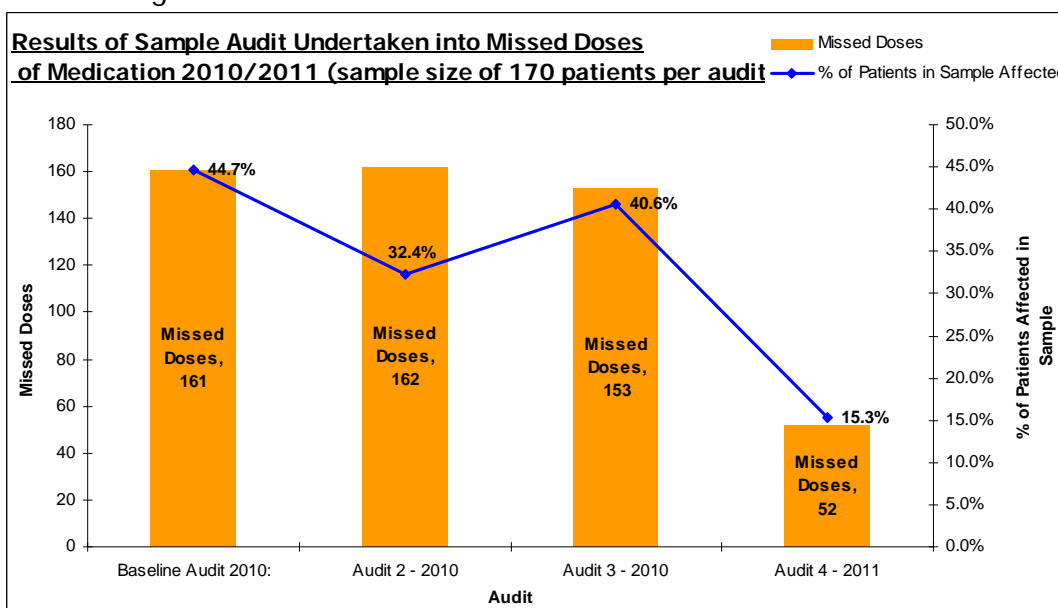
and their medicines over a three week period to inform reasons why patients do not receive their medicines at the prescribed time. Key findings were:-

- Medicines in bedside lockers were not moved with the patient when they moved wards



- Patients with long term conditions do not always bring their medicines into hospital
- Confusion regarding the roles and responsibilities of pharmacy and nursing staff to optimise medicines supply.

findings of the audit and the Trust is participating in the SHA wide poster campaign to raise awareness of the green bag scheme encouraging patients to bring their medicines into hospital. A recent audit demonstrates improvement in the number of omitted doses as illustrated in the chart below:


Pharmacy and nursing teams have worked together to address the



**Theme 6 - Ensure the correct medicines are given to the right patient**

What did we say we would do?	Did we achieve this?
Reduce medication errors occurring on patient discharge. Work will focus initially on the nurse discharge check list and identify when and how patient compliance sheets should be issued.	
Manage demand for medicines to be supplied in compliance aids. There is increasing demand for discharge medicines to be supplied in Monitored Dosage Systems (MDS)/compliance aids. A recent high profile study in care homes concluded that dispensing in MDS imposes high demands on pharmacy time yet its contribution to safety is unclear. It is proposed that a tool is developed which must be completed before any new patients are provided with medicines in MDS.	 <p>Despite our efforts, this continues to be a challenge. Much of the demand is driven by Social Services and we will need to identify opportunities for greater partnership working with the Local Authority to take this work forward.</p>

**Theme 7 - Document Patient's Medicine allergy status**

What did we say we would do?	Did we achieve this?
To consolidate the Model for Improvement methodology piloted on one medical ward and roll out to other wards across the organisation.	



Whilst we did not fully achieve one of our targets, the approved medication strategy has been beneficial in raising the profile of medication safety across the organisation. It has engaged all members of the health care professions involved in the

prescribing, supply and administration of medicines, improved their awareness of the risks associated with medicines and gained their ownership of issues identified. Medication Safety will remain a high priority for the organisation.

## Priority 4: Reduce harm from falls

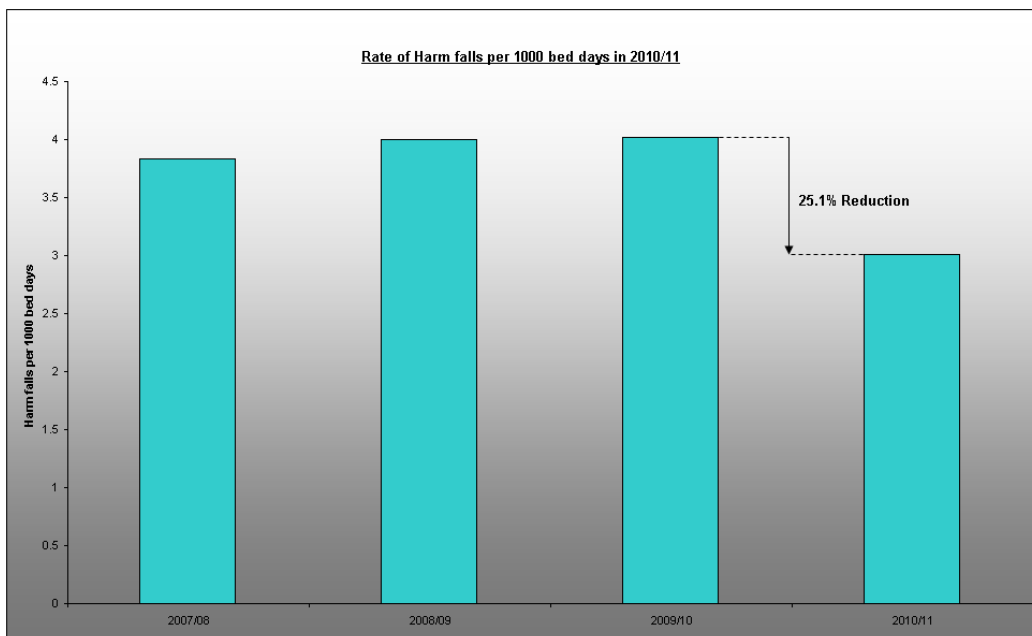


Across England and Wales patient falls are the single most common event reported to the National Patient Safety Agency. Falls are consistently our top reported incidents in the Trust with approximately 50% of these resulting in some form of harm to the patient. That is why this was chosen as a key priority for 2010/11.

What did we say we would do?	What did we achieve?	
Reduce the number of falls by 10% in 2010/11	We reduced the number of falls from 1607 in 2009/10 to 1448 in 2010/11. We have therefore reduced our number of falls by 159 achieving a 9.9% reduction	
Reduce the number of falls resulting in harm by 10% in 2010/11	We reduced the number of falls resulting in harm to patients from 793 in 2009/10 to 537 in 2010/11. We have therefore reduced the number harmful falls by 256 achieving a 32.3% reduction	

We have also calculated our rate of harmful falls per 1,000 bed days which takes into account the fluctuation in the number of patients admitted to hospital rather than just numbers of patient that have fallen.

In this way we can more accurately assess improvement over time. We are happy to report that we have achieved a 25.1% reduction in the rate of harmful falls per 1,000 bed days.



We set up a strategic falls group that has overseen the development and implementation of a programme of improvement work.

We have developed our systems for reporting falls to improve the information reported. This provides us with better information on the circumstances surrounding the patient's fall and has helped us address the issues through training and education of staff. We have also held education sessions for our staff as well as those from nursing homes and the community.

We have focused on ensuring the 4 basic measures for preventing falls are in place. These are

1. Ask patients on admission if they have fallen recently
2. Avoid unnecessary hypnotic and sedative medicines
3. Ensure patients have appropriate footwear
4. Ensure call bells are in easy reach

One of the ways we have done this is through sending Good Practice Bulletins to relevant staff in the Trust and carrying out audits.

We have focused on ensuring all patients are assessed for the risk of falling when admitted to hospital and we have improved our compliance with this from 25% to 75%

When patients who have dementia are in hospital they often become

more confused, have high anxiety levels and have a tendency to wander around the ward. This places them more at risk of falling. We have started to introduce distraction therapy for these patients which involves providing them with familiar items such as dominos, playing cards, photographs and tables to sit at in sight of the nurses' station. They are less likely to wander and it is expected that this initiative will have a positive impact on the number of falls for this group of patients.

We held a Trust wide event on reducing falls that involved speakers from the local authority, primary care as well as our Trust. This focused on areas of good practice, services available to patients and our new initiatives to reduce harm from falls.

We will continue to build on this work in 2011/12

## Priority 5: Reduce harm from hospital acquired pressure damage

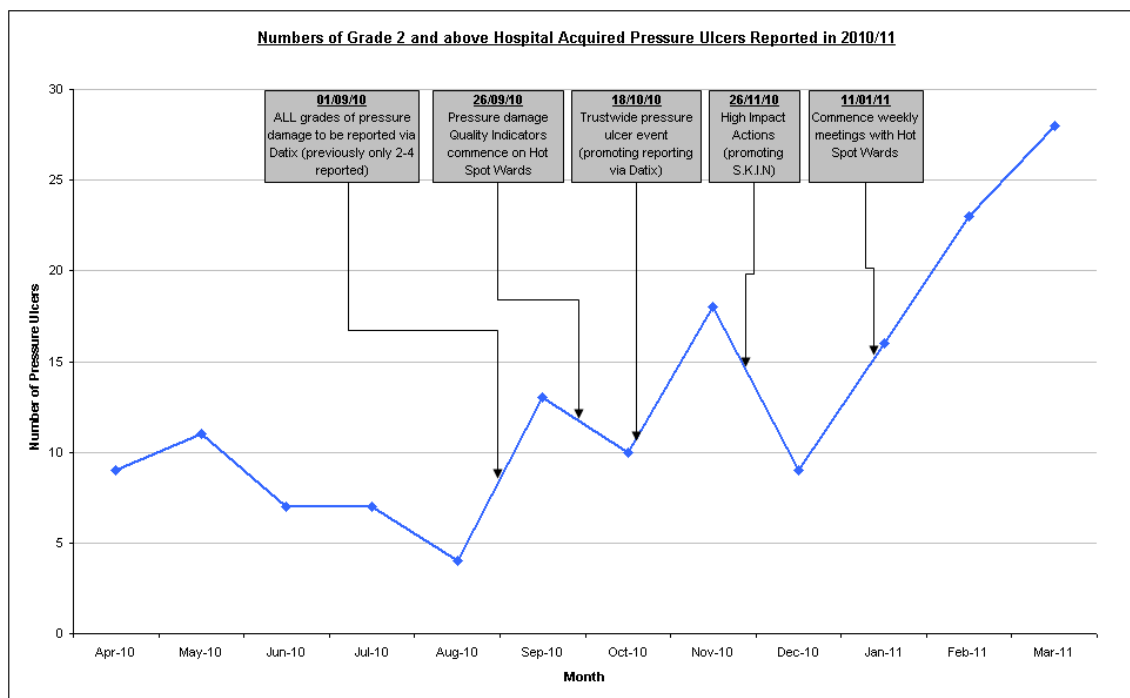


Pressure ulcers represent a major burden of sickness and reduced quality of life for patients. They can occur in any patient but are more likely in high risk groups such as the elderly, obese and malnourished. We aimed to reduce the number of pressure ulcers acquired in hospital in 2010/11.

### What did we say we would do?

Reduce the incidence of hospital acquired pressure damage of grade 2 and above by 30%.

### What did we achieve?



We are disappointed that we did not achieve our planned improvement target. We had 155 cases of grade 2 and over pressure damage within the year.

However we believe that this is largely due to increased reporting of pressure damage by our staff who, through our vast programme of work, became more aware of the need to report every case of pressure damage.

What we found is that in April 2010 when we started this work, only 9 episodes of pressure damage were reported. We started to investigate (Root Cause Analysis; a process described earlier) all episodes of hospital acquired grade 4 pressure ulcers. Further to this in October 2010 we started to investigate all grade 3 hospital acquired pressure ulcers. We have used this information combined with the latest best practice evidence, to continually update our policies and procedures

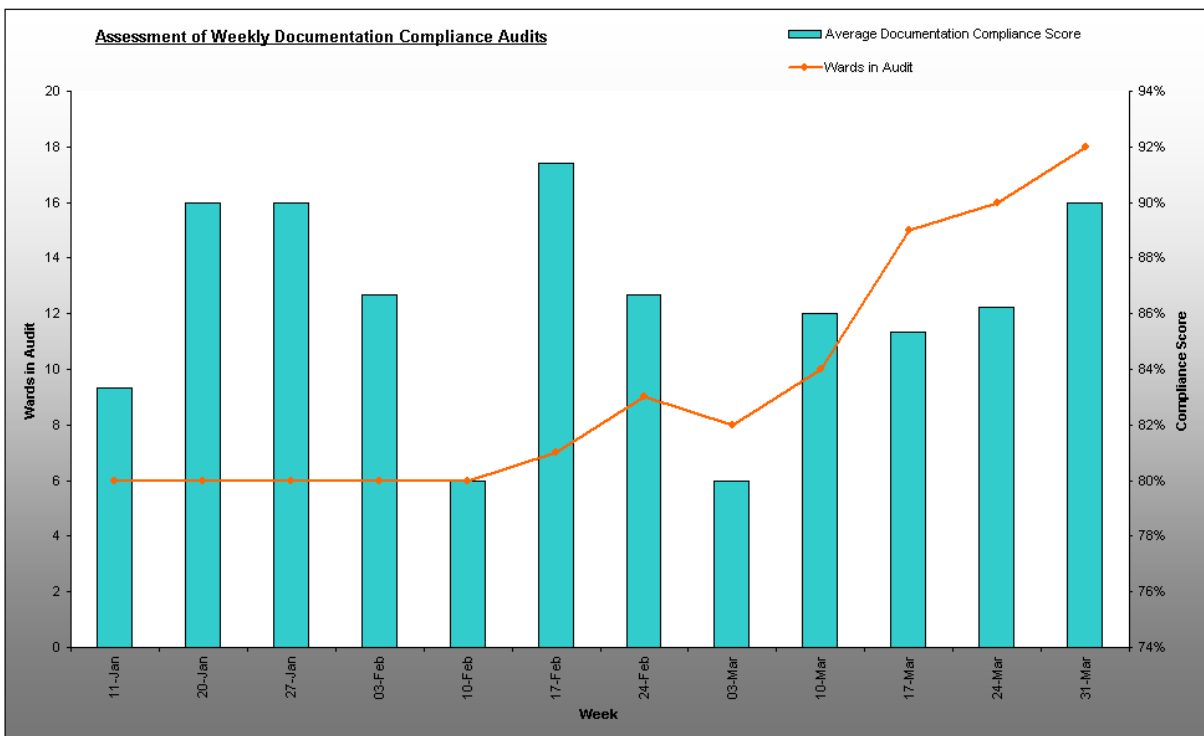
which in turn helps us to improve the quality of our care.

Considerable work has been undertaken to improve the reporting tool to ensure we capture the most important information. As we embarked on our programme of improvement it became clear that we needed to better understand what we needed to change to reduce pressure damage and this included improved reporting.

In September/October 2010 we increased the awareness of reporting pressure damage on the wards by introducing the pressure damage quality indicators on wards with high risk patients and by holding a Trust Wide SafeCare event to promote reporting. We see increased reporting of pressure damage as a positive thing as it has helped us to look at individual cases to understand why these patients developed pressure ulcers.

From January 2011 we have met on a weekly basis with the nurse managers of the wards with the highest incidence of pressure damage, reviewing individual cases and supporting them in making improvements.

We have developed a set of measures that enables us to record a quality score related to whether patients are receiving the appropriate care in the prevention of pressure damage. This includes whether the patient has been risk assessed, has the relevant pressure relieving mattress and has had their position changed in line with their individual needs. This has initially involved the ward areas with the highest incidence of pressure damage. The results of this are in the graph below. This will expand to all wards across the Trust from April 2011, who will report these through our web based dashboard on a weekly basis.



We are confident that episodes of pressure damage are reported and appropriate treatment and care is given to patients to reduce the avoidable deterioration of pressure ulcers.

We launched our new Wound Formulary to provide practitioners with up-to date, evidence based guidance on wound management products. It covers a wide range of wound types, descriptions and advice on the most appropriate product(s) to use. This was launched in October at our SafeCare Trust Wide Event on Preventing Pressure Damage. In addition, we

have invested in new equipment that helps prevent pressure damage such as special sheets for moving patients and heel pads.

We have a better understanding and clear definition of the grades of pressure ulcers and when it is hospital acquired. We have done considerable work and are committed to making an improvement. This important element of patient care remains a priority for us and we expect to see an improvement in the coming year. Our initiatives for 2011/12 are detailed in section 2.2.

## Priority 6: Increase the percentage of patients reporting a positive experience



Feedback from our patients is essential in order that we accurately focus on what matters to them and that we continue to develop sustainable quality services.

In 2010/11 we set an aim to improve out patients' experience in the five key areas highlighted by the Department of Health as requiring the greatest improvement nationally. These are measured through the annual National Inpatient Survey who calculate an overall score for the five key questions.

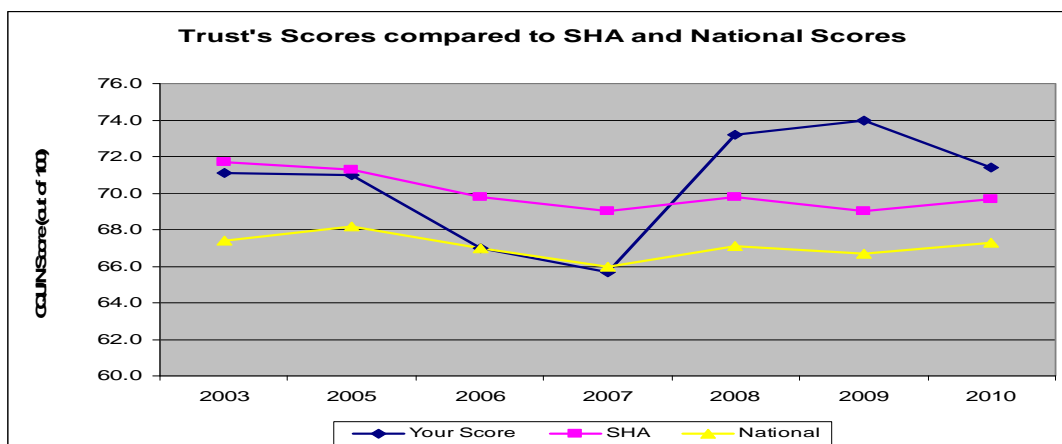
The specific questions are related to how well we respond to the personal needs of our patients and are:

- Were you as involved as you wanted to be in decisions about your care?

- Did you find someone to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Were you told about medication side effects to watch out for when you went home?
- Were you told who to contact if you were worried about your condition after you left hospital?

What did we say we would do?	What did we achieve?	
Improve our performance with the composite of 5 indicators of responsiveness to personal needs from 73 to 75	71.4	

The graph below also shows our position against the national average since 2003




We did not meet our target for the combined score, however we were the second best performing Trust in the North East of England with the

best Trust achieving 71.5%. The graph above also shows how we positively compare with the national average 67.3%.

The Picker Institute was commissioned by 75 Trusts to undertake the Inpatient Survey 2010. Out of these 75, the Trust was placed in the top 14 best performing organisations.

We also said we would improve the patient experience in relation to the information they received on leaving hospital. Whilst we did not achieve our target, we did improve our patient experience score from the previous year as illustrated in the Table below.

What did we say we would do?	What did we achieve?	
Improve on the provision of written information for patients on what to do after leaving hospital from 56 to 63	61	

Our results in this area do not reflect the amount of work that has recently been carried out to improve the patient experience in these particular areas.

A patient discharge summary/checklist was developed to improve the overall discharge process and is now in place. A copy is given to all patients. It provides a prompt for nursing staff as well as a written record on a range of key information related to the patient's care. It includes a record of the discussions and written information regarding the discharge medicines, as well as information for the patient on who to contact should they need to after leaving hospital.

We have had an extensive programme of work related to improving the privacy and dignity of patient care.

We developed a robust programme for delivering same sex accommodation and this included:

- Converting some of the wards to all same sex

- Adjustments to the patients' journey within the medical admissions unit
- Changes to bed management documentation
- Initiatives to raise awareness to staff using posters and leaflets
- Undertaking audits of the patients' experience of same sex accommodation

Further initiatives around improving privacy and dignity have involved:

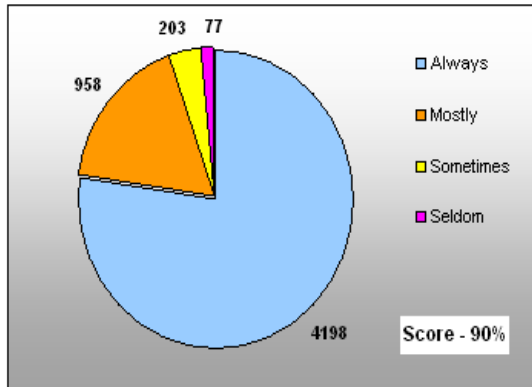
- Holding a Privacy & Dignity Conference involving national speakers which was very positively received
- Development of a privacy & dignity website
- Ensuring systems are in place to receive user feedback regarding privacy and dignity.
- Developing standards for transferring patients between various areas of the hospital with portering staff

Whilst national surveys are helpful in providing feedback on our patients' experience whilst in hospital, we are now doing much more work at Trust level to help us really understand

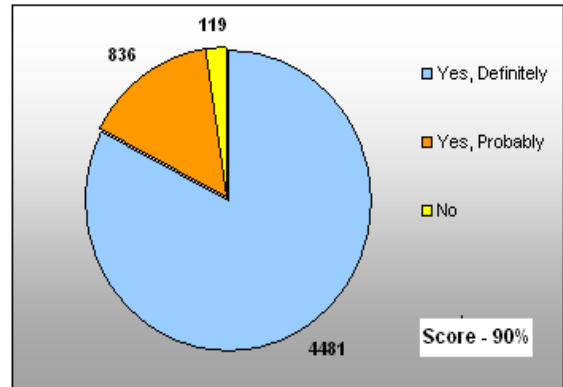
what matters to our patients. We have implemented, over the past 12 months, a process for capturing and responding to real time service user feedback. Patients are asked a number of questions with a choice of responses during their stay or visit to

the hospital. Each response is given a score and these are calculated to provide an overall score out of a hundred for each question. The charts below show what patients think about our services. These responses are very positive.

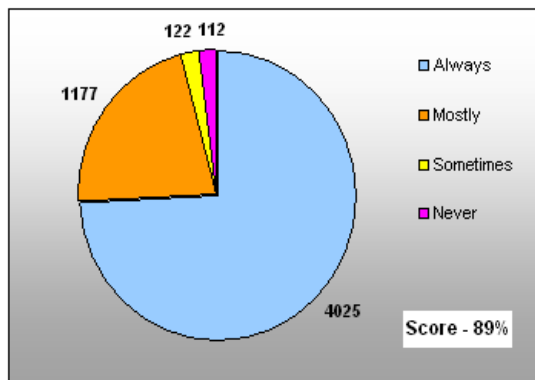
**Were you given enough privacy when discussing your condition or treatment?**



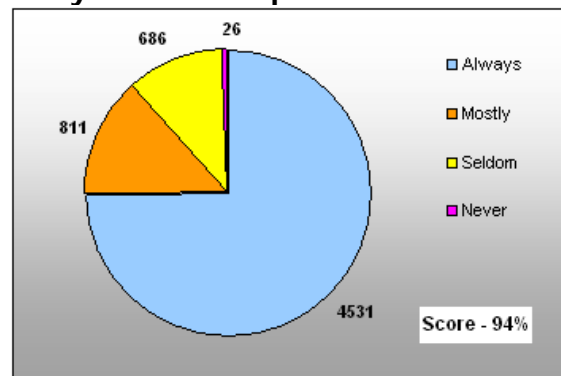
**Would you recommend this hospital to family and friends?**



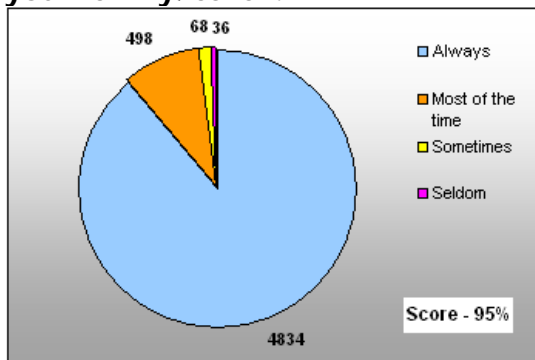
**Did you receive the information you needed from the staff about your care?**



**Do you think the ward/department was nice and clean during your stay/visit to hospital?**



**Have staff been courteous to you and your family/carer?**



Through these processes we have learnt that in order to effectively capture feedback from our diverse service user population we need to develop and implement a range of methods. This will ensure that service improvement is specific to local need as well as addressing organisational wide priorities.

This important element of patient experience remains a priority for us and we hope to see an improvement in our position in 2011/12.

## 2.2 Our 2011 / 2012 priorities for improvement

We have set 6 key priorities for quality improvement for 2011/12 and these are linked to patient safety, effectiveness of care and patient experience.

This Quality Account is at the centre of our wider SafeCare Strategy, and is one important vehicle for driving quality improvement. Additional areas for quality improvements will continue to be identified and programmes of work implemented as part of each Divisions Annual SafeCare Plans.

These priorities were chosen from a list developed through the following mechanisms:

- Consultation with our staff through a variety of forums and meetings. Council.
- Public Engagement Exercise
- Governor Workshop
- Discussions with our Patient Panel
- Discussions with commissioners and alignment to our CQUIN scheme
- Divisional SafeCare plans and identified priorities
- Internal and external data sources and reports including Care Quality Commission standards, NHSLA standards, NPSA alerts, local and external audits and analysis of complaints and incident reports.
- Existing quality improvement work and priorities identified in the 2009/10 accounts. The Trust views the Quality Report/Accounts as a means of accounting and communicating to the public on our continuous quality improvement work. The reports will build on each year's work, hence a number of the quality improvement priorities identified in this year's report have been continued into 2011/12 to ensure actions and improvements are fully embedded.
- Alignment with our SafeCare Strategy 2010/13.

Each of the priorities for 2011/12 and proposed initiatives are described in detail on the following pages including how these will be measured, monitored and reported.

## Our quality priorities for 2011/2012

Following Board consideration of our analysis, this year the Trust has identified six priority areas for quality improvement:

Priority 1: To reduce hospital deaths

Priority 2: Improve the care for patients who have suffered a stroke

Priority 3: Further develop our 2010/11 medicines safety programme.

Priority 4: Improve the quality and timeliness of patient discharge summaries to  
General Practitioners

Priority 5: Reduce harm from pressure damage

Priority 6: Improve our patients' experience

Two of our six priorities for 2011/12 are new for this year. The 2010/11 priorities of reducing harm from falls and healthcare associated infections, are now embedded in our quality improvement work streams and our quality reporting framework and we will continue to monitor progress. Our governors and Board are particularly keen to ensure the progress on these areas is maintained

## Clinical Effectiveness

### Priority 1: Continue to focus on reducing avoidable deaths in hospital.

Reducing avoidable mortality and harm to our patients remains at the centre of our SafeCare Programme of work.

#### What will we do?

Achieve a year on year reduction in mortality utilising the CHKS crude mortality rate and the rebased 2011 RAMI.

#### How will we do it?

We will continue to strengthen and develop our processes for reviewing, monitoring and reporting mortality from the ward to the Board.

We will continue to develop our quality improvement work in the key areas that contribute to hospital mortality such as VTE, the deteriorating patient, falls, infections, stroke and cardiology services. Some of this work will involve working with the North East Quality Observatory to develop our systems of data collection and analysis in key conditions and areas of patient safety.

We will network with other trusts to learn from the approaches they have applied to bring about a reduction in mortality within their organisations.

We will hold a Mortality Summit in July 2011 to engage with a variety of healthcare professionals from across the organisation. We will explore areas of high risk, areas for improvement and share good practice.

We will continue to learn from our mortality case review process and implement changes where indicated.

#### How will we measure it?

We will continue to use the CHKS data until the new national measure of Summary Hospital-Level Mortality Indicator becomes available.

#### How will we monitor and report it?

We will monitor and report progress through:-

- Monthly to the Board through the Quality & Safety Dashboard
- Monthly to the Improving Outcomes Steering Group
- Monthly Divisional Reports for Consultants and Clinical Leads with benchmarked performance
- Quarterly to the Board via a detailed report
- Twice a year to the SafeCare Council
- Twice a year to the Patient Quality Risk and Safety Committee (PQRS)
- Governor workshops

## **Priority 2: Improve the care for patients who have suffered a stroke**

People have a stroke when an area of their brain is deprived of its blood supply, causing some brain cells to die. Stroke is the third largest cause of death in England and is the biggest single cause of disability in adults. The Department of Health developed the National Stroke Strategy in 2007, which sets out a framework for delivering effective stroke services.

Every year, over 80,000 people in England are admitted to hospital following a stroke. Stroke can be devastating and life changing for people, however, timely treatment has been found to prevent disability and save lives. There are 9 recognised standards of care that are associated with better outcomes for patients who have had a stroke. These are:

<b>The 9 clinical standards of care</b>
Patients treated for 90% of stay in a Stroke Unit
Screening for swallowing disorders within 24 hours of admission
Brain scan within 24 hours of stroke
Commenced aspirin by 48 hours of admission
Physiotherapy assessment within first 72 hours of admission
Assessment by an Occupational Therapist within 4 working days of admission
Patient weighed at least once during admission
Mood assessed by discharge
Rehabilitation goals agreed by the multi-disciplinary team

### **What will we do?**

We will increase the number of eligible stroke patients that receive all nine care standards from the bundle of care from 60% in 2010/11 to 80% in 2011/12

### **How will we do it?**

We will continue to embed the changes we have made to the stroke pathway and monitor its impact to ensure that patients are receiving the best possible care. We will use patient feedback of their experience of their service to help us identify where changes may be needed.

We will work in collaboration with other Trusts in the region to develop a 24 hour 7 day a week stroke service. This will involve the use of

technology to enable a stroke specialist doctor to provide care across a number of hospital sites.

We will continue to provide our clinical teams with the relevant education and training to enhance their skill competencies in the care and management of patients who have suffered a stroke.

### **How will we measure it?**

We will utilise 'Capturestroke' an electronic system for capturing patient information related to their pathway of care. This will not only give us more accurate information but will also enable us to monitor the patient's progression through the nine standards of care

## How will we monitor and report it?

We will monitor and report progress:

- Monthly to the Board through the Quality & Safety Dashboard
- Monthly to the Improving Outcomes Steering Group
- Every two months to the Stroke Strategy Group
- Quarterly to the Board via a detailed report
- Quarterly to the our Quality Review Group with Commissioners
- Twice a year to the SafeCare Council
- Twice a year to the Patient Quality Risk and Safety Committee (PQRS)
- Governor workshops

## Patient Safety

### Priority 3: Further develop our 2010/11 medicines safety programme.

Medicines errors are one of the most common clinical mistakes in hospitals today. Preventing harm to our patients is our top priority. We want to sustain and enhance our 2010/11 work by expanding our 'Improving Medication Safety Strategy' programme of work.

#### What will we do?

We will further develop our seven theme medicines safety programme to focus on the following.

#### How will we do it?

##### **Theme 1 - Increase reporting and learning from medication incidents**

We will improve our processes for the investigation of medication incidents so that it is consistent across the organisation and enhances our ability to learn from mistakes.

##### **Theme 2 – Implement National Patient Safety Agency (NPSA) safer medication practice recommendations**

The NPSA have issued an alert, *'The adult patient's passport to safer use of insulin'*. We will scope the Trusts responsibilities in relation to this alert and develop a programme of work to implement its recommendations.

A key priority for the Trust will be to facilitate continuation of self administration of insulin when patients are admitted to hospital.

##### **Theme 3 – Improve staff skills and competencies**

Over the next 12 months we will be introducing "5 questions" - a rolling programme designed to deliver, and sustain, training and competency in medicines management to frontline healthcare professionals. A bank of questions will be developed themed around recognised risks of medicines management. This scheme will also promote improved interprofessional communication as it will be facilitated by clinical pharmacists at ward level.

##### **Theme 4 – Minimise dosing errors**

We will work with clinical staff to identify the barriers to safe drug administration. We will implement a programme of work that will inform updating of our current medicines policies and clinical practice.

##### **Theme 5 – Ensure medicines are not omitted**

As discussed earlier it is recognised that omitted doses of medicine is a National issue. Whilst these events may not seem serious, for some medicines or conditions delays or omissions can cause serious harm. Patients going into hospital with chronic conditions are particularly at risk.

We will increase the number of patients who bring their own medicines into hospital and maintain their use of these during their stay.

### **Theme 6 – Ensure the correct medicines are given to the right patient**

We will undertake observational audits of clinical practice to ensure drug policies and nursing professional standards of practice are adhered to.

### **Theme 7 – Document patient's medicine allergy status**

The Trust has reached high levels of compliance with this, however, significant barriers to further improvement are related to the perception of clinical staff, that many allergies reported by patients should more truly be classified as drug intolerance. We will therefore develop some patient information materials to improve patients' understanding and identification of true allergies.

#### **How will we measure it?**

A lead will be identified for each of the 7 themes and an action plan developed. An audit process will be integral to these and wherever possible meaningful metrics will be agreed to facilitate monitoring of progress against the agreed plan.

#### **How will we monitor and report it?**

We will monitor and report progress:

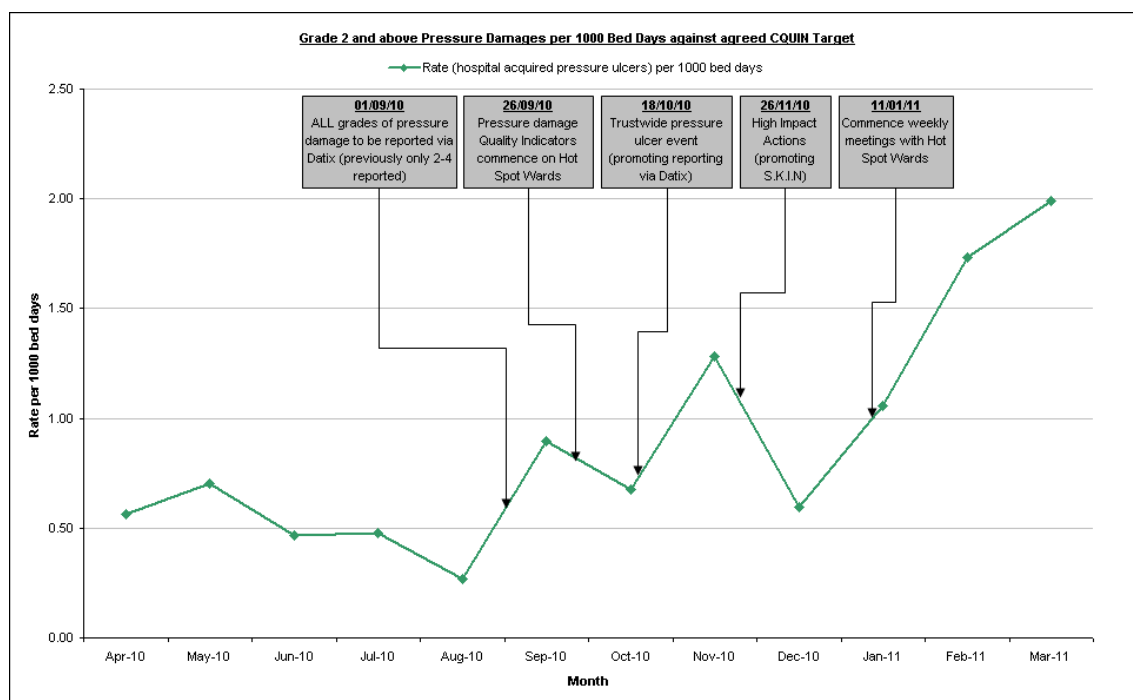
- Monthly reports on the incidence of medication errors to the Board

through the Quality & Safety Dashboard

- The action plans will be incorporated into the Annual Medicines Safety plan which is overseen by the Trust's Medicines Governance Group. This is a multidisciplinary group which meets 6 times per annum. Progress reports will be planned into the regular agenda.
- Quarterly to the Board providing a detailed report on the medication safety programme
- Twice a year to the SafeCare Council
- Twice a year to the Patient Quality Risk and Safety Committee (PQRS)
- Governor workshops

## Priority 4: Expand our programme to reduce harm from pressure damage

Pressure ulcers represent a major burden of sickness and reduced quality of life for patients and can create significant difficulties for patients, their carers and families. We will expand our programme of work focusing on actions that will reduce the number of patients suffering from hospital acquired pressure damage.



### What will we do?

We will reduce the rate per 1,000 bed days of avoidable hospital acquired pressure damage of grade 2 and above by at least 20% by the end of 2011/12.

### How will we do it?

Safety Express is a National initiative to reduce patient harm. We will liaise nationally through this network to learn from other hospitals that have experienced the greatest improvement in pressure damage.

We will expand our use of Root Cause Analysis to include all pressure damage of grade 2 and above.

We will report all grade 3 and above pressure damage as a Serious Untoward Incident to our commissioners and the National Patient Safety Agency.

We will introduce the quality measures tool across all clinical areas.

We will continue to meet weekly with ward managers and Matrons to discuss and monitor outcomes of Root Cause Analysis and the quality measure action plans.

We will introduce the "Patient Safety Cross", a visual tool that shows each time there is an episode of pressure damage to visually raise awareness

of pressure damage prevention with the ward team.

We will strengthen our existing programmes of staff education and training and monitor the uptake of this by our staff.

### **How will we measure it?**

Every time a patient develops a pressure ulcer we will report it through our hospital incident reporting system. This information will be investigated and validated by the tissue viability nurse specialists.

This number will be converted to a rate of pressure damage per 1,000 bed days.

We will also undertake a six monthly snap shot audit to measure the number of patients' with pressure ulcers in the hospital at that point in time. We will also measure our compliance with key aspects of our Pressure Ulcer Policy.

### **How will we monitor and report it?**

We will monitor and report progress:

- Monthly reports on the incidence of pressure damage to the Board through the Quality & Safety Dashboard
- Monthly to the Improving Outcomes Steering Group
- Monthly to the Board within the Infection Prevention and Control Report
- Quarterly to the Quality Review Group with Commissioners
- Twice a year to the SafeCare Council
- Twice a year to the Patient Quality Risk and Safety Committee (PQRS)
- Council of Governors workshops

## **Priority 5: Improve the quality and timeliness of patient discharge summaries to General Practitioners**

The primary goal of the patient discharge summary is to enable a smooth handover of care from the hospital setting to care providers in the community, so that appropriate follow-up care can be given to our patients. Information on any new or changes to a patient's existing medicines is of particular importance. We know from feedback from our GPs that we need to improve both the quality and timeliness of discharge summaries particularly for patients that are discharged from our medical wards.

### **What will we do?**

In 2011/12 we will develop a process that ensures that a high quality hand written discharge summary is produced on the day of the patients' discharge and sent to the General Practitioner within 24 hours.

We will also develop an electronic discharge summary which will be made possible through a new Patient Administration System that the Trust will implement in 2012.

### **How will we do it?**

We will work with our clinical teams to understand the current processes for producing the discharge summary and the key barriers and challenges.

Through involving the key clinical staff we will devise a future process that will ensure standard practice for the production of the discharge summary.

We will use a mixture of project management and quality improvement methodologies to achieve our targets in this area.

We will work with GPs in Gateshead to enable us to develop, monitor and measure the success of our work.

### **How will we measure it?**

We will develop an audit process and key performance indicators that will enable us to measure both the quality of the letter, its legibility and how quickly it reaches the GP.

Every month we will review the results of these measures with the clinical teams and use this information to make improvements to the process.

### **How will we report it?**

We will report our progress to:

- Monthly/quarterly to Clinical teams including GP's
- Every two months to the Clinical Communications Group
- Quarterly to the Board via a detailed report
- Twice a year to the SafeCare Council
- Twice a year to the Patient Quality Risk and Safety Committee (PQRS)
- Council of Governors workshops

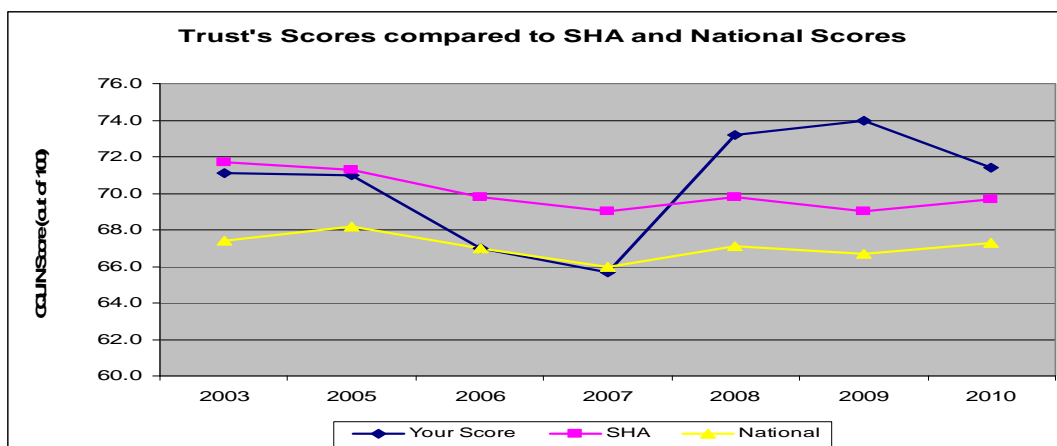
## Patient Experience

### Priority 6: Improve our patients' experience

Improving the overall patient experience remains a key priority for us and especially in the five areas within the National Inpatient Survey where our performance in 2010/11 was lower than we had hoped for.

#### What will we do?

We will achieve an improvement in our overall score for the five questions in the National Inpatient Survey from 71.4% to 72% in 2011/12.



#### How will we do it?

We will consult with our patients and staff on what we can do to improve these important areas of the patient experience. Based upon the outcome of these discussions we will develop and implement a plan of improvement work

We will develop our own programme of surveys in these key areas that will tell us how we are doing on an ongoing basis, rather than waiting for the results of the next national survey that will be published in 2012.

Every month we will ask patients on every ward the following three questions:

*Were you as involved as you wanted to be in decisions about your?*

*Did you find someone to talk to about your worries and fears?*

*Were you given enough privacy when discussing your condition or treatment?*

We will contact our patients following discharge and ask them:

*Were you told about medication side effects to watch out for when you went home?*

*Were you told who to contact if you were worried about your condition after you left hospital?*

*Were you given any written or printed information about what you should or should not do after leaving hospital?*

Every month we will discuss the results with the clinical teams and we will use the information given by patients to make improvements.

We will share the information with each ward and department so that they know what they are doing well and what they need to improve.

We will provide the support and resources required when improvement is needed. We will support our teams to achieve high standards.

We will develop a three year Patient Experience Strategy that will incorporate innovative and transformational approaches and enable us to continue to redesign and improve services around the needs of our patients over the next 3 years.

The Trust will continue to engage governors and members as we develop our program of work to improve patients' experience of care.

### **How will we measure it?**

We will use a variety of patient feedback measures such as surveys , focus groups, patient stories, analysis of complaints and PALS reports to help us to understand what changes we need to make to improve the patient experience of care and to track our progress over time.

### **How will we report it?**

We will report our progress:

- Monthly reports to the Board through the Quality & Safety Dashboard
- Monthly to the Improving Outcomes Steering Group
- Quarterly to the Board via a detailed report
- Quarterly to the Council of Governors
- Quarterly to the Quality Review Group with Commissioners
- Twice a year to the SafeCare Council
- Twice a year to the Patient Quality Risk and Safety Committee (PQRS)

We will report individual ward and department scores to the ward/department managers, Matrons, Assistant Divisional Managers and Divisional Managers.

We will display individual ward and department scores within these areas for staff, patients and the public.

We will display Trust level scores of patient experience on the television screens across the Trust.

## 2.3 A review of our services

During 2010-2011 the Gateshead Health NHS Foundation Trust provided and/ or sub-contracted 58 NHS services.

The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2010-2011 represents 100 per cent of the total income generated from the provision of NHS services by the Gateshead Health NHS Foundation Trust for 2010-2011.

### Participation in clinical audits and national confidential enquiries

During 2010-2011, 41 national clinical audits and 6 national confidential enquiries covered NHS services that Gateshead Health NHS Foundation Trust provides.

During that period Gateshead Health NHS Foundation Trust participated in 68% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust was eligible to participate in during 2010-2011 are as follows: The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust participated in during 2010-2011 are listed in Appendix 1.

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust participated in, and for which data collection was completed during 2010-2011, are listed in Appendix 1 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. Appendix 1 also gives details of the National Audit that the Trust was not eligible to take part in.

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

The reports of nine national clinical audits were reviewed by the provider in 2010-2011 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

#### **The College of Emergency Medicine – Pain in Children**

- Presentation and discussion of validated results with staff at the Department SafeCare Meeting
- Many excellent areas of practice were identified, especially compared to national performance
- There is still room for improvement, as many aspects of national/local performance in this audit did not meet national standards

- Staff encouraged to pay attention to performing regular pain scores, in a timely fashion.
- Explore methods of improving this through the use of trigger cards - these cards are given to the parents of children and it tells them to ask a member of staff to come and assess them if they have not been done by a certain time

### **The College of Emergency Medicine – Asthma**

- Presentation and discussion of validated results with staff at the Department SafeCare Meeting
- Some good areas of practice identified
- Staff encouraged to be more organised in keeping the ambulance patient record form sheet with the notes as we could not find some information for the audit because this was not filed
- Staff were encouraged to measure the peak flow on initial assessment, as well as repeating it after an intervention such as a nebuliser
- Staff were encouraged to document serial observations.
- The National British Thoracic Society asthma guidelines are laminated and available on the notice board and also electronically in resuscitation for reference.
- Staff were encouraged to improve some aspects of documentation, especially with regards to follow up arrangements
- Due to work on majors Patient Group Directives, it was anticipated that the peak flow would be better documented as this would be needed prior to protocol prescribed nebulisers.

### **The College of Emergency Medicine – Fractured Neck of Femur**

- Presentation and discussion of validated results with staff at the Department SafeCare meeting
- Some good areas of practice identified
- There were some areas of attention highlighted (getting analgesia for the patients earlier, re-evaluating pain scores within 2 hours).
- With some of the work being done on Patient Group Directives for nurse protocol prescribing in the majors area, we anticipate that this will improve.
- Big delays of getting patients to X-Ray - may be improved with the introduction of electronic ICE X-Ray ordering

### **National Cancer Patient Experience Survey**

- Cancer information Centre Manager to review processes to improve the access of advice available given to patients regarding appropriate benefits and financial support
- Review of current literature, local written patient information leaflets in order to improve relevant content
- The response rate to the survey in some tumour groups was low (expected due to annual new cancers & disease prognosis). Cancer Clinical Nurse Specialists are to localise questionnaire to use as part of Multidisciplinary Team (MDT) Survey

### **National Audit of Depression detection and Management of staff on long-term sick**

- The results of the audit demonstrated a significant improvement in results from the previous audit in 2008. On the majority of the standards the Trust scored higher than the national average.

- The processes for Occupational Health Nurses when taking history to be reviewed to ensure appropriate screening occurs

### **Implementing NICE Guidance for Health & Work: A National Organisational Audit**

- *Part 1 – Organisational Arrangements:* the Trust to develop assessment forms to inform an organisational approach to obesity, smoking and physical activity.
- *Part 2 – Obesity:* To provide greater advice re healthy food choices within staff catering service. To work with shops on Trust premises to encourage them to promote healthy food choices. To promote weight management processes and support.
- *Part 3 – Physical Activity and Building /Site Design:* to plan ways of encouraging staff to increase activity in and around the hospital sites, promoting schemes in place (reduced membership fees for local leisure facilities, bike purchase scheme) and monitor uptake.
- *Part 4 – Smoking Cessation* – promote awareness of services available for staff and publicising these.
- *Part 5 – Long Term Sickness Absence* – to review provision of psychological therapy for staff in line with NICE recommendations
- *Part 6 – Mental Wellbeing* – to consider whether training to promote and protect employee mental wellbeing should be mandatory for all line managers

### **Audit of Potential Organ Donors**

The results of audit demonstrated a lack of referrals for withdrawal of care patients, the following actions were implemented in order to increase referrals:

- Increased provision of medical and nursing staff education re referral processes for withdrawal of care patients
- Clinical Lead Organ Donation appointed
- Specialist Nurse Organ Donation appointed
- Non Executive Director appointed as Chair of Trust Donation Committee

### **National Sentinel Stroke Audit**

- Stroke patients will spend 90% of time on a stroke unit, currently at 80% - review stroke pathway and provision of services
- Patients to receive a personalised rehabilitation discharge plan – Stroke Co-ordinator currently exploring what is already in use to identify any gaps
- Patients have mood assessed prior to discharge – Stroke psychologist in post and funding has been acquired for 12 months to implement a more formal psychological approach to patients with stroke, assess staff knowledge and develop a staff education programme
- Therapists to identify standard way to document how much therapy undertaken taking into account how much patients are willing and able to tolerate – physiotherapist now records units of time on daily ward lists and also in pathway – meeting to take place with occupational therapist to make a decision as whether they should also be recording this information

## Trauma Audit and Research Network (Tarn)

### Head Injuries

- CT imaging of the head should be performed within 1 hour of arrival for patients meeting specific criteria. Our current time to CT is 1 hour exactly – we meet the standard, nationally the average time is 1.5 hours – improvements are currently ongoing with radiology looking at different fast track pathways to improve further on this time.
- **RCS / BOA Standards of Care** - There should be pre-hospital and hospital c spine protection – in hospital 100% of the patients who required c spine immobilisation received it – pre hospital 0% was recorded – data will now be collected for pre hospital c spine immobilisation.
- **RCS / BOA Standards of Care** – Patients with severe head injuries or focal signs should be transferred to the care of neurosurgery units, regardless of whether they need surgical intervention – 60% of our patients get transferred out to a neurosurgery unit – development of regional Major Trauma Centre have now changed the pathway for referral of head injuries so over the coming year should see an improvement.
- **RCS / BOA Standards of Care** - The system of care should achieve surgical evacuation of a significant subdural/extradural haematoma within four hours – 40% of this patient group got to a neurosurgical unit for surgical intervention – but with the introduction of regional Major Trauma Centre the pathway for referral of head injuries has now change/improved so over the coming year should see an improvement.

### Thoracic Injuries

- **ADVICE FROM NHS CLINICAL ADVISORY GROUP ON TRAUMA** - For the acute management of injuries, consultants should attend within 30 minutes. - NCEPOD Trauma: Who Cares? - A consultant must be the team leader for the management of the severely injured patient - in 2009 we only met this 40% of the time but in 2010 this has increased to 60% due increased number of consultants and consultant cover, but we strive to have on site 24hr consultant cover.

### ICNARC

Currently exploring the following problem areas that have been highlighted through this work and developing potential actions:

- Post Anaesthetic Care Unit (PACU) patients arriving at the same time in recovery
- Theatre scheduling
- Maximum 3 patients with epidural on ward 14A at any one time
- Surgical patients with epidurals not going to the ward at the moment
- Thrombolysis patients not going to the ward at the moment
- Lack of communication
- Recovery and CCD
- Anaesthetists and CCD

## Reports to be published later in 2011/12

National Comparative audit of blood transfusion – use of platelets  
National Comparative re-audit of the use of group O RhD negative red cells  
National Diabetes Audit in Paediatrics  
National Audit of Falls and Bone Health in Older People  
National Pain Audit  
National Audit of Dementia  
National Bowel Cancer Audit  
LUCADA  
MINAP

The reports of 190 local clinical audits were reviewed by the provider in 2010-2011 and Gateshead Health NHS Foundation intends to take the following actions to improve the quality of healthcare provided:

The themes that have been identified from the review have enabled us to develop action plans to address these and has informed quality improvement work within the organisation.

### Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust from April 2010 – March 2011 that were recruited during that period to participate in research approved by a research ethics committee was 319.

Participation in clinical research demonstrates Gateshead Health NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff will stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. Gateshead Health NHS Foundation Trust was involved in conducting 214 clinical research studies in a variety of areas including – cancer, dementia & neurodegenerative disease, diabetes, medicines for children, mental health, stroke and various specialty groups between April 2010 – March 2011.

The improvement in patient health outcomes in Gateshead Health NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatments for patients.

There were 96 clinical staff participating in research approved by a research ethics committee at Gateshead Health NHS Foundation Trust during 2010/2011. These staff participated in research covering 7 medical specialties.

As well, in the last three years, 25 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

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

## **Use of the Commissioning for Quality and Innovation Framework**

A proportion of Gateshead Health NHS Foundation Trust income in 2010-2011 was conditional on achieving quality improvement and innovation goals agreed between Gateshead Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

A monetary total of £2,289,630 of the Trust's income in 2010/11 was conditional upon achieving Quality Improvement and Innovation Goals of which an associated payment of £2,110,143 was made.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at <http://www.gatesheadhealth.nhs.uk/cquin/>

## **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 reporting period 2010-2011.

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

## **Our Data Quality**

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

Gateshead Health NHS Foundation Trust recognises that it is essential for an organisation to have good data quality in order to provide fit-for-purpose information to facilitate effective decision making and has an implemented Data Quality Strategy. This provides corporate leadership, governance, monitoring, audits and action plans to address any data quality issues within the organisation. Data quality leads throughout the Trust promote and implement data quality policies and procedures to ensure that data quality becomes an integral part of the Trust's operational processes.

Gateshead Health NHS Foundation Trust has been shortlisted for the CHKS Data Quality Award, one of only 5 Trusts across England that have excelled in all data quality indicators. CHKS provides comparative information and quality improvement services for healthcare across 20 countries and this prestigious award provides recognition for the dedication to providing world-class healthcare.

Gateshead Health NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient's valid NHS Number was:	%	Which included the patient's valid General Medical Practice Code was:	%
Percentage for admitted patient care	98.4%	Percentage for admitted patient care	99.7%
Percentage for outpatient care	98.8%	Percentage for outpatient care	99.9%
Percentage for accident and emergency care	85.8%	Percentage for accident and emergency care	94.6%

### **Information Governance Toolkit**

Gateshead Health NHS Foundation Trust Information Governance Assessment Report score overall score for 2010-2011 was 75% and was graded Green (satisfactory).

### **Standards of Clinical coding**

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010-2011 by the Audit Commission.

## Review of quality performance

The Trust's vision has been rolled out across the organisation and is now embedded in the day to day delivery of services, placing patients at the very heart of all that we do. Aligned to our Vision and Strategic Priorities, our SafeCare Strategy 2010/13 sets out a framework for how we will reduce harm and improve the quality and safety of patient care. The framework consists of 6 key domains that further develop the 3 dimensions of quality:

- Effective Culture and Inspirational Leadership
- Effective, Efficient and Innovative Teams
- Safe and Reliable Care
- Right Care, Right place, Right time
- Positive Patient Experience
- Safe Environment and appropriate equipment and supplies

Our SafeCare Improvement Map provides an overview of the key areas within the Strategy and the programmes of work that have continued throughout 2010/11. The strategy is underpinned by quality management systems and an accountability framework that ensures ward to board assurances regarding our quality improvement activities.

# Delivering SafeCare



## Trust Strategic Priorities



## SafeCare Strategy 2010-13

### SafeCare Improvement Map



## 3.1 Patient Safety

### Building our Safety Culture

Developing a culture for safety and quality improvement has been a fundamental element of our work and we have continued to develop a culture where patient safety and quality care is central to the business of the organisation.

An important piece of work carried out at the beginning of the SafeCare programme in 2007 involved utilising the Manchester Patient Safety Framework to undertake a baseline assessment of the safety culture within the Trust.

The Manchester Patient Safety Framework (MaPSaF) is a tool developed to help NHS organisations assess their progress in developing a safety culture. MaPSaF uses 'dimensions' of patient safety and for each of these describes what an organisation would look like at five levels of patient safety.

Level	Description
1. Pathological	Why do we need to waste our time on patient safety issues?
2. Reactive	We take patient safety seriously and do something when we have an incident.
3. Bureaucratic	We have systems in place to manage patient safety.
4. Proactive	We are always on the alert/ thinking about patient safety issues that might emerge.
5. Generative	Managing patient safety is in integral part of everything we do.

Our assessment identified that overall the Trust was between bureaucratic and proactive. It enabled the identification of common themes, examples of best practice and learning points in relation to safety that were developed into action plans for implementation within the divisions. We have undertaken a further assessment in 2010 and are pleased to report that our staff have reported a positive shift in the safety culture to between proactive and generative.

### Maternity NHSLA Level 3

The Trust was awarded level 3 of the NHSLA maternity risk management standards in 2010/11. This means that we have been recognised for the way we manage the risks associated with pregnancy and childbirth when measured against national standards. The scheme has three levels of assessment and we are one of the first to be awarded the top level pass against the new national maternity criteria.

## Executive Quality and Safety Walkabouts

The Executive Quality and Safety Walkabouts were implemented in January 2010. They involve an Executive Director, a Clinical Lead, a SafeCare Facilitator and Public Member of the Trust visiting a clinical area. They take place each Friday afternoon and their main aim is to:

- Increase the awareness of quality and safety issues among all staff
- Make quality and safety a priority for senior leaders by spending dedicated time promoting a quality and safety culture
- Educate staff about quality improvement and patient safety concepts
- Obtain and act on information gathered that identifies areas for improvement
- Build communication and relationships with front line staff

The walkabouts have been well received by staff who have been able to raise any concerns around the quality and safety of patient care in their areas. We aim to address any actions required within 60 days of the walkabout taking place and progress on these actions are monitored on a monthly basis through the Trust Quality & Safety Dashboard.

*“During the executive walkabout, we as a team identified areas in our ward for improvement. We highlighted the need for patient recliner chairs and a new computer.*

*We have since received these chairs which have in turn improved the quality of the patient experience on ward one. Patients who before were unable to sit out of bed are now able to in comfort and safety”.*

*Ward Manager, Ward 1*

## The Productive Operating Theatre

The Trust commenced The Productive Operating Theatre, a national programme of work supported by the NHS Institute of Innovation and Improvement. The aim of the project is to maximise the time available for nurses and therapists to spend on patient care thereby improving safety, efficiency and quality in the operating theatre. Some of the work we have undertaken has involved standardising and de-cluttering of theatres using the lean principles, improvements around the storage and administration of medicines and standardisation of all anaesthetic rooms and the use of visual management.

## **SafeCare Alerts and Good Practice Bulletins**

The Trust issues these to relevant staff in response to information we gain through national, regional and local sources such as serious untoward incidents and audits where the potential for local learning and the need for action have been identified. During 2010/11 5 Good Practice Bulletins and 12 SafeCare Alerts were issued. Some examples can be seen on the following page.

## SafeCare Alerts and Good Practice Bulletins Examples

Issue No 26  
12/06/10

**SAFECARE ALERT**

**Use of Blue Cardiac Arrest Drugs Boxes**

Issue

- In recent months there has been a notable increase in used emergency drugs boxes being returned to pharmacy with waste items left inside of the box.
- This clearly poses a significant and unacceptable risk to pharmacy staff to retrieve used syringes and sharps from the blue drugs box whilst re-stocking them.

Action

- Dispose of all used syringes, vials, ampoules and sharps in the appropriate sharps box – DO NOT put them back in the blue emergency drugs box!



Dr D M Beaumont  
Medical Director

Mrs SA Richardson  
Director of Nursing and Midwifery

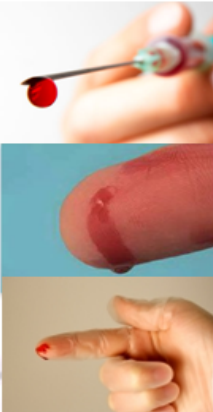
Issue No 28  
19/07/10

**SAFECARE ALERT**

**Avoidance of  
Needle Stick Injuries**

Issue

There has been a 17% increase (a total of 54) in sharps incidents during January to June 2010 compared to the same time last year. Those of particular concern are incidents that could have been prevented if staff followed correct procedures and used the safety devices that are attached to the vacutainers and butterflies. We want to encourage staff who are unsure how to use these devices to contact the Occupational health department who will be happy to provide further training. Staff should also continue to ensure that sharps are disposed of correctly and that sharps bins are not overfilled and are to hand when carrying out procedures. On a positive note it is good to see that sharps incidents are continuing to be reported in accordance to the Trust policy and that staff are carrying out the correct procedure when reporting a sharps injury.



Dr D M Beaumont  
Medical Director

Mrs G MacArthur  
Director of Nursing and Midwifery

Issue No 8  
05/08/10

**Good Practice Bulletin**

**Preventing Falls**

Falls are common health events that can cause discomfort and disability for patients and stress for carers and visitors. There will always be a risk of falls in hospital but there is much that can be done to reduce that risk and minimise the effects of any resultant harm. Many falls previously considered unavoidable actually are avoidable even when allowing patients freedom and mobilisation during their hospital stay so as to maintain and achieve their optimum level of independence.

**Your role in improving patient safety**

During a patients hospital stay it is important that health care professionals incorporate Falls prevention strategies into everyday clinical practice.

- Ensure a falls risk assessment is completed within 24 hours of admission.
- Falls history to be obtained on admission.
- Ensure patients are wearing appropriate footwear.
- Ensure the patient can see, reach and feel comfortable using the call bell.
- Consider whether the patient is taking any medication that could increase the risk of falls and whether a medication review is needed.
- Implement care standard 21 if applicable

**Providing safe, quality care is everyone's responsibility. By adopting the simple practices above you can make a positive contribution.**

Mr D Beaumont  
Medical Director

Mrs G MacArthur  
Director of Nursing and Midwifery

Issue No 7  
04/06/10

**Good Practice Bulletin**

**Communication with GPs**

**Right information, Right place, Right time**

Transfer of information from hospital to GP is a key part of providing excellent care to our patients. Our letters should be structured in a way that makes transfer of information quick and accurate for all parties. Feedback from GPs indicates some variation in practice regarding letters.

**Discharge Information**

The GP user group identifies 6 pieces of information they most value on a discharge summary:

1. Patient Demographic details
2. Admission Diagnosis
3. Brief summary of treatment.
4. The New Medication
5. What the patient has been told
6. That all entries are legible
7. What (if anything) we want the GP to do next.

Please ensure these key elements are included on the handwritten discharge summary to be issued at the time of patient discharge so that it arrives with the GP on the next working day.

Dr D M Beaumont  
Medical Director

Mrs SA Richardson  
Director of Nursing and Midwifery

### Safety Express

The Trust is taking part in the QIPP Safety Express, a national programme of work that is being delivered through mobilising patients, frontline teams, organisational leaders, strategic health authority teams and national partners.

The aim of the Safety Express programme is to significantly reduce harm from pressure ulcers, catheter acquired urinary tract infection (CA-UTI), falls and venous thromboembolism 'VTE' (the collective name for deep vein thrombosis (DVT) and pulmonary embolism (PE)) within two years.

### **Improving our system for requesting and reporting tests**

The Trust implemented the ICE Order Communications system on 1<sup>st</sup> October 2010. It is an electronic system that allows our staff to request blood tests and investigations like x-rays and scans electronically from all wards, clinics and GP surgeries. The system ensures that accurate and relevant information is captured at the point of request. This reduces the numbers of samples that the laboratory cannot process and the number of radiology referrals that are rejected or delayed due to insufficient information.

Abnormal results are flagged which raises alerts for patients with unsuspected cancers, unexpected fractures and anything else that may change the management of the patient. Over 25 Gateshead GP practices are now live with ICE. This means the GPs can view reports for investigations that have taken place at the Trust which enables them to deliver more timely treatment or referral of their patients.

## 3.2 Clinical Effectiveness

### Improving Stroke Services

The Trust has worked over the past year to develop a more consistent approach in the management of patients who have suffered a stroke. Previously acute stroke patients and those undergoing rehabilitation were cared for in different areas of the hospital. To improve services for these patients, we have developed an integrated unit where these two groups of patients are cared for in one area. We have improved the pathway for patients who have suffered a stroke to ensure patients are receiving specialist treatment in a more timely manner. We now have 6 specialist nurses, who are available from 9am – 9pm 7 days a week. They provide a rota of assessing a patient after an acute episode, usually in Accident & Emergency but sometimes on a medical or surgical ward. They then facilitate the patient's admission to the stroke unit. Staff working on the stroke unit have undertaken specialist training in the management of acute stroke. This training includes the assessment of swallowing disorders, which is crucial in preventing associated problems and the nurses are able to undertake this in a timely manner once the patient is admitted to the unit. A multidisciplinary team of Consultants, ward nurses, occupational therapists, physiotherapists and the Community Stroke Team meet regularly to discuss patients' progress, assess and plan their rehabilitation goals. The community stroke team and social services, having been already involved in the patient's care, once the patient is ready for discharge ensure a smooth transfer back to their home.

### Paediatric Audiology Services

The Audiology Department have successfully implemented the transfer of Gateshead Paediatric Community Audiology services from primary care into our Trust. The service commenced in September 2010, transferring approximately 500 children's care.

Children aged 4 years and under who have failed an hearing assessment in school or have been identified by a health professional as having potential hearing problems are now able to access a pathway whereby Audiology tests are undertaken within 5 weeks of referral. These children then go on to be referred into ENT if deemed appropriate.

The new model for Audiology led Paediatric Hearing Service has been developed to meet the following goals which aim to improve clinical effectiveness and efficiency whilst introducing a greater scope for patient choice.

- GP's, Health Visitors and professionals including link Teacher of the Deaf can refer if there is concern about a child's hearing.
- Paediatric service co-ordinator can then decide correct care pathway for the child based on referral information.
- Patient appointments can be carried out in the most suitable facilities
- Delays in diagnostic processes have been eliminated
- Diagnosis can be shared with the child and family in a more timely manner

- Habilitation / rehabilitation programmes can be agreed and implemented in a timely manner

The ability to standardise protocols and share knowledge across the service has enabled the Audiology/ ENT team to provide an equitable high quality service whereby early intervention and treatment can be delivered to help reduce the long term effects of hearing impairment.

## **Breast Screening Services**

Our breast screening unit has almost finished installing digital systems at its base at the Queen Elizabeth Hospital and at screening venues at Sunderland Royal Hospital and Blaydon Primary Care Centre as well as on two new state-of-the-art mobile screening trailers serving Durham, Chester-le-Street and Jarrow. Before the new technology was installed, radiographers took images using film, which was then processed back at the Queen Elizabeth Hospital. The new digital systems allow radiographers to see the images immediately to ensure that the examination is complete and remove the possibility of images being damaged in film processing.

The new technology will contribute to a more efficient workflow in which images and patient information will be readily available and the digital images will be more detailed, improving our ability to diagnose cancer at an earlier stage to benefit the long term survival of women.

*"I was reassured to know that the new digital equipment means that it is much less likely that a technical issue could occur with the images which would require another visit. It's always good to know that women are benefitting from technical advances in breast screening equipment."*

Breast Screening Patient

## **Reducing Caesarean Section rates**

Increasing normal births and reducing caesarean sections is associated with shorter hospital stays, fewer adverse incidents and admissions to neonatal units and better health outcomes for mothers. Throughout 2009/10 our caesarean section rate ranged between 16-28% with an average of 21.7%, this was compared to a national average of 24%. We started 2010/11 at 22.5%. We carried out detailed audits and implemented a plan of action to promote normal birth and to help us reduce our rate of caesarean sections in 2010/11. We are pleased with our progress and have reduced our rate to 13.9% for March 2011.

## **Cardiology services**

We held an Rapid Process Improvement Workshop involving the clinical teams who look after chest pain patients to identify how the care these patients received could be improved further.

Beds on the cardiology ward and specialist beds on the coronary care unit were in separate locations within the hospital. Doctors and nurses felt that a new integrated unit which combined nursing teams in one area, supported by a cardiac outreach team, would ensure that patients are seen by the right people in the right place, at the right time.

The clinical teams felt the idea of bringing the coronary care unit and the cardiology ward together would have many benefits for patients, including improving the clinical care available to them, providing a better environment for their care, reducing the amount of time people spend in hospital and improving outreach work across the hospital to make sure cardiology patients receive the specialist care they need as quickly as possible.

As a consequence we have successfully submitted a business case for the development of an integrated cardiology / coronary care unit and work on this has already commenced.

### **3.3 Patient Experience**

#### **Patient and Public Engagement Activities**

The Trust is committed to involving patients and the public in the development and improvement of services. To make sure that health services best meet the needs of our service users now and in the years to come, we invited the residents of Gateshead and the surrounding area to a special public event at the local leisure centre. Staff from across the Trust, including senior nurses, were on hand to hear the thoughts of local people and answer questions about the services we run. The event proved very successful in gaining both positive feedback on our services as well as highlighting areas for service development and improvement.

We have continued to involve patients and the public in our work in many ways for example in the Rapid Process Improvement Workshops, the redesign of future emergency services and patient pathway, procurement of a replacement Patient Administration System and the Executive Quality and Safety Walkabouts.

The SafeCare Patient Panel have continued to undertake a programme of work involving gaining feedback from patients on the quality of their experience, providing feedback on the quality of hospital signage within the Breast Screening Unit, reviewing patient information and providing feedback on the priorities for this year's Quality Account.

#### **Patient feedback activities**

The Trust has used a range of methods to gather feedback from patients including National Postal Surveys, comments and suggestions cards, real time patient feedback as well as PALS and complaints. These methods provide continuous and regular sources of feedback and help inform improvement both large and small.

Our current system of real time patient feedback has enabled us to gather vast numbers of patients' views from across our services. However in 2011/12 we will implement an improved electronic system which will help us to capture more in depth and meaningful information.

Our 3 year Patient Experience Strategy will provide a framework for the Trust to deliver an excellent patient experience through working with our patients and their families.

#### **Learning from Complaints**

Complaints about our services are taken seriously and are an important source of information about the quality of our services and how they can be improved. Each formal complaint received is reviewed by the Chief Executive and the Medical Director, with regular reports made to the Trust Board. There has been a reduction in the number of formal complaints received over the last two years. During 2009/10 the Trust received a total of 206 formal complaints compared to 223 received in 2008/09. During 2010/11 there has been a further reduction with a total of 194 formal complaints being received.

Complaints and PALS continue to work closely to provide an effective and timely service to anyone who raises concerns about the experience they have had whether they are a

patient, relative or visitor to the Trust. Some of the changes we have made within the past year as a result of complaints and concerns include:

- Development and implementation of an integrated care chart that enables important information regarding the patient's care such as fluid intake and output, nutrition record of their dietary intake and nursing care to be recorded in one place. This will help enhance our patients' care.
- Improving our capacity for early pregnancy ultrasound scanning.
- Implemented processes to improve the communication between clinical teams when patients move from one area to another.

### **Improving communication with families and carers**

We have developed a Carer's Clinic which gives patients' families more opportunities to speak to nursing staff on the wards about their relative's condition, updates on their care and to answer any questions the family may have. A further initiative within the medical division is the Consultant drop-in clinics. Slots of time are allocated to relatives in order that they can come in and speak to the Consultant responsible for the patient's care. This new service is being piloted on one of the wards with the intention of rolling the service out should families and carers evaluate it positively.

### **Cancer Patient Experience Survey**

The 2010 National Cancer Patient Experience Survey questioned patients from 158 hospital Trusts across the country between May and October 2010. The survey asked cancer patients to rate the overall care they received from the Trust, as well as about the care they received from medical and nursing staff and their cancer clinical nurse specialist, who acts as the key contact for cancer patients. We are very pleased to report that Gateshead Health NHS Foundation Trust were ranked 2<sup>nd</sup> in the whole of England on the outcome of the survey. We are delighted that our patients have rated our cancer services so highly. It is very important to us that patients feel well informed and able to make choices where appropriate.

### **Health Care for All**

Over the last few years, there has been a national drive in the health service to improve the health of people with a learning disability and to ensure they receive the same level of care as any other patient.

Healthcare for All is a report that sets out a series of recommendations for healthcare providers to make certain that people with learning disabilities receive personalised, safe and reliable healthcare and treatment.

Several initiatives have been introduced in the Trust to support people with learning disabilities and incorporate the recommendations of Healthcare for All into the way we provide care and include:

- A flagging system implemented on our patient administration system to alert staff if a patient is known to have a learning disability
- Disability awareness training for all staff including a section covering learning disability
- Clinical pathways for patients with a learning disability in disability resource files and on the intranet, including a section in with tools to aid communication, assess pain and provide advocacy services for patient with learning disabilities.
- A Health and Social Care Disability Forum. Service users/local disability groups and members from other organisations in Gateshead attend
- An exit questionnaire for patients with a learning disability and their carers about their experience in our Trust
- The Learning Disabilities Liaison Nurse, works part time in the Trust in adult services to offer advice and support to staff and patients
- The Disability Champions Network, a group of volunteers from all areas of the Trust who regularly promote awareness of disability issues
- Signing up to Mencap's Getting it Right Campaign in September 2010. This is a pledge to get it right when treating people with a learning disability
- Using My Health Record, a document carried by the patient providing details about their likes, dislikes and general information to help us provide person-centred care

### **Using Lean Methods to Improve the Patient Experience of Services**

The Trust is committed to continual quality improvement and eradicating inefficiencies whilst reducing costs. For some years we have used 'Lean' – a method that identifies and eliminates waste and inefficiency in the healthcare process making it possible for staff to deliver the highest quality and safest patient care. At the heart of this work is looking from a patient point of view about what really matters, and working with staff and patients to ensure our services match this. Lean uses a number of improvement techniques and we have particularly focused on week long workshops, known as Rapid Process Improvement Workshops where staff have the opportunity to spend time out from their department to work with trained leaders, testing their own ideas as to how to improve their service.

A number of Rapid Process Improvement Workshops have been carried out throughout the year. Some of the areas we have focused on include the pathway of care of patients with a suspected DVT between Primary and Secondary Services, administration processes within Ear, Nose and Throat, reviewing the appointments process within Ultrasound Services, the care of patients admitted as an emergency with shortness of breath and improving our portering services.

### **Compass Team**

We have set up a new team called 'Compass', to help facilitate the prevention of hospital admissions and promote safe and timely discharges.

The team brings together the specialist skills and knowledge of three different teams previously known as the Clinical Liaison and Discharge Team (CLAD), the Community Resource Team for Older People (CROP) and the Older People's Assessment and Liaison Team (OPAL).

The compass team has various aims in improving the patient experience including:

- preventing the admission of patients who could be managed in another way
- ensuring an effective in-patient pathway for patients that need to stay in hospital or are already in-patients
- well planned patient discharge and a timely transfer of care from hospital for patients
- prevent readmission and support patients in their own home

The various skills in the team help ensure they can meet the needs of all patients.

*“Since the compass team began working on ward 2 we have found a great improvement to the service provided to patients in relation to hospital discharge. Close working with the team has resulted in improved planning and streamlined, timely discharges, which has greatly improved the patient experience”.*

Ward Manager, Ward 2

### **Patient Environment Action Team (PEAT) Assessment**

PEAT is an annual assessment of inpatient healthcare sites in England. It is self assessed and inspects standards across a range of services including food, cleanliness, infection control and patient environment. The assessment is a benchmarking tool to ensure improvements are made in the non-clinical aspects of a patient’s healthcare and shares best practice across the NHS. NHS organisations are given scores from 1 (unacceptable) to 5 (Excellent) for standards of privacy and dignity, environment and food within their buildings and the Trusts results were as follows:

Hospital	Environment Score	Food Score	Privacy & Dignity
Queen Elizabeth Hospital	Excellent	Excellent	Excellent
Dunston Hill Hospital	Excellent	Excellent	Excellent

## 3.4 Focus on Staff

### Staff Health and Well-being

The Trust is committed to safeguarding the Health and Well-being (HWB) of staff and has had a good track record in, for example, health, safety and security; preventing violence and aggression; ergonomics; accident prevention and measures to combat the causes of work-related stress.

During 2010 this work was stepped up further in the light of the recent Boorman Report on health and well-being in the NHS, which makes further recommendations to keep staff fit and healthy at work. There is reliable proof that healthier staff, in both body and mind, are more likely to be happier in their work and provide better care to our patients and service users.

This year a HWB Steering Group was established, which includes a number of Staff Representatives, to develop a HWB Strategy which brings together all of the strands of work under one umbrella. There is now a working group attached to each of these:

- Caring for You
- Safe Working
- Mindful Employer
- Health promotion
- Improving Working Lives

A high profile event took place in November to mark the launch of the new HWB branding, an orange umbrella, which staff would come to instantly recognise as the sign of a health and well-being message.

As well as the steering and working groups, we have established a broad infrastructure of support at departmental level through HWB Leads. Staff Reps and Health and Safety Reps are also giving their backing to this important scheme of work.

In January 2011 Gateshead Health was the first hospital trust in the region to be awarded the prestigious Investors in People (IIP) Health and Well-being Good Practice Award. Part of this award is about raising staff awareness of what support is available to them and highlighting to managers their role in keeping staff fit and healthy at work.

The Trust recognises that a more satisfied and healthy workforce will be better able to engage in change and service improvement and provide a safer, high quality service to our patients and service users. Our new HWB Strategy will make sure that we continue to develop in this important area of work.

### Listening to our staff through the NHS Staff Survey

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

By investing in a census of all staff in October 2010, the Trust received views from 1,487 staff via the NHS National Staff Survey, making our response rate for our census 47% and a response rate of 52% for our survey sample. The Trust is constantly striving to be a model employer by improving the quality of working lives for staff, which directly impacts positively on the quality of care to users of our services.

Measured against 38 Care Quality Commission key indicators, we came out most favourably compared to other acute trusts in the UK in the following areas:

	2009/10		2010/11		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
<b>Top 4 ranking scores</b>					
% of staff experiencing harassment, bullying or abuse from staff in the last twelve months	11%	18%	9%	15%	Decrease 2%
% of staff suffering from work-related stress in the last 12 months	23%	28%	22%	28%	Decrease 1%
% of staff believe the Trust is committed to work-life balance	72%	68%	72%	68%	Same
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last twelve months	14%	21%	10%	15%	Decrease 4%

The Trust's lowest 4 ranked scores were:

	2009/10		2010/11		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
<b>Bottom 4 ranking scores</b>					
% of staff feeling valued by their work colleagues	78%	77%	68%	76%	Increase 10%
% of staff believe there is effective team working	-	-	73%	74%	Information not available
% of staff reporting errors, near misses or incidents witnessed in the last month	96%	95%	94%	95%	Decrease 2%
% of staff experiencing physical violence from staff in the last 12 months	2%	2%	2%	1%	Same

**Our ratings show that we are:**

- in the top 20% of acute Trusts for 17 key scores;
- better than average in 10 key scores;
- average in 5 key scores;
- below average in 5 key scores and
- in the lowest 20% of acute Trusts for 1 key score

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

- Work pressure felt by staff
- Trust commitment to work-life balance
- Work-related injury
- Work-related stress
- Work pressure felt by staff
- Availability of hand washing materials
- Staff witnessing potentially harmful errors/near misses/incidents in last month
- Good communication between senior management and staff
- Staff experiencing discrimination at work

**Our areas for improvement over the coming year include the following:**

- Increase staff feeling valued by their work colleagues;
- Promote opportunities for staff to develop their potential at work;
- Improve error, near miss or incident reporting;
- Reduce staff feeling under pressure to attend work feeling unwell
- Further improve ability to contribute towards improvements at work;
- Increase overall job satisfaction;
- Decrease physical violence towards staff;

- Further reduce incidence of harassment, bullying and abuse;
- Continue to reduce work-related stress;
- Increase annual staff appraisal;
- Improve perceptions of job fulfilment and making a difference to patients;
- Continue to address variations in performance across divisions.

## **Developing Leadership Capability**

The Trust has a long history of leadership development, supporting enabling and empowering staff of all levels and profession. Our strategic aim is to sustain a culture that reflects the values set out in the Vision. This includes encouraging behaviours and pathways of working that promote quality of care and services improvement, innovation, best practice and positive change. Individual responsibility, strong team working and effective communication, are all core values that underpin this approach. The Trust has a well established leadership strategy which is reviewed annually and submitted to Human Resources Committee for discussion and feedback. During 2010/11 the Trust has continued to invest in the delivery of an established suite of leadership development programmes and opportunities including:

- A one-day Introduction to Leadership;
- Kaleidoscope – a development programme for front-line managers;
- Leading Empowered Organisation (LEO) three-day workshops;
- Consultant development programme
- RCN leadership programme;
- Nursing leadership development from preceptorship nurses through to matrons
- The Trust supports the attainment of Leadership and Management NVQ at Level four and assists staff with the achievement of Masters qualifications;
- Managers “Leading for Change workshops”
- Coaching, action learning and 360 degree feedback

### **3.5 Quality overview - performance of Trust against selected indicators**

In the following sections are a range of quality indicators where the Trust performance can be seen. These further develop the three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience). The indicators themselves have been extracted from NHS Compliance Framework 2010/11, Vital Signs Monitoring, Commissioning for Quality and Innovation (CQUIN), and locally determined measures. Trust performance is measured against a mixture of locally and nationally agreed targets. Where applicable, benchmarking has been applied to the indicators using a range of data sources which are detailed in the relevant sections. The Trust recognises that benchmarking is an important attribute that allows the reader to place the Trust performance into context against national and local performance. Where benchmarking has not been possible due to timing and availability of data, the Trust will continue to work with external agencies to develop these in the coming year.

## 1) Visible Leadership for Safety and Culture



*Outcomes of Trust Wide MaPSaF Assessment:*

2007/08	2010/11	Target
Pro-Active Bureaucratic	Pro-Active / Generative	Pro-Active / Generative

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

	2009/10	2010/11	Target for 2011/12
Cumulative Walkabouts Undertaken	10	42	48
Average Walkabouts Undertaken per month	5	3.5	4
Cumulative Actions Identified	22	101	n/a
Cumulative Actions Implemented	4	77	n/a
Outstanding Actions (more than 60 days old)	n/a	15 (85% completed within 60 days)	90% less than 60 days old

## 2) Team Effectiveness / Efficient / Innovative



	2007/08	2008/09	2009/10	2010/11	Target	National Benchmark
Mandatory Training Compliance (Percentage take up on allocated places)	66%	59%	55%	64%	90%	n/a
Personal Development Plan (PDP) Compliance (Staff with a timely completed PDP)	Not available	42.4%	51.9%	48.6%	90%	n/a
Staff Sickness and Absence (As reported from personnel)	5.26%	5.29%	4.96%	4.49%	3.90% Local Target	01/02/10 to 31/01/11 4.23%
Staff Turnover (Labour turnover based of Full Time Equivalent)	13.47%	12.08%	10.54%	12.44%	n/a	n/a

### 3) Safe Reliable Care / No Harm

A) Reducing Harm from Deterioration →



B) Reducing Avoidable Harm →



C) Infection / Prevention and Control →



#### A) Reducing Harm from Deterioration: 😐

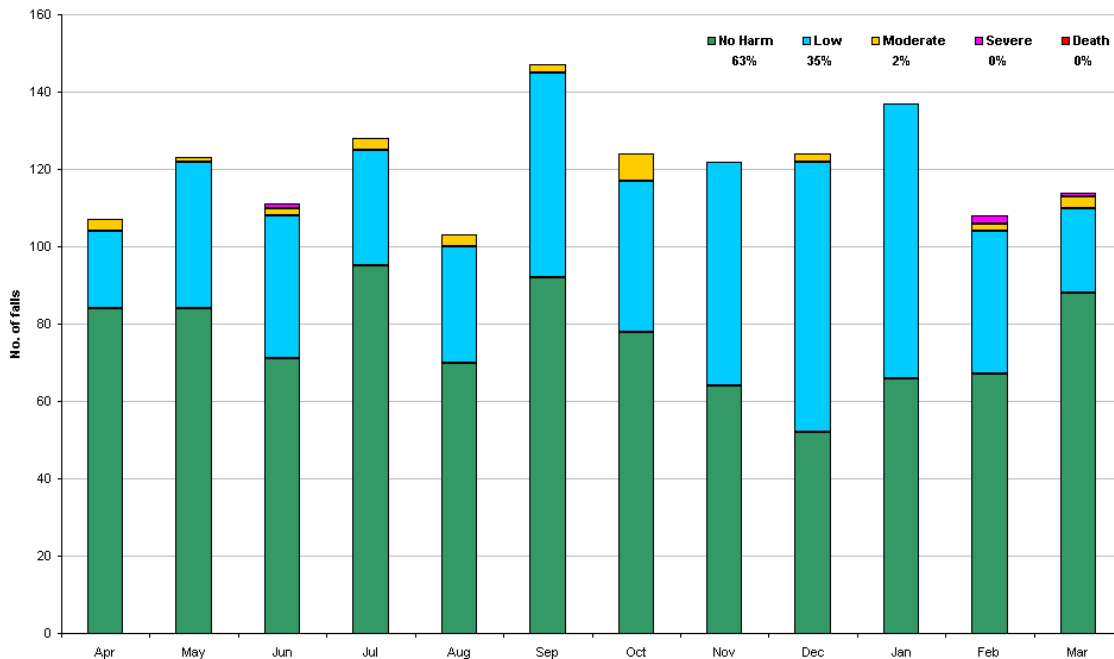
	2007/08	2008/09	2009/10	2010/11	Target	National / Peer
Risk Adjusted Mortality Index Score taken from CHKS using RAMI 2010	94	91	82	82	Less than 100	81
Crude mortality rate taken from CHKS	3.02%	2.71%	2.68%	2.51%	Improve Year on Year	1.64%
Number of calls to the CRASH team	213	194	165	180	n/a	n/a
Of the calls to the arrest team what percentage were actual cardiac arrests	38.5%	52.1%	46.7%	48.3%	n/a	n/a
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.375	0.506	0.390	0.490	n/a	n/a

#### B) Reducing Avoidable Harm: ★

	2007/08	2008/09	2009/10	2010/11	Target
Rate of adverse events per 1000 bed days using the Global Trigger Tool (rate stated is average achieved across all audits undertaken in the year)	n/a	23.95	30.99	34.78	n/a
Number of Medication Errors	324	375	398	305	Year on Year Reduction
Hospital Acquired Pressure Damage (grade 2 and above)	Not available	Not available	54 Sept10 to Mar11	155	30% Reduction (less than 76)

Community Acquired Pressure Damage (grade 2 and above)	Not available	Not available	Not available	228 Still being validated	n/a
Number of Patient Slips, Trips and Falls	1579	1601	1607	1448 9.9% reduction	10% Reduction (Less than 1447)
Rate of Falls per 1000 bed days	7.90	7.63	8.14	8.13 0.12% reduction	10% Reduction (Less than 7.33)
Number of Patient Slips, Trips and Falls Resulting in Harm	765	840	793	537 32.3% reduction	10% Reduction (Less than 714)
Rate of Harm Falls per 1000 bed days	3.83	4.00	4.02	3.01 25.1% reduction	10% Reduction (Less than 3.61)
Ratio of Harm to No Harm Falls (i.e. what percentage of falls resulted in Harm being caused to the patient)	48.4%	52.5%	49.3%	37.1%	Year or Year reduction

Falls by Severity of Harm for 2010/11:



Never Events	0	0	0	0	0
Total Incidents per 100,000 bed days	2088	2373	2802	2949	n/a

**C) Infection Prevention and Control:** 

	2007/08	2008/09	2009/10	2010/11	Target
MRSA Bacteraemias apportioned to Acute Trust post 48hrs	32	16	7	3	5
MRSA Bacteraemias per 1000 bed days	0.146	0.080	0.035	0.017	0.051*
Clostridium Difficile Infections post 48hrs	197	107	105	48	108
Clostridium Difficile Infections per 10000 bed days	9.014	5.362	5.319	2.702	3.87*
Uniform Policy	n/a	98.0%	99.1%	99.2%	100%
Hand Hygiene	n/a	96.5%	97.0%	98.6%	100%
Intravenous Cannular	n/a	85.3%	91.9%	95.2%	100%
Indwelling Catheter	n/a	91.9%	96.4%	95.6%	100%
Equipment Clean and Records Up To Date	n/a	97.6%	97.7%	98.6%	100%

\* Target taken from North East Quality Observatory and figure quoted is National rate for 09/10

#### 4) Right Care, Right Place, Right Time



##### Care of patients following a Stroke:

	2007/08	2008/09	2009/10	2010/11	Target	Benchmark
Percentage of patients who spend >90% of time within a dedicated stroke unit	n/a	63.6%	78.4%	82.9%	80%	71.9%+ April 10 to December 11 National Average
Stroke Bundle of 9, percentage of patients who receive bundle of 9 key elements of care	n/a	n/a	n/a	39.1%	20%	32%++ 1 <sup>st</sup> April 10 to 30 <sup>th</sup> June 10 National Average

+ Data taken from the Vital Signs Monitoring section within the Department of Health website for April 2010 to December 2011. The figure quoted is the combined quarterly data for England for the time period stated. At the time of data collection quarter 4 data was not available, but the following link is where this data will be published.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Vitalsignsmonitoring/DH\\_112528](http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Vitalsignsmonitoring/DH_112528)

++ Data taken from the National Sentinel Stroke Clinical Audit 2010 Round 7 report published May 2011. The full report is available using the following link.

[http://www.rcplondon.ac.uk/sites/default/files/national-sentinel-stroke-audit-2010-public-report-and-appendices\\_0.pdf](http://www.rcplondon.ac.uk/sites/default/files/national-sentinel-stroke-audit-2010-public-report-and-appendices_0.pdf)

##### Other Indicators:

\*\* 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.

	2007/08	2008/09	2009/10	2010/11	Target	Benchmark
Percentage of Cancelled Operations from FFCE's**	1.10%	0.68%	0.74%	0.50%	0.8%	
Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	n/a	523	482	556	n/a	n/a
Fragility Fracture Neck of Femur operated on within 48hrs of admission /	n/a	n/a	86.8%	91.0%	100%	80%+++

diagnosis						
Uptake on Cardiac Rehabilitation	75%	67%	79.8%	71.8%		41%++++ National Average 2008/09
Proportion of patients undergoing knee replacement who are readmitted within 30 days	Not Available	Not Available	3.99%	4.67%	Improve Year on Year	
Proportion of patients undergoing hip replacement who are readmitted within 30 days	Not Available	Not Available	4.68%	4.80%		
Proportion of patients assessed for risk of VTE	n/a	n/a	n/a	93.3% in Quarter 4	90% by Quarter 4 (Target)	

+++ This benchmark is taken from The National Hip Fracture Database National Report 2010 – Extended Version which is available from the link below. The 2011 Report is due to be published in July 2011 and will be available from the same link.

<http://www.nhfd.co.uk/>

++++This benchmark is taken from the 2010 Annual Statistical Report of the National Audit of Cardiac Rehabilitation and is the national average for patients who have had a heart attack, angioplasty, or bypass surgery who then take part in cardiac rehabilitation. The audit is funded by the British Heart Foundation and a copy of the report is available using the following link <http://www.cardiacrehabilitation.org.uk/nacr/docs/2010.pdf>.

## 5) Positive Patient Experience



		2007/08	2008/09	2009/10	2010/11	Target
Patient Experience Scores	Did the patient receive the information they needed from the staff about their care?	n/a	n/a	89%	89%	90%
	Was the patient given enough privacy when discussing their condition or treatment?	n/a	n/a	91%	90%	90%
	Did the patient think the ward/department was nice and clean during their stay/visit to hospital	n/a	n/a	94%	94%	90%

Were the staff courteous to them and their family/carer?	n/a	n/a	96%	95%	90%
Would the patient recommend the hospital to family and friends?	n/a	n/a	90%	90%	90%
Overall Patient Experience Trust Score	n/a	n/a	92%	92%	90%
Complaints	201	223	206	194	Less than 206

**6) Safe, Effective Environment, Appropriate Equipment & Supplies**



	2007/08	2008/09	2009/10	2010/11	Target
PEAT assessment – FOOD score	n/a	Excellent	Excellent	Excellent	n/a
PEAT assessment – ENVIRONMENT score	n/a	Excellent	Excellent	Excellent	n/a
PEAT assessment – PRIVACY and DIGNITY score	n/a		Excellent	Excellent	n/a
No Harm to Staff – Needle Stick Injury	76	67	68	94	0
No Harm to Staff – RIDDOR Reportable Injury	34	44	43	28	0
Maximiser Results (average taken from all results in 2010/11)	n/a	n/a	98.56%	98.82%	98%

## National targets and regulatory requirements

Please note that the cancer data is processed with a 1 month delay due to timescales for national uploads, therefore Quarter 4 performance is predicted.

The national average data supplied against the cancer indicators is taken from the "Open Exeter" system and is for April 2010 to March 2011.

No	Indicator	Q1	Q2	Q3	Q4	Year to Date	Target	National Average	
1	Clostridium difficile infections	24	13	4	7	48	108	n/a	★
2	MRSA bacteraemias apportioned to Acute Trust (post 48hrs)	2	0	0	1	3	5	n/a	★
3	Maximum waiting time of 31 day subsequent treatments for all cancers – <i>Anti cancer drug treatment</i>	99.3%	98.8%	100%	99.4%	99.3%	98%	99.6%	★
4	Maximum waiting time of 31 day subsequent treatments for all cancers – <i>Surgery</i>	100%	97.7%	100%	98.5%	99.0%	94%	97.1%	★
5	Maximum waiting time of 31 days from diagnosis to treatment for all cancers	99.0%	99.3%	99.7%	99.3%	99.3%	96%	98.4%	★
6	Maximum waiting time of 62 days for first treatment – <i>Urgent GP Referral</i>	86.2%	93.0%	90.1%	88.1%	89.4%	85%	86.8%	★
7	Maximum waiting time of 62 days for first treatment – <i>Consultant Screening Service Referral</i>	98.8%	92.0%	97.0%	98.6%	96.6%	90%	93.6%	★

No	Indicator	Q1	Q2	Q3	Q4	Year to Date	Target	National Average	
8	Maximum waiting time of 62 days for first treatment – <i>Upgraded Referrals</i>	81.8 %	90.9 %	91.4 %	81.8 %	87.1%	No operational standard set for 2010/11	93.5%	
9	Maximum waiting time of 2 weeks from urgent GP referral for all urgent suspect cancer referrals – <i>all cancers</i>	94.5 %	93.3 %	93.6 %	96.1 %	94.4%	93%	95.5%	★
10	Maximum waiting time of 2 weeks from urgent GP referral for all urgent suspect cancer referrals – <i>symptomatic breast patients</i>	94.7 %	89.8 %	93.3 %	96.7 %	93.5%	93%	94.8%	★
11	Screening of all elective in-patients for MRSA	146.8 %	147.4 %	154.7 %	124.2 %	143.9%	Greater than 100%	n/a	★
12	Maximum waiting time of 4 hours in A&E	98.5 %	98.1 %	98.0 %	97.4 %	98.0%	95%	97.4% +++++	★

+++++ National average calculated by aggregating the quarterly performance scores for 2010-2011 displayed on the Department of Health website. The quarterly performance scores and associated files are available using the following link.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performanceandstatistics/AccidentandEmergency/DH\\_079085](http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performanceandstatistics/AccidentandEmergency/DH_079085)

The Trust achieved all cancer targets in all quarters in 2010/11, with the exception of the two week wait breast referrals in Q2. Patient choice was the main contributory factor to the under performance in this area. We have, subsequently worked collaboratively with Primary Care to introduce further adaptations to the electronic booking system and put in place an educational programme to ensure that two week wait cancer breast referral target is achieved consistently.

The Trust has in place a robust performance framework to ensure sustainability, providing the mechanisms to ensure that pressures in achieving cancer waiting time targets are minimised with robust escalation plans. In 2010/11 the Trust introduced weekly proactive tracking mechanisms to ensure that potential issues surrounding capacity and choice were managed and risk minimised.

## 4 Feedback on our 2011-2012 Quality Accounts

This section contains the actual feedback on an earlier Quality Account draft from our local Overview and Scrutiny Committee and Commissioners.

### 4.1 Gateshead Overview and Scrutiny Committee

Based on Gateshead Healthier Communities OSC's knowledge of the work of the Trust during 2010-11 we feel able to comment as follows:-

#### **Quality Priority 3- Patient Experience**

We consider that there is good evidence that the Trust is carrying out work to ensure a positive patient experience.

The Trust has been involved in the development of a Gateshead Carers Strategy for 2011-14 along with the Council, PCT and other health trusts, voluntary sector and carers themselves to reflect their priorities and needs.

The Trust is to implement an early alert system into their emergency care department which will help alert palliative care patients at the point of admission, helping to reduce the overall length of stay.

St Bede's Palliative Care in-patient unit has been re-provided to the QEH site. The new facilities will provide a greatly improved environment for patients and there will be a reduced need for patients to travel from the west for investigations.

At St Bede's day care, Dunston Hill, a heart failure programme and a six week well-being programme have been implemented to support palliative care patients.

Twice monthly support groups for people struggling with loss and bereavement have been introduced.

An evaluation of experience of the views of next of kin following death of patients at the QEH in 2010 has been carried out.

There have been continued developments with discharge teams to ensure timely support for patients to provide end of life care at home.

The OSC previously advised the trust that it would be helpful to include a section on learning from complaints within future Quality accounts - the OSC is pleased to note the Trust has taken on board its comments. However, it was considered that it would be helpful in future if there was information relating to the number of complaints upheld and comparative information. It would also be helpful to have a linear trend line for national peers so that it is possible to compare Gateshead's position in the future.

It was also suggested that the Quality Account should contain more detailed information about the ways in which carers and users are contributing to improving the performance of the Trust overall.

#### **Improvement Priority 4 - Reduce harm from falls**

We consider that there is evidence that the Trust is carrying out work to reduce harm from falls.

The OSC has previously highlighted the importance of appropriate communication between hospitals and social care, particularly when transferring patients from hospital, to help reduce falls. The OSC is pleased to note that a trust wide event on reducing falls was held involving the Council and PCT which focused on areas of good practice, services available to patients and new initiatives.

However, whilst there had been a good reduction in the number of falls the OSC considered this was an area which still needed to see greater improvements and which the Trust should continue to focus on as a priority into the future. The OSC has sought reassurances from the Trust on this issue and has been advised that this area of work will continue to be priority for the organisation.

#### **Improvement Priority 5 - Reducing Harm from Hospital Acquired Pressure Damage**

We consider that there is evidence that the Trust is carrying out work to reduce harm from Hospital Acquired Pressure Damage.

The OSC has previously highlighted that the position regarding pressure sores can represent a safeguarding issue as it can indicate possible neglect. The OSC stressed the importance of reviewing all information about a patient to ensure safeguarding issues are raised.

The OSC is pleased to note that the Trust is carrying out Root Cause Analysis and using this information along with best practice to update policies and procedures, improve care and monitor areas of high incidence. Individual cases are also reviewed to make improvements.

In terms of the Quality account generally the OSC felt it would be helpful if all of the information could be reproduced in an understandable format in black and white in future.

## **4.2 Gateshead LINKS**

1. We are pleased that you have improved the timeliness of discharge to GPs and that further improvement remains a target for the future. Gateshead LINK worked with the Queen Elizabeth Hospital and distributed a questionnaire to discharged patients earlier this year. The results of this questionnaire confirm that timeliness of discharge is seen as a major issue in Gateshead and we are pleased to see it being addressed.

2. The overall aim of improving communications is also one we endorse. We would welcome the chance to work with you on this as we make the transition to become a local HealthWatch.
3. The target of moving towards all information being typewritten by 2012 is one we agree with. The questionnaire showed that 16% of respondents were unhappy with the information received with some finding it hard to read/illegible. Consistency of print would be a major step towards improving this.
4. Having been involved with the 'Green Bag' initiative for medicines and with the mobile dispensing unit, we would like to see this rolled out to more wards than at present. We will be happy to monitor the effectiveness of this and to promote results.
5. The report itself was not completely accessible. We'd like to see a consistent font size of at least 12 and when colour is used the contrast needs to be better (e.g. one graph features a black line and a blue line which are not easily distinguished between).
6. An easy read version of the quality account would be welcomed

Gateshead LINK has worked closely with Gateshead NHS Trust in 2010 – 2011. We have been represented on the PCPI Group and on the Francis Board and have jointly run a training session in complaints procedures. Our hospital discharge questionnaire was distributed by Gateshead NHS Trust staff in an excellent example of partnership working. We promoted the LINK at 2 events organised by the trust.

We regard the Trust as one of our major partners. We're happy with the way we have worked together in the past and look forward to continuing in the future.

#### **4.3 South of Tyne and Wear Primary Care Trust**

NHS South of Tyne and Wear (serving Gateshead, South Tyneside and Sunderland PCTs) aims to commission safe and effective services that provide a positive experience for patients and carers. Commissioners of health services have a duty to ensure that the services commissioned are of good quality. NHS South of Tyne and Wear takes this responsibility very seriously and considers this to be an essential component of the commissioning function.

Throughout 2010/11 NHS South of Tyne and Wear had monthly quality and contract review meetings with Gateshead Health NHS Foundation Trust. The mechanisms in place with local foundation trusts to monitor the quality of the services provided and to encourage continuous quality improvement are well established. The purpose of the quality review meetings is to:

- monitor a broad range of quality indicators linked to patient safety, clinical effectiveness and patient experience
- review and discuss relevant trust reports e.g. Incident and Complaints reports
- review and discuss relevant external reports e.g. Care Quality Commission patient surveys
- monitor action plans arising from the above

There are a number of areas where the trust has made significant quality improvements that have been particularly important for patient care and to commissioners, for instance:

- care of stroke patients,
- development of systems and process and measurement linked to reducing harm from pressure ulcers,
- development of real-time patient feedback using handheld devices,
- breast feeding initiation and caesarean section rates.

The trust continues to perform very highly in national staff and patient surveys and many other external assessments such as NHS Litigation Authority assessments, this consistency in performance is reassuring.

It is positive to note that the priorities for improvement in 2010/11 identified within the report closely align with NHS South of Tyne and Wear priorities that have been included in the 2010/11 CQUIN scheme with the Trust.

Much of the information contained within this Quality Account is used as part of the quality monitoring process described above e.g. performance against locally agreed quality measures and achievement against CQUIN indicators. As required by the NHS Quality Accounts regulations, NHS South of Tyne and Wear has taken reasonable steps to check the accuracy of this information and can confirm that it is believed to be correct.

## 5 Annex: 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 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that 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 2010-11;
- 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 2010 to June 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the commissioners dated 23/05/2011
  - Feedback from governors dated 16/3/2011
  - Feedback from LINKs dated 06/06/2011
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, (the Board has reviewed the data submitted by the Trust for publication in this national report due to be published later in the year).
  - The 2010 national patient survey published January 2011
  - The 2010 national staff survey 28/02/2011
  - The Head of Internal Audit's annual opinion over the trust's control environment dated May 2011.
  - CQC quality and risk profiles dated 23/9/10, 22/10/10, 22/11/10, 21/12/10, 18/2/11 and 18/3/11.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has

been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at [www.monitornhsft.gov.uk/annualreportingmanual](http://www.monitornhsft.gov.uk/annualreportingmanual)) as well as the standards to support data quality for the preparation of the Quality Report (available at [www.monitornhsft.gov.uk/annualreportingmanual](http://www.monitornhsft.gov.uk/annualreportingmanual))).

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

By order of the Board



22 June 2011

.....Date.....Chairman



22 June 2011

.....Date.....Chief Executive

## Appendix 1

### Gateshead Health NHS Foundation Trusts Participation in National Clinical Audits in 2010/11

Name of Audit	Trust Participating	No of cases required	No of cases submitted	% of requirement
Neonatal Intensive and Special Care	Yes	All admissions to Special Care Baby Unit – 224	224	100%
Paediatric Pneumonia	No	N/A	N/A	N/A
Paediatric Asthma	No	N/A	N/A	N/A
Paediatric Fever	Yes	50	50	100%
Childhood Epilepsy	Yes – data collection commences 01.05.11	N/A	N/A	N/A
RCPH National Paediatric Diabetes Audit	Yes	No requirement	104	N/A
Emergency use of Oxygen	No – service pressures	N/A	N/A	N/A
Adult community acquired pneumonia	No – service pressures	N/A	N/A	N/A
Non invasive ventilation	No - Intending to participate in 2011/12	N/A	N/A	N/A
Pleural procedures	No – service pressures	N/A	N/A	N/A
Cardiac Arrest	Yes	No requirement	86	N/A
Vital Signs in Major	Yes	50	50	100%
Adult Critical Care	Yes	All ICU admissions	1,099	N/A
Potential Donor Audit	Yes	All deaths in: Critical Care – 118 A&E - 94	Critical Care – 118 A&E - 93	100% 99%

Name of Audit	Trust Participating	No of cases required	No of cases submitted	% of requirement
National Adult Diabetes Audit	Audit not due to start until mid 2011 – Trust will be taking part	N/A	N/A	N/A
Heavy Menstrual Bleeding	Yes	- organisation audit – 10/11 - patient data collection – Feb 2011 – Jan 2012	100% - patient data collection – Feb 2011 – Jan 2012	100% - patient data collection – Feb 2011 – Jan 2012
National Pain Audit	Trust has registered for audit but it does not commence until April 2011	N/A	N/A	N/A
National IBD Audit	Yes	40 – data collection ends Aug 2011	data not available until Aug 2011	data not available until Aug 2011
National Parkinson's Audit	No	N/A	N/A	N/A
COPD	No – service pressures	N/A	N/A	N/A
Adult Asthma	No – service pressures	N/A	N/A	N/A
Bronchiectasis	No – service pressures	N/A	N/A	N/A
Hip, Knee and Ankle Replacements	Yes	N/A	814	N/A
PROMS	Yes	N/A	925	N/A
Peripheral Vascular Surgery- Vascular Surgery Database	Yes	All patients who have AAA or CEA – 22 AAA eligible, 22 CEA eligible	22 AAA 22 CEA	100%
Carotid Interventions	Yes	All cases – 21 eligible	21	100%
Heart Failure Audit	Yes	10 per month =120	172	143%
Pulmonary Hypertension Audit	No – service pressures	N/A	N/A	N/A

Name of Audit	Trust Participating	No of cases required	No of cases submitted	% of requirement
Acute Stroke (SINAP)	Yes	Number not yet determined	249	N/A
National Sentinel Stroke Audit	Yes	60	59	98%
Renal Colic	Yes	50	50	100%
Lung Cancer	Yes	All cases	211	N/A
Bowel Cancer	Yes	All cases	101	N/A
National Hip Fracture Database	Yes	Every fractured neck of femur that is admitted	302	100%
TARN	Yes	N/A	100	N/A
National Falls & Bone Health	Yes	60 = 40 – fragility fractures 20 – Neck of femurs	60	100% 40 – fragility fractures 20 – Neck of femurs
POMH	No – only a small number of topics relevant to Trust which are included in local audit programmes	N/A	N/A	N/A
National audit of schizophrenia	No – number of patients too small to be part of national audit. Programme of audit as per NICE guidance is undertaken internally	N/A	N/A	N/A
National Comparative Audit of Blood Transfusion – O Negative Blood use	Yes	40	29	73%
National Comparative Audit of Blood Transfusion – Platelet use	Yes	40	6 – platelets aren't given very often – only able to enter one for each patient	15%

The Trust was not eligible to take part in the following National Audits listed by the Department of Health as we do not provide these services.

Paediatric Intensive Care	CABG and valvular surgery
Paediatric Cardiac Surgery	Familial hypercholesterolemia
Cardiothoracic Transplant	Renal Replacement Therapy
Liver Transplantation	Renal Transplantation
Coronary Angioplasty	National Kidney Care Audit
National Audit of Psychological Therapies	Head & Neck

The Trust has taken part in the following National Audits additional to the list provided by the Department of Health:-

- Implementing NICE guidance for Health & Work: a national organisational audit
- National Audit on Depression – Occupational Health
- National Cancer Patient Experience Survey
- National Care of the Dying Audit Hospital 3<sup>rd</sup> Round
- National Colonoscopy Audit
- National Mastectomy and Breast Reconstruction
- Sloane Project
- UK NHS Emergency Laparotomy Network Aid
- National Oesophago Gastric Audit
- Surgical Site Infection
- National Audit of Dementia

### **Gateshead Health NHS Foundation Trusts Participation in National Confidential Enquiries 2010/11**

<b>Name of Enquiry</b>	<b>Trust Participating</b>	<b>No of cases required</b>	<b>No of cases submitted</b>	<b>% of requirement</b>
NCEPOD Cardiac Arrest Procedures	Yes	4	4	100%
NCEPOD Perioperative Care Study	Yes	6	5	83%
CMACE Maternal Deaths	Yes	N/A	1	N/A
CMACE Perinatal Deaths	Yes	N/A	32	N/A
CMACE Head Injury in Children	Yes	N/A	41	N/A

## Appendix 2

### **Independent Assurance Report to the Council of Governors of Gateshead Health NHS Foundation Trust on the Annual Quality Report**

I have been engaged by the Council of Governors of Gateshead NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Gateshead Health NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

#### **Scope and subject matter**

I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

#### **Respective responsibilities of the Directors and auditor**

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to March 2011;
- papers relating to Quality reported to the Board over the period April 2010 to March 2011;
- feedback from the Lead Commissioner dated May 2011;
- feedback from Governors dated May 2011;
- feedback from LINKS dated May 2011;
- the Trust's annual complaints data from the Trust's draft Annual Complaints report dated May 2011;
- the 2011 national patient survey;
- the 2011 national staff survey;
- the draft Head of Internal Audit's annual opinion over the trust's control environment for the period April 2010 to March 2011; and
- Care Quality Commission quality and risk profiles during 2010/11.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Council of Governors of Gateshead Health NHS Foundation Trust as a body, to assist the Council of Governors in

reporting Gateshead Health NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report.

To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Council of Governors as a body and Gateshead Health NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

### **Assurance work performed**

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

- making enquiries of management;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents listed previously.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

### **Limitations**

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

### **Conclusion**

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

### **Certificate**

In my report dated 1 June 2011, I explained that I could not formally conclude the audit on that date until I had completed the work to provide external assurance on the Trust's annual quality report. I have now completed this work. No matters have come to my attention since that date that would have a material impact on the financial statements on which I gave an unqualified opinion.

I certify that I have completed the audit of the accounts of Gateshead Health NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Cameron Waddell  
Officer of the Audit Commission  
Audit Commission  
Nickalls House  
Metro Centre  
GATESHEAD  
NE11 9NH

22 June 2011