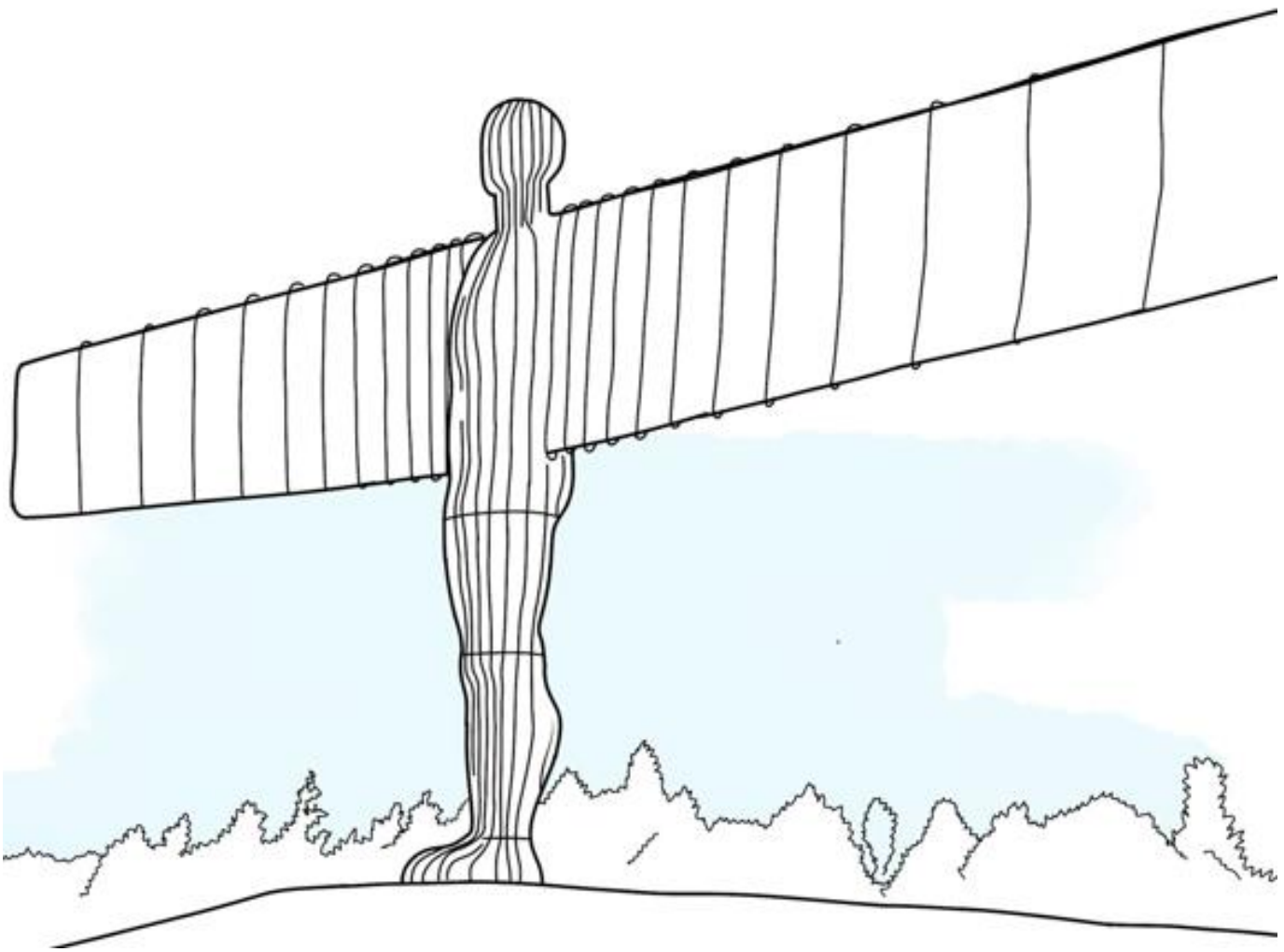
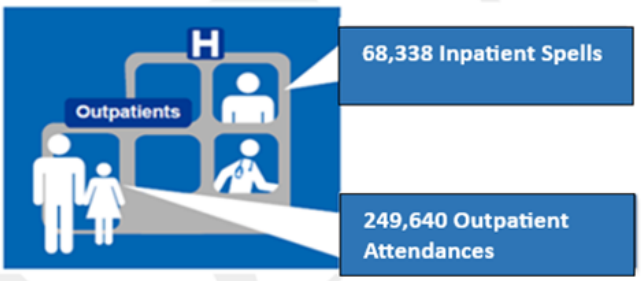
NHS
Gateshead Health
NHS Foundation Trust

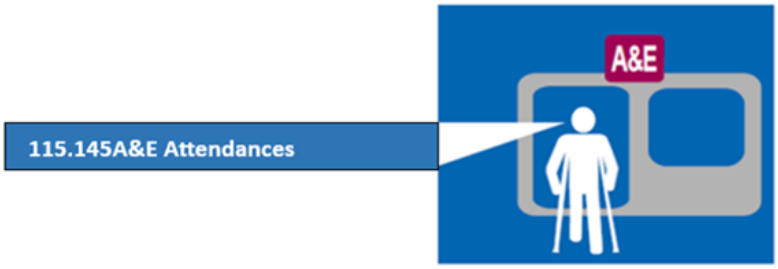


Quality Account

Gateshead Health NHS Foundation Trust 2023/24

Gateshead Health NHS Foundation Trust at a glance…





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Part 1

Quality Account – Chief Executive's Statement

Statement on Quality from the Chief Executive

#HelloMyNameIs Trudie.

I am delighted to be able to present my second Quality Account as Chief Executive of Gateshead Health NHS Foundation Trust. Providing great care and achieving great outcomes for our patients, their families and carers is at the heart of everything we do. There is no doubt that 2023-24 has again been a challenging year for us here at Gateshead as well as across the wider NHS and social care system. Our improvement journey has seen us focus on what is best for our patients and staff and as a result we have begun to see some improvements in key areas. Our ambulance handover times have improved markedly freeing up ambulances and their crews to get to the sickest patients in the community. We focussed on how long patients stay in hospital and working with our social care colleagues, we have significantly improved how long people wait for a social care placement meaning that our patients get home to their loved ones more quickly. None of this would have been possible without the skill and care of our clinical teams and I am extremely grateful to each and every one of our staff for the outstanding care that they show to patients every day.

In this Quality Account, we share with you details about the quality of patient care we have provided over the past 12 months and our achievements as well as our quality priority areas for 2024-25. These incorporate the pillars of quality - patient experience, patient safety, clinical effectiveness and for us here at Gateshead, we also include staff experience as it is inextricably linked to the quality of care. Our biggest priority over the next 12 months is to ensure that we are a clinically led and management supported organisation. This means that we need to increase our opportunities for engaging with staff and we need to listen and act on the concerns that are raised. This year we welcomed our new full time Freedom to Speak Up Guardian and one of our priorities in this account is to improve staff access to the freedom to speak up programme by introducing a network of champions.

Gateshead Health NHS Foundation Trust is continuing the journey to further increase our partnership working. This year we have been part of a developing Great North Healthcare Alliance with colleagues in Newcastle upon Tyne NHS Foundation Trust, North Cumbria Integrated Care NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust. I am committed to lead Gateshead Health with vision and clarity towards our common goal of achieving success and we will continue to do this through developing trusted relationships, being inclusive and respectful of others and ensuring that as a good partner, the standard of care delivered within the hospital and within Gateshead's community remains high. It is clear that in the current climate we can only be that successful partner by working closely with our neighbours and sharing best practice for the benefit of our patients and our people.

The last 12 months have seen exciting developments within the patient safety field. We have now embedded the national patient safety incident response framework and we are working through the detail of how we develop this for Gateshead. We have also welcomed a new lay patient safety partner to the team and our Integrated Care Board colleagues into our Quality Governance Committee to give a higher level of transparency that we have ever had before. This year we have also changed our incident reporting system so that we can give our people easier, faster access to information about patient safety at the point of care. The forthcoming year will be the time to let these new developments bed in whilst focusing on our priority areas to improve the safety of our patients.

I never cease to be grateful to our staff for the dedication and compassion that they show every day. It is therefore sad that we have had to include this year a campaign about “zero tolerance” to abuse of our staff. Our staff survey shows that a worrying number of staff (21.4%) have been exposed to harassment, bullying or abuse while at work from patients or members of the public. We have also experienced some distressing incidents where colleagues have been abused via social media. This is simply not something that we can tolerate, and we continue to work with our teams to identify where this has happened, to support them and to take whatever action we can to live our values of respect and care. On behalf of myself and our Trust Board, I would like to thank every member of staff, our governors, our volunteers and partners for their hard work and commitment during these challenging times and assure you of our commitment to keeping you safe at work.

To ensure that the Quality Account fairly presents our position, it has been reviewed by key stakeholders and by Trust board members, including our Non-Executive Directors. I can confirm, in accordance with my statutory duty, that to the best of my knowledge, the information provided in this Quality Account is accurate.

Signed Date: 26.06.24

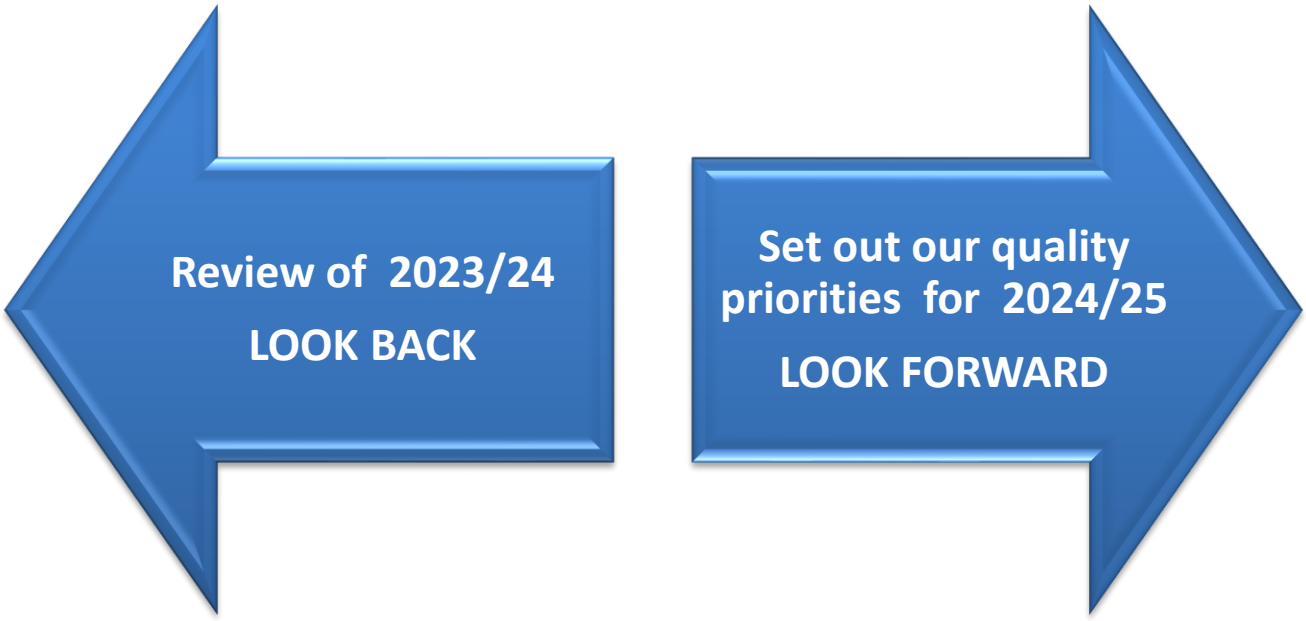
Chief Executive

What is a Quality Account?

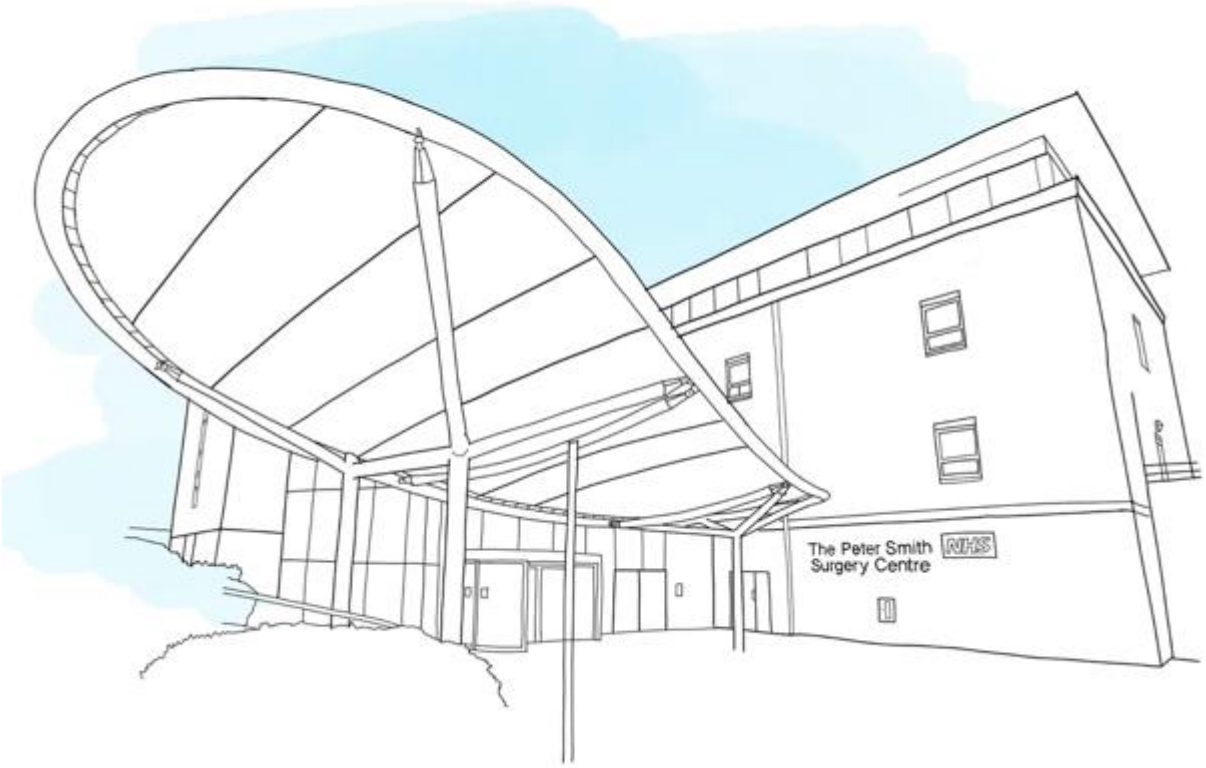
The NHS is required to be open and transparent about the quality of services provided to the public. As part of this process all NHS hospitals are required to publish a Quality Account (The Health Act 2009). Staff at the Trust can use the Quality Account to assess the quality of the care we provide.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

The dual functions of a Quality Account are to:

- Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2023/24.
- Outline the quality priorities and objectives we set ourselves going forward for 2024/25.



Part 2
Quality Priorities



2. Priorities for Improvement

2.1 Reporting back on our progress in 2023/24

In our 2022/23 Quality Account we identified 13 quality priorities that we would focus on. This section presents the progress we have made against these.

PATIENT EXPERIENCE:

Priority 1: We will work with our Volunteer Service to develop new roles

Having an excellent volunteer service not only supports our patients and staff but also offers an opportunity for volunteers to experience the hospital environment and helps many into meaningful employment and therefore supports our strategic ambition of being an anchor institution in the Gateshead area.

What did we say we would do?

- We will develop new volunteer roles.

➢ Did we achieve this?

- We have achieved this.

➢ How we achieved it:

- Worked with palliative care team to support bid for a volunteer grant via charitable funds to support the funding of the volunteer coordinator post.
- Started initial conversations with People at The Heart, and our drug and alcohol team around lived experience volunteers. The purpose of this role is to add value to the existing patient experience role by connecting people who have shared experiences.
- The recruitment of volunteers is on-going and associated training continues. Volunteer profiles continue to be reviewed and strengthened.

➢ Evidence of achievement:

- Bid for volunteer coordinator post has been submitted.
- Volunteers continue to be invaluable in the running of our services.
- Volunteers are now involved in the 15 steps challenge.

➢ Next steps:

- Volunteer Strategy to be developed in consultation with patients, the public and staff.
- Using the strategic model of the organisation, we will focus upon three key areas for volunteers; support and development of women's health services, Community Diagnostic Centre and supporting patient's with long term conditions.

Priority 2: We will improve the way we learn and make improvements following complaints

Complaints are a vital part of our patient experience metrics. Every complaint is reviewed by the Chief Nurse/Deputy Chief Executive and is taken very seriously to ensure that we are open and transparent with our patients. However, we do recognise that there is more work for us to do to ensure that learning from complaints is embedded throughout the organisation.

- What did we say we would do?
  - We will demonstrate learning and improvements made as a result of feedback from complaints.

- Did we achieve this?
  - We partially achieved.

- How we achieved it:
  - The feedback module which encompasses informal complaints, formal complaints, compliments, comments & feedback and information requests is now live on Inphase.
  - The Complaints Policy and Process has been reviewed and amended.
  - The Patient Advice and Liaison Service (PALS) has been reset as a rapid response service for patients and/or families. Work was undertaken by the Patient Experience Team and clinical staff to triage and streamline the processes and a monitoring process implemented.

- Evidence of achievement:
  - Funding has been sourced for complaints training to be carried out by an external provider. This will focus on the initial management of the complaint and composing of response letters.
  - Remodelled PALS with response times and >50% of enquires receiving a response within 24 hours.

- Next steps:
  - Complaints training to be finalised and offered to staff across the organisation.
  - Continue to improve the responsiveness of the PALS service.
  - Learning panel to receive monthly learning from complaints responses.

Priority 3: We will strengthen our partnership working with collaborative patient forums to enhance patient engagement and involvement

We recognise that during the pandemic some of our opportunities for working with members of the public disappeared. Public involvement is such a vital part of our work that we have missed those opportunities and have therefore included this as a priority area for development.

- What did we say we would do?
  - We will develop and introduce new patient forums in collaboration with the North East and North Cumbria Integrated Care System (ICS).

➢ Did we achieve this?
- We achieved this.

➢ How we achieved it:
- We have re-engaged with Gateshead Carers Partnership and representatives from Gateshead Council and Gateshead Carers have been invited to Trust meetings e.g., the Patient Experience Group.
- The previous patient experience group has been re-launched to include a wider range of stakeholders.
- The 15 Steps Challenge restarted in January 2024 with volunteer support

➢ Evidence of achievement:
- 15 steps challenge relaunched.
- Patient Experience Group relaunched with wider representation from stakeholders.

➢ Next steps:
- Ensure inclusive representation at the Patient Experience Group
- Identifying priorities to determine the delivery plan
- Ensure carers are supported and included within the work.

STAFF EXPERIENCE:

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

We know that having staff who feel happy and safe at work leads to better patient outcomes. Unfortunately various national reports have demonstrated that staff need to have a mechanism to speak out that is independent of line management arrangements. We are committed to providing these opportunities for all our staff so that they can feel safe at work.

➢ What did we say we would do?
- Develop supporting leaflets on Freedom to Speak Up (FTSU) for both staff and leaders in the organisation.
- Update our FTSU Policy based on national guidance and local people strategy.
- Refresh our approach to reporting on FTSU across the organisation.
- Develop a communication plan to make staff aware of what FTSU is, communicate what the role involves and look to seek expressions of interest for additional FTSU Champions.

➢ Did we achieve this?
- We have achieved this.

➢ How we achieved it:
- Relaunched the FTSU service.
- Introduced full time permanent FTSU Guardian.
- Updated our FTSU policy in line with National Guardian Office Policy.

- Introduced a communications plan to ensure regular awareness and updates are available to staff.
- Introduction of the Trust Culture Board Program
- Increased education and training in number of different forums for FTSU
- Changed our data collection for FTSU to be able to identify key themes, trends, and hotspots to link into the Culture Board Program work streams.
- Recruitment and relaunch of FTSU Champions with wider representation from all areas across the Trust and staff forums.
- Working collaboratively with POD, Trade Unions, Senior Management Team, and staff forums.

➢ Evidence of achievement:
- Increased number of FTSU concerns reported in Q3 & 4.
- Culture Board program workstream outcomes; zero tolerance campaign- show racism the red card, and "it's not ok" campaign.
- Changes in Trust Policies.
- Cross representation of Champions across the Trust.
- Training and education packages.
- Communications plan.
- More robust data collection and follow up
- Introduction of feedback for users of service and review for continuous improvement of service.
- Change in governance processes of reporting FTSU information.
- Realigned to patient safety.

➢ Next steps:
- Increase the number of FTSU Champions.
- Training for all champions.
- Network meetings for champions.
- Development of resources and information across different platforms- webpage, Facebook Page, Newsletter section.
- Continuation of Culture Board Program.
- Further education and training at middle manager level to support managers with FTSU.
- Further education and training opportunities to be explored with POD team.
- Development of listening up space for FTSU.
- Development of FTSU posters and leaflets to continue raising awareness.

Priority 5: We will listen to staff experience in relation to waste and duplication

Not only are our staff our greatest asset for clinical care, but they can help us to see where there is waste and duplication within the system.

➢ What did we say we would do?
- We will listen to staff experience in relation to waste and duplication.

➢ Did we achieve this?
- We partially achieved this.

➢ How we achieved it:
- We carried out staff engagement events in the QE Hub, Bensham café and outside Costa asking people for their ideas and areas for improvement.

- We have completed three cohorts of certified leaders training and quality improvement training on managing well.
- In the last 12 months we have carried out Rapid Process Improvement Workshops (RPIW) with endoscopy, HR recruitment process, site resilience, Occupational Health, Audiology, and the discharge teams with community services.
- We have carried out service improvement events relating to, discharge lounge, lung cancer pathway, outpatients, procedure investigation unit, same day emergency care, emergency admissions unit, clinical coding, medical staffing, ward and board rounds on ward 22, hospice at home, podiatry, orthopedic diabetic pathway, autism referrals, rapid response, children's bowel and bladder, older persons mental health, children outpatients palliative care
- Well Organised Hospital, has included maternity, theatres, critical care, wards in scheme 3. This project has resulted in multiple areas of cost saving and waste reduction and reduction by reduction of overstocking and clearer relationship with the supplies team.

➢ Evidence of achievement:

- We have more staff trained in improvement and lean approaches which focuses on identifying waste and duplication.
- We have a Well Organised Hospital programme running which has been working within clinical environments to ensure we have identified good stock management and environments organised to prevent duplication and waste in day-to-day processes.
- We continue to offer training and run RPIWs which have resulted in:

  - Reduction in length of time to onboard new starters
  - Increased number of induction days
  - Reduction in wait for management referral to occupational health
  - Electronic form for referral to occupational health
  - Better utilisation of space in occupational health
  - Reduction of waiting list for audiology patients
  - Reduction of did not attends (DNAs) in audiology
  - Standardisation of ICE results reporting across the organisation
  - Reduction of unfiled results
  - Creation of information sharing between the community, local authority and hospital for the management of patients requiring discharge.

➢ Next steps:

- Continuing to roll out the Well Organised Hospital.
- A number of service improvement events are planned, including surgical preassessment, digital care planning, community services projects, outpatient projects, and the community diagnostic centre.
- Training continues in the managing well course and prospectus training.
- Web site is activated with the opportunity for staff to tell us their ideas and areas for improvement to continue to reduce waste in the organisation.

- Access for staff to the Quality Improvement information and tools to assist with Plan, Do, Study, Act (PDSA) cycles.

Priority 6: We will focus on safe staffing including reducing the movement between clinical areas

Our staff have told us that one of their biggest frustrations is being moved between departments at short notice and being ask to work in an unfamiliar area. There is evidence that more accidents and incidents happen when staff are in unfamiliar environments, so we have therefore prioritised this as a development area.

➢ What did we say we would do?

- We will use approved tools for all clinical areas in line with national requirements, making sure we are assessing staffing appropriately e.g., Birthrate Plus, SNCT, Mental Health Optimal Staffing Tool (MHOST) etc.

➢ Did we achieve this?

- We partially achieved this. We have used the relevant staffing tools, but still have staff movement between clinical areas.

➢ How we achieved it:

- Over 2023/24 we have improved our overall vacancy position across the trust. We have successfully recruited 171 internationally educated nurses, introduced a four year apprentice program taking school leavers through an educational program from 'new to care' to qualified registered nursing while training on site. We have also continued to develop our healthcare support worker workforce, supporting them to complete higher level educational studies to become Nursing Associates or further to complete Registered Nurse training.
- The Head of Nursing for Workforce with clinical expertise in safe staffing has supported the organisation to further develop the safe staffing arrangements.
- Our annual safe staffing reviews have ensured safe staffing levels are monitored and reported to Trust Board on a biannual basis, making recommendations on amendments to establishments based on patient acuity levels in line with skills required to support care needs.
- Although we are unable to totally eradicate the need to move clinical staff between areas a substantial reduction in movement of staff is evident when reviewing metrics with staff only being moved to support critical shifts.

➢ Evidence of achievement:

- We have successfully improved the nursing staffing position across the organisation reducing the overall nursing vacancy rate from 9.0% (February 2023) to -1.3% (February 2024).
- Reduction in annual agency spend within the trust.

➢ Next steps:

- Ongoing work on retention, looking at ways to support experienced workforce to remain in healthcare positions after retirement retaining valuable skills and knowledge.
- Further work to improve safe staffing monitoring in non-inpatient based areas such as community, A&E and outpatients.

PATIENT SAFETY:

Priority 7: We will reduce length of stay for our inpatients

Every day that a patient is in hospital is a day that they are away from their loved ones. Also, there is evidence that being in hospital results in deconditioning for some patients potentially leading to an increase in falls and a decrease in function. It is therefore important that every day is hospital is a meaningful day when patients are actively being treated. Therefore, it makes sense for us to concentrate on reducing the length of stay for patients where it is safe to do so.

➢ What did we say we would do?

- We will reduce length of stay for our inpatients.

➢ Did we achieve this?

- We achieved this.

➢ How we achieved it:

- Our monthly average length of stay decreased from 4.96 days to 4.83 days in 2023/24.
- We achieved this through a renewed focus on getting the patient to the right place for their care. This was done by collaborative working across the hospital, with community services, social care and GPs which formed part of our winter governance structures. A number of initiatives have been introduced to support earlier discharge including increased availability of social care, virtual ward arrangements for respiratory and frailty, a renewed focus on our weekly stranded patient meetings where any blocks to patients progressing home are identified and new site management arrangements to ensure that this is monitored and improved.
- The improvement in length of stay is set against an overall increase in patient attendances and acuity of patients.
- We recognise that although we have achieved this priority, there is minimal improvement and further work is required to maintain this achievement.

➢ Evidence of achievement:

- Overall length of stay reduced from 4.96 days to 4.83 days.
- Evidence of closer working with primary and social care colleagues

➢ Next steps:

- Reducing length of stay forms part of our improvement work in 24/25 with a target stay of an average of less than or equal to four days as agreed by the Trust Board.

Priority 8: We will implement the Patient Safety Incident Response Framework (PSIRF) with further work streams on falls and civility

Last year we concentrated on implementing the new national patient safety incident response framework. This approach to incident management is a completely new way of investigating incidents and learning from them. Now we need to consolidate this approach and ensure that

the just and restorative approach to investigations is fully embedded throughout the organisation.

➢ What did we say we would do?

- We will create a project board and working group for PSIRF.
- We will strengthen our existing falls prevention group workstreams through improved engagement with business units.
- Understand the organisations current position with regards to civility and its impact on patient safety and staff wellbeing.

➢ Did we achieve this?

- We achieved this.

➢ How we achieved it:

- Fortnightly PSIRF working group meeting was established with all relevant stakeholders invited to enable effective co-production as part of PSIRF implementation.
- The Trust's patient safety improvement plan priorities has been developed with quarterly updates to the Learning Panel and the Quality Governance Committee.
- Patient Safety Lead involvement in discussions and plans for Culture Transformation Programme including Civility Saves Lives initiative as well as plan to review People and OD policies related to Just Culture principles.

➢ Evidence of achievement:

- The PSIRF project board and working group were operational for the duration of PSIRF implementation. The meetings are no longer deemed required following 'go-live' on 1 November 2023 and the Trust now being in the embedding phase.
- The Terms of Reference for the Falls Strategic Group (workstream) have been updated and the invite to attend has been more widely circulated to include Ward Managers and Matrons as well as Chief Matrons to ensure appropriate stakeholder involvement for system improvement.
- The Trust's Patient Safety Incident Response Plan was approved by the ICB in November 2023.
- The Civility Saves Lives initiative is part of the Trust's Culture Transformation Programme. This programme includes initiatives in line with the culture principles of the national Patient Safety Strategy and PSIRF.
- The Trust formally transitioned from the Serious Incident Framework to the PSIRF on 1st November 2023, meeting the majority of the PSIRF standards with some in development as expected/appropriate according to NHS England and CQC expectations.
- Falls Strategic Group meeting is now chaired by Deputy Chief Executive/Chief Nurse with improvement priorities and plans discussed and next steps agreed.

➢ Next steps:

- Work to become fully compliant with PSIRF standards will continue to develop as we embed the principles and work under the Framework.
- The Trust's PSIRP including the patient safety improvement priority areas and associated plans will continue to be developed and be updated as appropriate as the National Patient Safety Strategy and PSIRF are fully embedded and evolve over time.

Priority 9: We will undertake improvement work around the processing of clinical results

The impact on patients of not having timely access to clinical results can be catastrophic. There are a number of failsafe mechanisms in place for results such as cancer, but we do still see incidents occurring where result have been filed incorrectly or have not been seen by the relevant clinical staff. While many aspects of clinical care have been improved by moving to electronic results reporting, we recognise that there is further work to do to ensure that all processes are consistently followed.

➢ What did we say we would do?

- Building on the workshop held in Q4 2022/23 we will hold a full rapid process improvement workshop (RPIW) to review the processes for managing all results on the ICE system with a view to developing a standard operating procedure

➢ Did we achieve this?

- We partially achieved this.

➢ How we achieved it:

- An improvement event took place from 4-6th December 2023.
- The workshop was attended representatives from general surgery, acute medicine, general medicine, surgery, systems team for RIS, PACS and ICE.
- Whilst a new process was developed this has failed to achieve the full improvement that we were looking for. This priority will therefore roll over to next year.

➢ Evidence of achievement:

- A trust level standard operating procedure was developed for requesting and reviewing tests on ICE, with departments to be asked to produce their own individual procedures to demonstrate how these indicators will be met. Guidance was produced on system use and closing the safety gaps. Options were proposed around efficiency of requests, including how to stop over requests and use of ICE mail and alerts and the potential to stop over reporting of results.
- Framework was developed for the engagement of clinical teams – first presentation for consultation took place at Clinical Strategy Group on 10th January 24.

➢ Next steps:

- Compliance with management of ICE results determined difficult to monitor – reports hard to access and interrogate – this is to be made simpler and made more readily accessible along with overview provided to Quality Governance Committee.
- Future developments include move to version 8 of ICE in the short term and in the longer term procurement of a fully integrated Electronic Patient Record.

Priority 10: We will implement a maternity and neonatal improvement plan

A number of reports about failings in maternity in other organisations gives an insight into the impact on our patients when thigs go wrong. We therefore continue to focus on maternity to raise awareness of learning from other Trusts and to improve our standards where we can.

What did we say we would do?

- Continue to give the Trust Board assurance around the Trust's compliance with the Immediate and Essential Ockenden actions (IEA).
- Review existing bodies of work that are running concurrently and incorporate into an overarching maternity and neonatal plan for the Trust. This will include the national Maternity and Neonatal Delivery Plan; any actions outlined by CQC in the latest Maternity inspection report as well as existing projects such as Birmingham Symptom Specific Obstetric Triage System (BSOTS) and cycles of audit.

Did we achieve this?

- We achieved this.

How we achieved it:

- Monthly reporting of agreed data, Maternity Incentive Scheme (MIS), Ockenden compliance to Trust board via separate Maternity Integrated Oversight Report (IOR).
- Good rating from CQC during recent inspection.
- Full compliance with the MIS.
- Individual compliance plans are embedded within governance processes.

Evidence of achievement:

- Performance with all targets is now embedded into reporting processes.
- Full compliance with MIS confirmed by the ICB and Local Maternity and Neonatal System.
- CQC Good rating.

Next steps:

- Complete and publish Midwifery strategy.
- Continue to achieve year 6 of the MIS.
- Implement learning from CQC inspections across the region
- Continue to work with our maternity voices partnership to improve the experience of our women.

CLINICAL EFFECTIVENESS:

Priority 11: We will embed a culture of research in the Trust and make "Research Everyone's Business"

We know that being an organisation that is active in research gives patients better outcomes. Many patients wish to be part of research trials and so we continue to strive to have as many opportunities as possible available for patients and for our staff.

➢ What did we say we would do?
- Offer every patient and member of staff the opportunity to "Be Part of Research"

➢ Did we achieve this?
- We partially achieved this.

➢ How we achieved it:
- We engaged in the "Your Path in Research" campaign and "The Associate Primary Investigator Scheme". Patients can search for and join relevant active National Institute for Health Research portfolio research projects listed on the Be Part of Research database.
- Promotion has also continued through annual events such as #Red4Research and International Clinical Trials Day.
- The R&D Twitter page @QEHResearch, continues to be very successful with over 450 followers so far.
- We raised research awareness for staff via newsletters.
- We extended our hosted research portfolio, especially in under-served clinical specialty areas and in areas of health inequality.
- We ensured staff have a basic understanding of research through our "Introduction to Research" course.

➢ Evidence of achievement:
- We have continued to manage and deliver a complex portfolio of research across the Trust recruiting over 1,600 participants into more than 50 studies in the last year. All research that is carried out in the Trust has appropriate ethical and regulatory approval.
- The Patient Research Experience Survey (PRES) gives research participants the opportunity to feedback about their research experience via an online survey. This showed that in our Trust, 98% of participants recruited in 2023/24 would consider taking part in research again.
- The number of hosted research studies has increased from last year.
- R&D welcomed seven new Principal Investigators.

➢ Next steps:

- Encourage support for research to be embedded in clinical services, across all workstreams and recognised as part of direct clinical activity.
- Continue to actively promote research through annual events such as the Your Path In Research
- Continue to focus on enabling people to take part in research by increasing the number of active research studies; increasing the number of participants recruited to research studies and increasing the number of research active staff.

Priority 12: We will strengthen how we learn from deaths

When someone dies in our care it is important that families have the opportunity to ask questions about their loved one's care. We need to be assured that we have done everything possible for that patient and that where we could have done better we learn from it. The medical examiner service allows us the opportunity to work with families and staff to ensure that we improve our care.

➢ What did we say we would do?

- Expand the medical examiner (ME) system to non-coronial deaths outside of the acute trust

➢ Did we achieve this?

- We partially achieved this.

➢ How we achieved it:

- The Lead Medical Examiner Officer has delivered presentations to GP practices either via Teams or in person to explain the new process, demonstrate how to refer into the service using generic proforma set up within EMIS community and answer any questions or concerns. Also attended the GP Fellows meeting to introduce service to GP trainees and attended the GP Timeout event in mid-March.

➢ Evidence of achievement:

- All 28 GP practices within the catchment area contacted:-
  - 20 GP practices are now referring into ME service on a regular basis.
  - Three practices have agreed in principle and await receipt of first referrals.
  - One practice has agreed a start date of 01.04.2024.
  - Seven practices, four of which are under one umbrella company, have either refused to engage or wish to wait until official 'go live' date of the legislation "Death Certification Reform and the Introduction of the Medical Examiner". The 'go live' date has been confirmed as 9th September 2024.
- Referrals into the ME service from GP practices have increased from approximately 10 per month to over 40 cases in February 2024.

➢ Next steps:

- From 'go live' date – 9th September 2024, all GP practices will be required to send completed Medical Certificate for the Cause Death (MCCDs) to ME office for sign off by the Duty ME before submission to Registrars.

Priority 13: We will work with our clinical effectiveness team to improve the experiences of people with a learning disability, mental health or autism

We know that health outcomes and experiences for people with a learning disability and/or autism fall below that for other patients. Review of our incidents shows that we do no always offer the reasonable adjustments necessary for more vulnerable patients. Education of our staff is the key to raising the standards for our patients and that is why we chose this as a priority area for our quality accounts.

➢ What did we say we would do?

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

➢ Did we achieve this?

- We partially achieved this.

➢ How we achieved it:

- Raising awareness of learning disabilities and autism is a key priority across the NHS, following a drive for the introduction of national 'Oliver McGowan training'.
- We have provided the Diamond Standards training to our staff, for many years now and will continue to do so until the code of practice is available to Trusts.
- Our learning disabilities service aims to improve awareness of learning disabilities and autism and how us make reasonable adjustments to improve the healthcare outcomes
- Although throughout 2023/24 we have made substantial progress through training and education, further work is required to embed this learning.
- We review the care delivered by auditing both inpatient care and care prior to death to ensure the best possible care has been delivered.

➢ Evidence of achievement:

- Diamond Care Standards training is provided across the trust for all clinical areas who currently come into care contact with patients who have a learning disability. This training is provided by our specialist nurse team for learning disabilities.
- The learning disabilities nurse and the palliative care team made a presentation to Trust Board about reasonable adjustments.
- We have participated in the Learning from Deaths reviews (LeDeR) for people with learning disabilities and/or autism.

➢ Next steps:

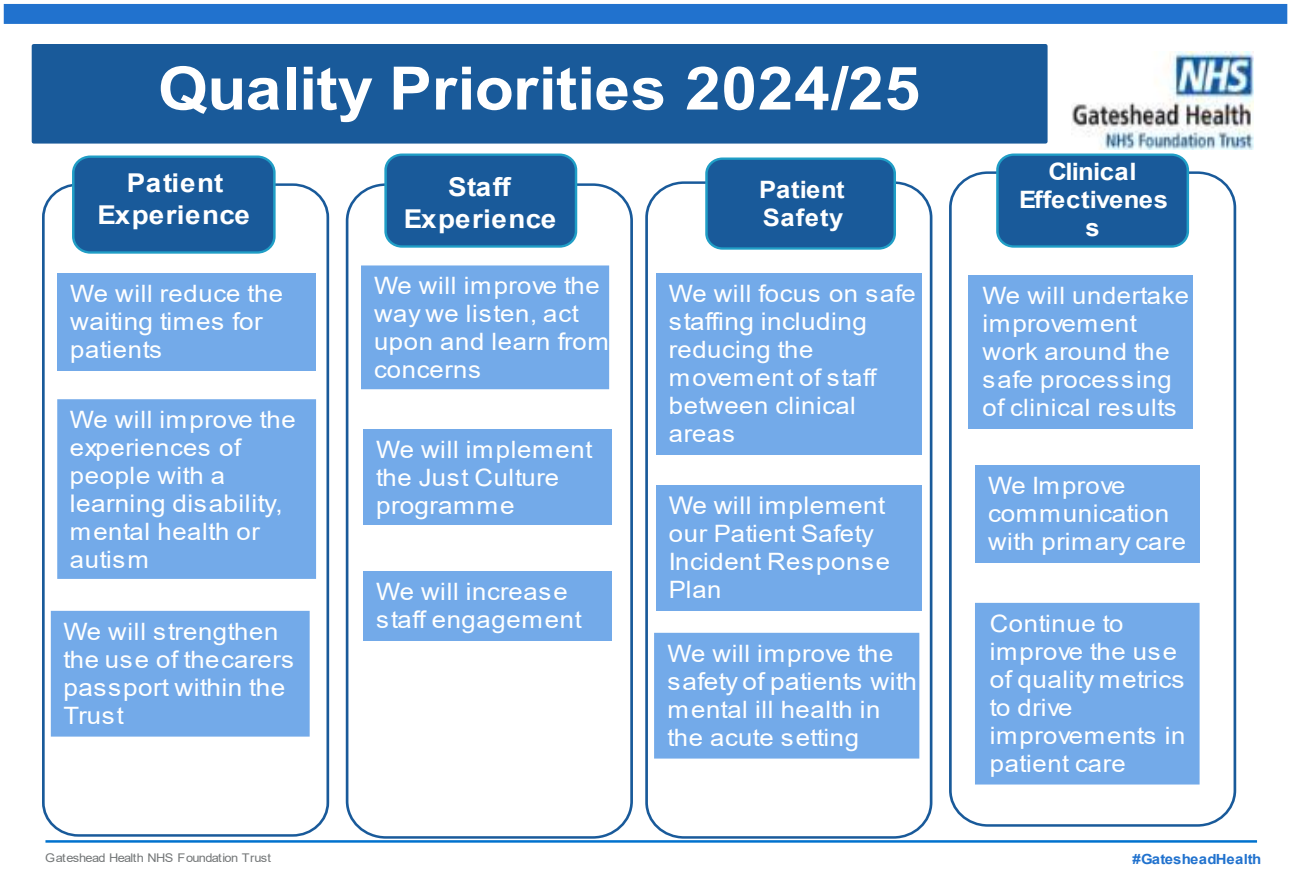
- Following the national requirement to introduce specific training, the trust is working with ICB partners to develop an enhanced training programme across the region.
- The service is currently reliant on one individual and the Trust will review options to strengthen this service.
- We will continue to review and audit the care given to our patients to improve services where we can.

2.2 Our Quality Priorities for Improvement 2024/25

We have engaged with our partners and stakeholders to understand what the quality account priorities should be for 2024/25. It was agreed that we should continue to define our priorities under the four headings of:

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

The table below shows the Quality Account Priorities for 2024/25 in summary form



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

PATIENT EXPERIENCE				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will reduce the waiting times for patients	We will reduce the waiting time for people needing an elective operation so that no patient will wait more than 52 weeks *	Increased focus on validation of our lists and adherence to rules about seeing patient in chronological and clinical priority order	No patient will wait longer than 52 weeks for their elective operation by end of June 2024*	Waiting times for patient waiting for elective care
	We will reduce the waiting time for people in our emergency department *	Increased focus on flow through the department and seeing patients in clinical priority order	78% of patients in the emergency department will be seen within 4 hours	4 hour waiting time standard
	We will achieve 62 days' time to first treatment for patients with cancer for no less than 70% of patients	Increased focus on the standard with the introduction of the cancer group and the cancer clinical advisory group	70% of patients will start their first definitive treatment within 62 days of diagnosis	Cancer waiting times reports
We will work with our teams to improve the experiences of people with a learning disability, or neurodiversity	Raise awareness of learning disabilities and neurodiversity to improve the healthcare outcomes and reduce health inequalities for this group of patients.	Roll out of the GHFT mandatory level 1 learning disability and neurodiversity training. 85% of staff will receive this training by end September 2024.**	Increase staff awareness of learning disabilities and neurodiversity and their individualised needs Increase in staff confidence when caring for patients with a learning disabilities or neurodiversity	ESR reports Evaluation pre and post training
		Develop a plan for the level 1 face to face, interactive training of staff in line with the mandatory training requirements from June 2024**		

		Develop a plan to implement level 2 training for the staff that need this in line with the Oliver McGowen training requirements		
We will strengthen the use of carer's passports within the Trust	Ensure that carers who wish to use a carers passport can access the information relating to passports	Complete audit of the use of passports. Complete awareness raising campaign and reaudit the use of the passports	More carers will have access to the passports and will be using them within the Trust	Audits reported to patient experience group.

*indicates a Leading Indicator
** indicates a breakthrough indicator

STAFF EXPERIENCE				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will improve the way we listen, act upon and learn from concerns.	Develop a network of freedom to speak up champions across a diverse range of staff groups	Further campaigns to recruit more champions with a targeted approach to improve diversity of champions.	Increasing the number and diversity of FTSU Champions we have across the organisation. Increasing staff awareness of what FTSU is and who the champions across the organisation are.	The number of active champions that we have across the trust The number of concerns reported to the FTSU guardian and champions Strategy is in place and being used
	Develop and share the FTSU vision and strategy across the	Develop the strategy and vision by working with the staff forums and meetings	Strategy is in place and understood by the organisation	

We will implement the culture programme	We will introduce a zero-tolerance campaign as part of the culture programme	Full campaign plan will be developed including communications and engagement plan. Policy has been rewritten to include elements of this programme	Staff will be empowered to report incidents of incivility and aggression Incidents will be managed swiftly and in line with the new policy	New policy is embedded. Inphase incidents reported relating to violence, aggression, incivility and any form of racism or intolerance Incidents are being managed in line with the policy
We will increase staff engagement*	We will review the structure of the organisation and the governance arrangements to ensure that the clinical voice is input at the correct levels through the organisation.	New structure has been developed following a significant engagement exercise and will be implemented following the appropriate consultation period.	New structure will provide the opportunity for staff voices to be heard at various levels of the organisation	New structure is fully implemented and embedded

*indicates a Leading Indicator
** indicates a breakthrough indicator

PATIENT SAFETY				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will focus on safe staffing, including reducing the movement of staff between clinical areas.	We will use approved tools for all clinical areas in line with national requirements, making sure we are assessing staffing appropriately e.g. Birthrate plus, SNCT, MHOST etc.	The appropriate staffing tools will be completed twice a year and reported to Trust Board in line with the national requirements	Report will be presented to Trust Board twice yearly	Review of Trust Board papers

	As vacancies in ward areas are filled, we will implement a system to monitor and record the level of movement between wards and departments	Implement systematic review of all staff movements	We will reduce the movement of staff between clinical areas.	Reports of staff movement between different areas
	We will look for opportunities to adapt the workforce to the requirements of the patients	Review the advanced practice roles across the organisation and align with national job profiles	Roles will be standardised in line with national profiles and benchmarking	Review of advanced practice will be completed
We will implement our Patient Safety Incident Response Plan **	We will develop the six identified workstreams (falls, pressure damage, digital, maternity, infection, prevention and control and medicines management)	Each workstream will have an agreed work programme with timescales and identified leads	Identified improvements will be made in each of the six areas in line with the work plans	Achievement of the targets identified within the workplans
		Workstreams will report into SafeCare Steering Group		
We will improve the safety of patients with mental ill health in the acute setting	We will identify a programme of work to improve our management of mental ill health, not just in our older persons' mental health team, but across the Trust	The violence reduction work will source a training programme covering better management of patients displaying challenging behaviours	Training programme will be attended by key individuals within the organisation	Reduction in the number of incidents relating to challenging behaviours and rapid tranquilisations Better compliance with the Mental Capacity Act policy
		Improve compliance with our Mental Capacity Act policy through training and audit**	Compliance with the policy will improve.	
		We will seek to reduce the	Reduction in the number of Rapid	

		number of rapid tranquilisations undertaken throughout the Trust	tranquilisation events in the Trust	
	Engage in national cultural work around mental health	Key members of GHFT staff will take part in the national programme	Improved understanding of improvement processes in mental health	QI programmes undertaken as a result of the programme

*indicates a Leading Indicator
** indicates a breakthrough indicator

CLINICAL EFFECTIVENESS				
Quality Priority	**What will we do?**	**How will we do it?**	**Expected Outcome?**	**How will it be measured?**
We will undertake improvement work around the safe processing of clinical results.	Building on the workshop held in 2023 we will undertake further work to review the processes for managing all results on the ICE system	Develop and monitor an improved standard operating procedure Communication strategy to raise awareness of new process Audit the effectiveness of previous changes	Reduction in incidents in relation to ICE reporting	Monitoring via incident management system Mortality reviews
Improve communication with primary care partners	We will reduce the duplication of GP discharge letters	Develop a plan with software developers to reduce the number of duplicated discharge letters	Reduced reports of duplicated discharge letters going to GP practices	SIRMS reports
	Improve the efficiency and quality of discharge letters	Review systems providing discharge letters to primary care and ensure potential for missed letters are minimised	All discharge letters arrive in GP practices with 48 hours of discharge	System reports about delivery of discharge letters

Following the introduction of a suite of ward-based quality metrics#, we will continue to improve the use of data to drive improvements in patient care at the front line.	Develop the dashboard of quality metrics currently being used in ward areas to include community and other outpatient areas	We will review the metrics at every nurse professional forum and support teams where improvement plans are required	Quality metrics will be used to drive improvements within the Trust	Quality metrics report will be provided and published at each nurse professional forum

*indicates a Leading Indicator
** indicates a breakthrough indicator
# ward based quality metrics are a suite of indicators including measures such as hand hygiene compliance, controlled drug checks, resus trolley checks, staff vacancy rates, patient falls, complaints and incidents used to assess the quality of care provided in ward areas.

2.3 Statements of Assurance from the Board

During 2023/24 the Gateshead Health NHS Foundation Trust provided and/or sub-contracted 30 relevant health services. The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services. The income generated by the relevant health services reviewed in 2023/24 represents 100% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2023/24.

Participation in National Clinical Audits 2023/24

During 2023/24, 35 National Clinical Audits and five National Confidential Enquiries covered relevant health services provided by Gateshead Health NHS Foundation Trust.

During that period Gateshead Health NHS Foundation Trust participated in 94% of National Clinical Audits and 100% of National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that Gateshead Health NHS Foundation Trust participated in, and for which data collection was completed during 2023/24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit title	Participation	% of cases submitted/number of cases submitted
Case Mix Programme (CMP)	Yes	800 cases were submitted – no minimum requirement
Elective Surgery (National PROMs Programme)	Yes	256 cases – Hip 358 cases – Knee No minimum requirement
Mental Health (Self- Harm)	Yes	Data collection still ongoing
National Audit of Inpatient Falls (NAIF)	Yes	16 cases were submitted – no minimum requirement
National Hip Fracture Database (NHFD)	Yes	354 cases were submitted – no minimum requirement
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	100% of cases were submitted
National Diabetes Inpatient Safety Audit (NDISA)	Yes	81 cases were submitted – no minimum requirement
National Pregnancy in Diabetes Audit (NPID)	Yes	To be confirmed
National Diabetes Core Audit	Yes	1250 cases were submitted – no minimum requirement
COPD Secondary Care	Yes	799 cases were submitted – no minimum requirement
Pulmonary Rehabilitation	Yes	166 cases were submitted – no minimum requirement
National Audit of Cardiac Rehabilitation	Yes	457 cases were submitted – no minimum requirement

Adult Asthma Secondary Care	Yes	117 cases were submitted – no minimum requirement
National Audit of Care at the End of Life (NACEL)	Yes	Data collection still ongoing
National Audit of Dementia (NAD)	Yes	78 cases were submitted – no minimum requirement
National Breast Cancer Audit	Yes	678 cases submitted – no minimum requirement
National Cardiac Arrest Audit (NCAA)	Yes	49 cases were submitted – no minimum requirement
National Heart Failure Audit (NHFA)	Yes	412 cases were submitted – no minimum requirement
National Audit of Cardiac Rhythm Management (CRM)	Yes	450 cases were submitted – no minimum requirement
Myocardial Ischaemia National Audit Project (MINAP)	Yes	296 cases were submitted – no minimum requirement
Audit of Blood Transfusion against NICE Quality Standard 138	Yes	36 cases were submitted – no minimum requirement
Bedside Transfusion Audit	Yes	Data collection still ongoing
National Emergency Laparotomy Audit (NELA)	Yes	124 cases were submitted – no minimum requirement
National Bowel Cancer Audit (NBOCA)	Yes	209 cases submitted – no minimum requirement
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	103 cases submitted – no minimum requirement
National Prostate Cancer Audit (NPCA)	Yes	151 cases submitted – no minimum requirement
National Lung Cancer Audit (NLCA)	Yes	234 cases submitted – no minimum requirement
National Joint Registry	Yes	605 cases were submitted – no minimum requirement
National Maternity and Perinatal Audit (NMPA)	Yes	100% of cases were submitted
National Neonatal Audit Programme (NNAP)	Yes	21 cases were submitted – no minimum requirement
National Audit of Seizures and Epilepsies in Children and Young People	Yes	To be confirmed
National Paediatric Diabetes Audit (NPDA)	Yes	134 cases were submitted – no minimum requirement
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	35 cases were submitted – no minimum requirement
Inflammatory Bowel Disease Audit IBD Registry	No	Benefits of the audit did not outweigh the cost to participate.
National Diabetes Footcare Audit (NDFA)	No	Due to clinical commitments at present the teams do not have the admin support to enable data submission.

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

The reports of 8 national clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2023/24 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Hip Fracture Database (NHFD)

The Trust continues to input data into the NHFD which records a number of clinical parameters for patients admitted with a fracture of either the neck or shaft of Femur. For the year 2023 we continue to perform at a high standard being ranked third overall in the UK, and best in the North East of England, in terms of complete Best Practice Tariff (BPT) achievement which covers a number of key benchmark performance areas. We scored in the top quartile nationally for time to admission to the orthopaedic ward and prompt orthogeriatric assessment and while our overall performance fell from 91% to 87% this is reflected nationally with other trusts experiencing similar issues. Our main reason for failing BPT remains getting patients to theatre promptly but this is often due to factors outside our control such as the patient being too unwell initially. Every BPT failure is discussed in the Orthopaedic SafeCare Group with learning points identified and an InPhase report completed in each instance. Our incidence of inpatient hip fractures has fallen from 9% in 2002 to 5% in 2023 and each such case is reviewed as part of our participation in the National Audit of Inpatient Falls (NAIF). Our incidence of inpatient-sustained pressure damage (in which we have been an outlier in previous years) remains low and below the national average in this area. We have successfully appointed a second Orthogeriatric Speciality doctor this year which has significantly improved our coverage in this area and our governance of this service.

Action Points:

- We will continue to discuss all hip fracture cases that fail BPT in the Orthopaedic SafeCare Meetings and complete InPhase reports. We will continue our efforts in evaluating inpatient falls and monitoring for inpatient pressure damage. One area in which we scored in the third quartile was mobilising patients out of bed on the first day post-surgery and we will investigate whether this is a data anomaly or whether we can do anything to optimise our practice in this area.

National Joint Registry (NJR)

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

In 2014 the NJR introduced annual data completeness and quality audits for hip and knee cases, with the aim of improving data quality. From 2020/21 the data quality audit was extended to include ankle, elbow and shoulder cases.

Action Points:

- The Trust will continue to contribute to these audits and was awarded the Gold Quality Data Provider Award for 2023.

Myocardial Ischaemia National Audit Programme (MINAP)

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

Our aim is to continue to provide and maintain a high standard of care and more importantly, personalised care.

Action Points:

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

The Case Mix Programme (CMP)

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

In the past 12 months the Critical Care Unit has uploaded data on approximately 800 patients to the CMP. Data uploads (via Platform X) are being performed on an approximately weekly basis. CMP/ICNARC continue to publish Quarterly Quality Reports (QQR) for each individual critical care unit. ICNARC have made some changes to the QQR in the past year utilizing new data from the updated V4.0 data set which is being collected. These changes include the introduction of new quality measures including delayed admissions and potential mis-triage to the ward.

Our most recent QQR, including data for Q3 23/24 shows good performance in all areas, with no measures showing performance worse than comparable units, and strong performance in some areas including unplanned readmissions and delayed admissions. Our overall standardised mortality rate was slightly below what would have been expected (17.3% v 17.8%), and mortality for patients with a low predicted mortality was very low.

We continue to use Medicus software for data collection and this has been upgraded to the most recent version in the last month. A link for lab results to be directly transferred into Medicus should be established in the next couple of months.

Our data completeness is excellent, with around 100% data completeness for all quality measures and very high levels of completeness for patient data. The quality of our data submission has been highlighted by ICNARC, with QE selected as an exemplary site and invited to deliver a presentation on our data submission processes to the CMP Annual Conference in London.

Action Points:

- Continue to collect and submit data to Intensive Care National Audit and Research Centre (ICNARC)/CMP.
- Continue to work with Medicus to complete setup/implementation of lab link.
- Ongoing education of ward clerks and Nursing/Medical staff regarding the correct entry of data, assisted by the ICNARC data clerk.
- Consideration of the ICNARC data clerk role becoming a full-time role to allow more data collection to occur e.g., quality measure data, etc.
- Use the QQR to ensure timely identification of any areas of deterioration in performance and address these when they occur.
- Continue to share QQR and other CMP/ICNARC data with relevant teams within the Trust.

National Paediatric Diabetes Audit (NPDA)

Real time data is collected and reviewed locally three monthly by the diabetes team and six monthly by the NENC Regional Children and Young People's Diabetes Network. We have submitted data on 134 patients to the NPDA 2023-24: 129 of these patients had Type 1 diabetes; 77.8% are on insulin pump therapy; 22.2% are on an intensive multiple daily injection regime; 95% are on CGM (continuous glucose monitoring) with alarms; 63.5% are on HCL systems. 100% of patients had a HbA1C; 100% had a BMI; 94.7% had their thyroid function tests; 95.8% had a blood pressure; 94.4% had a urinary albumin; 87.3% had their feet examined; 94.7% were recommended influenza immunisation; 98.3% were given sick day rules advice; 95.7% had psychology screening. 100% new patients had thyroid screening and 100% had coeliac screening within 90 days diagnosis, 85.7% newly diagnosed patients had dietetic support with carbohydrate counting within 14 days diagnosis. The mean HbA1C was 60.9mmol/mol (median 59.5mmol/mol.) This is an ongoing improvement since the 2022/23 audit.

Action Points:

- To continue to support Children and Young People (CYP) and their families and carers to improve or maintain optimal glucose levels measured by HbA1C and Time in Range to ensure CYP have the best possible health outcomes and life chances.
- Raised concerns at ICB, regional and trust senior management level re lack of dietitian on CYP diabetes MDT.
- There has been significant challenges within Paediatric Diabetes Specialist Nurse (PDSN) staffing. We are working with management teams to ensure that the PDSN staffing focuses on service delivery as per the best practice Tariff (BPT) and national paediatric diabetes workforce recommendations.
- We are proactively encouraging and facilitating retinal screening in all our eligible young people with diabetes. An audit of local retinal screening showed duration of diabetes to be the main risk factor for retinal abnormalities supporting the need for intensive management from diagnosis and importance of offering access to all new patients to available immunotherapy trials. This is ongoing and the new NICE hybrid closed loop (HCL) technology appraisal (TA) also has a retinal screening pathway and we are currently doing an audit to identify patients who require catch-up screening and have linked with the local NHS screening providers to ensure the appropriate screening can be offered going forward to those young people who have commenced HCL therapy.
- To ensure that diabetes MDT members are supported to access the appropriate training to enable safe and expert support for patients using diabetes technology in particular the implementation of the NICE HCL TA.
- To continue to deliver ward staff diabetes training to enable the staff to offer safe optimal care including use of diabetes technologies to newly diagnosed patients and known diabetes patients with a diabetes related admission or any other illness.
- To continue to work across multi agencies to support the significant number of CYP requiring local authority support, mental health/MDT psychology services and /or safeguarding.
- To continue to improve education for CYP and their carers/ families and school staff to enable them to use new technology and ensure CYP with diabetes are fully included in all aspects of school life and achieve their full potential.
- Ongoing review of the transition pathway and working with the adult service, primary care and young people to develop a dedicated young person (19-25 years) clinic within adult services with adult dietetic provision; a dedicated Young Person's Adolescent Diabetes Support Nurse (ADSN); psychology provision; to facilitate

access to age appropriate education programmes for those with Type 1 & Type 2 Diabetes; to improve engagement - as complex needs prevent regular clinic attendance and potentially results in Did Not Attends (DNAs) and effectively early discharge from the adult service. We have reinstated our transition meetings jointly with the adult diabetes team.

- There is a need for the MDT to continue to focus on timely and complete data entry into the dendrite clinical data base and the trust to invest in increased admin time in particular dedicated data analysis and diabetes technology administration plus IT support to ensure sustainable processes to ensure good quality data in the long term and access to technology for CYP living with diabetes. This is particularly important with the move to quarterly NPDA submissions commencing Q1 2024.
- We continue to value the voice of children and young people and their families in service delivery and improvements and are working towards an "Investing in children membership award"
- We are contributing to a pilot program supported by the Child Health and Well being network/ICB to support our children and young people living with Type 2 Diabetes or at high risk of developing Type 2 Diabetes to achieve a healthier weight and lifestyle.

PROMS National Audit

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

Action Points:

- Continue to collect and submit data to the national proms audit programme
- Continue to share our data with relevant teams within the Trust

National Joint Registry (NJR)

The Trust continues to contribute to the National Joint Registry. Data is entered regarding all hip, knee, ankle, elbow and shoulder replacement operations, enabling the monitoring of the performance of joint replacement implants and the effectiveness of different types of surgery. In 2014 the NJR introduced annual data completeness and quality audits for hip and knee cases, with the aim of improving data quality. For 2020/21 the data quality audit was extended to include ankle, elbow and shoulder cases. The Trust continues to contribute to these audits and was awarded the Gold Quality Data Provider Award for 2023.

Action Points:

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

National Cardiac Arrest Audit

The Resuscitation Department is part of the National Cardiac Arrest Audit which is part of ICNARC. We collect data from all 2222 calls made by wards and departments. All calls are documented on our dynamic database which allows us to look at trends across the organisation, provide information for people who are involved in RCAs and provides valuable information for training purposes. Patients who are over the age of 28 days and have received chest compressions and or defibrillation are entered onto the national database. We receive quarterly and annual reports from this which is again useful for training and is also shared with Site Resilience, Cardiology and the Resuscitation and Deteriorating Patient

Committee meeting. The audit compares our cardiac arrest data with similar hospitals and also all participants.

Action Points:

- We continue to have more non shockable rhythms than other participants which suggest we are allowing patients to deteriorate to the point of cardiac arrest. Having said that, we are trying to resuscitate older, frailer patients than other hospitals. We have recognised this and have increased the numbers of HCA AIM (Acute Illness Management) courses which focus on recognition of the deteriorating patient and cardiac arrest prevention.
- We have also recently introduced Fluid Balance study sessions for HCAs to raise awareness of the importance of patient hydration.
- Continue to participate in this annual audit and supply the most accurate data we can

The reports of 12 local clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2023/24 and Gateshead Health NHS Foundation Trust intends to take actions to improve the quality of healthcare provided. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of our services:

Business Unit	Speciality	Actions identified
Clinical Support and Screening	Adult Occupational Therapy (Acute)	**Occupational Therapy Acute Adult Team adherence to PP42 Work attire and Appearance Policy** Training was required, Staff to be provided education on Trust work attire policy especially around jewellery to ensure increased adherence to PP42 Work attire and Appearance Policy. In service session planned for all Acute Adult OT staff and verbal communications was given at the latest team meeting. At the time of each staff member completing the audit they were verbally informed of the areas they need to improve on. An email was then sent to the entire team which had the Trust Policy included highlighting our areas for improvement. **Actions:** • This email also notified the team a re-audit will be done in the near future. • A presentation was given to the full department about the audit results. • Reading the policy areas we need to improve on and verbally informing staff that a re-audit will be done soon to ensure the information has been taken on board and policy adhered to.
Surgical Business Unit	Breast Screening	**Supervised Physiotherapy In Breast Cancer Patients** The audit identified the gap in our service and has highlighted that we are now not adhering to NICE guidance. **Actions:** • The SLM in physio has taken this on board, and is currently working on the business case in recruiting dedicated breast physio to fill this gap.

Clinical Support and Screening	Interventional / Cardiovascular (Radiology)	**Compliance with IR(ME)R and the Employers Procedures with relation to the provision of and ICE request and the justification of all examinations in relation to the mini c-arm** This audit highlighted the need for further audit will be carried out. We have had a meeting the matrons for theatres to escalate the lack of compliance. She has shared this information with the theatre RPS and the lead orthopaedic surgeon and disseminated to the staff. A working group meeting involving Radiology and the relevant staff within theatre. **Actions:** • Booking team, RPS, has been planned to review the processes and the work instructions to see if we can stream line or make any changes that will improve compliance.
Clinical Support and Screening	Endoscopy	**Bowel prep audit** The audit results showed we need to Improve staffs understanding of the Boston stool scale to reinforce score bowel prep after washing. The scoring system diagram is now displayed in all the rooms, this has been fully discussed at the departmental safe care. **Actions:** • Highlighted and reinforced the requirement to score bowel prep after washing. • Notices are now on display in rooms to remind staff to score bowel prep after washing.
Clinical Support and Screening	Ultrasound (Radiology)	**Sonographer Neck Fine Needle Aspiration (FNA) Audit** The department has spoken to with the relevant team at Newcastle for neck imaging and Dr Kallis is going to investigate getting more outpatients currently transferred to Newcastle for FNA procedures to be seen within Gateshead Trust instead. **Actions:** • The audit for this year will be dependent on the outcome of his efforts, as numbers are currently too low to maintain skills.
Surgical Business Unit	Maternity	**Emergency caesarean section (Grade 1 and Grade 2)** The audit indicated that there is no one particular reason for the delays that have been documented and quite often there is a valid reason. Our badger system highlights that a reason for delay should be inputted if the timing of decision to delivery has not met the target time (note cannot be saved without an entry), but the reasons are quite vague and does include 'other' and this is then not expanded upon in the doctors documentation. **Actions:** • We have discussed with our consultant lead and will continue to strive to find a way this can be addressed.

Clinical Support and Screening	Plain Imaging / Mobiles (Radiology)	**An audit and re-audit to evaluate chest x-ray confirmation of nasogastric tube placement** The first audit identified the issues and after a couple of teachings, through it was identified through feedback that staff were hesitant to remove NG tubes on their own if they misplaced unless there were clear guidelines. **Actions:** • A re-audit was undertaken to check if there were improvements in the rest of the criteria, • The department are currently developing local guidelines for staff to follow, once this have been ratified and implemented a full review will take place again.
Clinical Support and Screening	Plain Imaging / Mobiles (Radiology)	**Compliance with the Employers Procedures Regarding the Exclusion of Pregnancy in Plain Film X-ray** This audit has identified that further training is required for staff following a substantial change in practice at the start of the year. Further training and communication is required to ensure that staff are working to the newest version of the Employers Procedures which include a new requirement to complete LMP documentation for those patients attending for imaging of their chest or knees. **Actions:** • The audit results were presented to all staff within the department and highlight the shortfalls. All staff have been asked to re- familiarise themselves with the Employer procedures and that a re-audit will be undertaken.
Medical Business Unit	Endocrinology	**A retrospective AUDIT to check compliance with management guidelines of euglycaemic Diabetic Ketoacidosis (DKA) in Adults patients on SGLT-2 inhibitors admitted to Queen Elizabeth hospital** All patients on SGLT2 inhibitors who presented to the hospital unwell were appropriately identified, assessed and treated for DKA according to trust protocol. The results showed non-compliance with the trust guidelines with regards to administering long-acting insulin to patients who were on no insulin prior to admission. Ketones and blood gases were done in all patients. Infection was the main contributor to DKA in this category of patients, but we noticed poor documentation regarding patients' knowledge about sick day rules and this might be linked to the fact that none of the patients stopped SGLT inhibitor while unwell. Documentation needs improvement with regards to checking patients' knowledge and communication with other relevant specialties. **Actions:** • Audit presented included updated education around SGLT-2's, DKA risk and sick day rules. • Planned re-audit in 12 months' time to assess improvement after interventions

Surgical Business Unit	Trauma and Orthopaedics (Medical)	**Ward 26 and 12; A Length of Stay (LOS) Audit.** The audit underscores the need for another comprehensive audit focusing on specific pathologies that significantly prolong LOS, especially in low back pain patients and ankle fracture patients. Consideration of early intervention for specific patient groups to ensure early discharge such as: Earlier pain team input for back pain patients for an earlier discharge. Early surgical interventions for ankle fracture patients or reviewing such patients in SDEC for swelling checks. More frequent reviews by either orthopaedic practitioners or ward cover SHOs of patients boarded onto ward 3 or 4 to ensure more early discharges. Streamlining transfer processes and transferring appropriate patients. **Actions:** • A newly appointed Consultant specialising in foot and ankle surgery has expressed an interest in implementing an ambulatory pathway for ankle fracture cases. • Currently, we are transferring a minimal number of neck of femur patients being admitted to ward 26. Instead, these patients are being managed in the larger ward 21, where they receive input from orthogeriatric specialists. • Furthermore, regional and local working groups are actively engaged in efforts to reduce the length of stay for patients experiencing back pain. • To enhance patient care and streamline discharge processes, a dedicated ward SHO has been assigned to ward 26.
Nursing, Midwifery and Quality	Trust Wide	**NerveCentre DNACPR Tag Audit** The total number of patients found to have a paper DNACPR was 123. The total number of patients with a matching DNACPR tag in Nervecentre was 68. The total number of patients with a paper DNACPR and no Nervecentre tag was 55. Compliance measured against the agreed standard was 55%. **Actions:** • Give nursing staff access to update DNACPR tag on Nervecentre. (Action complete) • Create SOP so staff understand the process (Action Complete) • Communicate with ward and department areas the change in process. (First round of comms and teaching complete, second round underway) • Raise the disparity with the Chief Nurse, Chief Clinical Information Officer and Chief Information Officer. (Matter has been discussed as EMT and agreement made to mitigate with the above actions and re-review) • Re-audit to measure the effectiveness of the above actions

Surgical Business Unit	Maternity	**Maternal Postnatal Readmission Audit** The audit identified that Maternal postnatal readmissions doubled (2022-2023), Pain management main reason for readmission, there are inconsistencies in Take home medications. Sepsis 6 pathway not utilised on Badgernet and the golden hour not being achieved, Auditable standards were not achieved for Sepsis and Caesarean Birth **Actions:** The main action, following on from the review, was our postnatal ward now stock and offer stronger pain relief for post-operative women, for when they go home. • We now, have less calls to our PAU and attendances/readmissions for post operative pain management. • Offer re-training of staff, for those not confident in cannulation. • Those reattending with raised BP, met the standards.

Participation in National Confidential Enquiries 2023/24

Enquiry	Participation	% of cases submitted
Juvenile idiopathic arthritis study: Organisational questionnaire Clinical questionnaire	Yes	 Completed 1/1 completed
Endometriosis: Organisational questionnaire Clinical questionnaire	Yes	 Not yet completed 1/5 completed - overdue
Testicular Torsion study: Organisational questionnaire	Yes	Not yet completed
Community Acquired Pneumonia: Organisational questionnaire Clinical questionnaire	Yes	 Not yet completed 0/8 completed - overdue
End of Life Care: Clinical questionnaire	Yes	1/5 submitted - overdue

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

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2023/24 that were recruited during that period to participate in research approved by the Health Research Authority (HRA) was 1,688.

Recruitment by Managing Specialty	Total
Anaesthesia, Perioperative Medicine and Pain Management	134
Cancer	194
Cardiovascular Disease	5
Children	2
Critical Care	3
Dementias and Neurodegeneration	86
Diabetes	4
Gastroenterology	15
Genetics	2
Health Services Research	17
Hepatology	47
Infection	2
Mental Health	2
Metabolic and Endocrine Disorders	45
Musculoskeletal Disorders	1
Public Health	9
Reproductive Health and Childbirth	916
Respiratory Disorders	7
Stroke	33
Surgery	13
Trauma and Emergency Care	151
Total	**1,688**

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

INGR1D2 INvestigating Genetic Risk for type 1 Diabetes (2)

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

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

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

Evaluation of MCM5 in postmenopausal bleeding patients

The objective of this study is to evaluate the performance Arquer's in vitro diagnostic test kit ADXGYNAE, an MCM5 ELISA as an aid in detecting endometrial cancer using urine specimens. Research has shown that detection of MCM5 in urine sediment is a sensitive and specific diagnostic test for endometrial cancer.

The results obtained with the MCM5 ELISA will be compared with the diagnosis based on standard of care clinical investigations in order to establish its utility in helping to diagnose endometrial cancer.

Evaluating the Saving Babies Lives Care Bundle Version 2 (eVOLVE)

The Saving Babies Lives Care Bundle Version 2. helps maternity providers improve the care that women and their babies receive throughout pregnancy and birth, with the goal of preventing deaths in and after pregnancy across England.

The study aims to find out how hospitals are using the Care Bundle and how this affects women's maternity care and birthing experience.

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

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

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

SQUEEZE UK: Postoperative vasopressor usage: Relation to AF

The SQUEEZE UK study is investigating how commonly patients need medication to maintain their blood pressure or develop life-threatening heart rhythm disturbances during or after surgery.

SQUEEZE-UK will provide a unique insight into post-operative vasoplegia and perioperative AF in the UK. Whilst complications such as vasoplegia occur in a small proportion of patients, because of the large number of people undergoing surgery, this potentially affects thousands of patients each year in the UK alone. Understanding the relationship between vasoplegia, new AF and outcome is vital to developing new ways to improve the patient journey through surgery and reduce complications.

The R&D Team attended the NHS Research and Development Forum (RDF) Annual Conference which was hosted by Newcastle and held at the Glasshouse, Gateshead in May 2023.

The event was the biggest ever annual conference of the RDF and was attended by 850 people from across the UK and featured over 50 speakers.

The RDF connects, supports and represents those individuals working in R&D roles, who are working to benefit patients and the public by enabling healthcare research and innovation to happen in the UK.

The North East Region has long been recognised for its ground-breaking research and commitment to innovation. Angela Topping (Head of the Newcastle Joint Research Office and Chair of the RDF) said “that the conference provided a unique opportunity to showcase our diverse health and life sciences community and we are eager to engage with delegates from various backgrounds to collectively shape the future of health and care research.”

Gateshead Nursing & Midwifery Conference

Ann Wilson and Bev McClelland attended the Gateshead Nursing and Midwifery Conference as representatives of the Research Nurses and Research Midwives within Gateshead Health NHS Foundation Trust.

The theme of the research stall was "**Research is Everyone's Business**". Bev and Ann were on hand to talk about the CNO's Strategic Plan for Research and her ambition to "create a people-centred research environment that empowers Nurses and Midwives to lead, participate in and deliver research.

Not everyone has the time or availability to be part of a Research Team and deliver research within the Trust, but there are other ways to get involved and everyone should be aware that the Trust is research active and should have an awareness of what research is happening on their ward or in their speciality.

Patient & Public Involvement (PPI) and the Make it Public Strategy

Patient and public involvement (PPI) in research means that patients or other people with relevant experience can contribute to how research is designed, conducted and disseminated.

Make it Public is a Health Research Authority (HRA) Strategy dedicated to research transparency about what research is going on, and what its findings are. It is important for patients and the public, as it builds trust and accountability. It's also essential for professionals as it avoids duplication of effort and enables findings to be used to develop new and better treatments for patients and service users. It also helps improve the quality of research.

The DETERMIND Research Team - Research Nurse Christine Kirkup and Research Workers Mandy Grahamslaw and Jacob Douglass, attended the Dementia Action Week in May 2023 at Shipley Art Gallery. Dementia Action Week is an annual awareness raising campaign which encourages individuals and organisations across the UK to act on dementia.

The DETERMIND study is designed to address critical, fundamental, and as yet unanswered questions about inequalities, outcomes and costs following diagnosis with dementia.

Participants who had taken part in the MET-PREVENT study enjoyed an afternoon of tea and cake whilst they found out about the study results first-hand from researchers from Newcastle University, the Chief Investigator (CI) Professor Miles Witham and the Gateshead Health Research Team - Sam Kanakarajan, Dr Claire McDonald, Research Nurse Bryony Storey, Research Fellow Ian Sayers, Research Nurse Wendy Stoker and Head of Research & Development Alison Harvey.

The aim of the MET-PREVENT study was to determine whether the drug metformin, commonly used to treat diabetes, could improve physical function in older people living with frailty.

MET-PREVENT achieved successful recruitment with high retention rates, however metformin did not improve physical performance and was poorly tolerated with high rates of adverse events in older people with sarcopenia.

Tea & Chat with CEO Trudie Davies

The R&D Team met with Trudie Davies (CEO) in June 2023 to discuss all things research including:-

- How staff still remain unaware that the Trust is research active despite the continuous promotion of research.
- How there is a need to embed research into everyday practice rather than research being seen as “in addition to”.

- How the Trust can best use research results to actively shape, improve and effectively change current clinical practices and/or services within the Trust.

The meeting went really well and it was good to hear from Trudie that research is regarded by the Trust as core business and features as a pillar in the Trust Framework – Research, Training and Innovation".

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

A proportion of our income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed through the Commissioning for Quality and Innovation (CQUIN) payment framework. A monetary total of £3.656million of our income in 2023/24 was allocated to CQUIN. However, changes to the arrangements for CQUIN meant that this amount was paid in full despite the Trust not being fully compliant in all areas requested by the CQUIN framework.

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 2023/24.

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

There were no announced or unannounced inspections by the CQC during 2023/24. Following the focused Maternity Services inspection which took place in February 2023, the Trust received the outcome report in June 2023. The Maternity Service was rated "good" overall and CQC highlighted the following outstanding practices:

- A grab bag for those fleeing domestic violence
- Implementation of postnatal contraception
- Pre-conceptive advice on tobacco dependency, alcohol misuse, positive
- Mental health, postnatal contraception, nutrition, and physical activity
- GDM education sessions including 1:1 with an interpreter; waiting room brief intervention conversations with MSW and Dietician."

The report showed that the service is managed by capable leaders who possess the necessary skills and abilities to address its priorities and issues. The report also highlighted how well the maternity team work well together for the benefit of women and birthing people. Our team continues to be dedicated to delivering excellent care to families.

There were no Mental Health Act (1983) Monitoring visits to either Cragside or Sunniside in during 2023/24.

Data Quality

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

Gateshead Health NHS Foundation Trust submitted records during 2023/24 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient's valid NHS Number was:	Trust %	National %
Percentage for admitted patient care*	99.8%	99.7%
Percentage for outpatient care*	99.9%	99.8%
Percentage for accident and emergency care†	99.3%	97.1%

Which included the patient's valid General Medical Practice Code was:	Trust %	National %
Percentage for admitted patient care*	99.5%	99.8%
Percentage for outpatient care*	99.6%	99.5%
Percentage for accident and emergency care†	99.9%	99.0%

* CDS Data Quality Dashboard - Based on the April-23 to February-24 Month 11 inclusion date

†ECDS DQ Dashboard from Wednesday, 1st March 2022 up to and including Saturday 30th March 2024.

Key

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

Information Governance Toolkit

Gateshead Health NHS Foundation Trust's Data Security and Protection Toolkit (DSPT) submission for 2022/23 was submitted 30/06/2023 as Standards Met. The baseline submission for 2023/24 was submitted on time on the 29/02/2024. This demonstrates the Trust is working towards its completion and the external audit of the Trust's DSPT progress will be conducted in April 2024 with an aim to maintain the previously achieved standards met.

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2023/24 by the Audit Commission.

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

The data quality strategy is now in place and the Trust is actively working to improve all areas of data quality and aligning this to the new corporate and meeting structures. It is worth saying that those percentages are extremely high, given the volumes of records we are talking about (well over 600k) and the shortfall is likely to be, predominantly, those who do not have a NHS Number e.g. overseas visitors.

2.4 Learning from Deaths

During 2023/24, there were 1,227 patient deaths within Gateshead Health NHS Foundation Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 315 in the first quarter.
- 239 in the second quarter.
- 345 in the third quarter.
- 328 in the fourth quarter.

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

In early April 2024, 1,205 case record reviews and 23 investigations (Mortality Council reviews) have been carried out in relation to 1,227 of the deaths included above.

In 23 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 314 in the first quarter.
- 238 in the second quarter.
- 334 in the third quarter.
- 319 in the fourth quarter.

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

- 0 representing 0% for the first quarter.
- 0 representing 0% for the second quarter.
- 0 representing 0% for the third quarter.
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the Trust's 'Learning from Deaths' policy. Reviewed cases are graded using the Hogan preventability score and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) overall care score following case note review.

170 case record reviews and 104 investigations were completed after 1st April 2023 which related to deaths which took place before the start of the reporting period. 0 death representing

0.0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the Trusts 'Learning from Deaths' policy. Reviewed cases are graded using the Hogan preventability score and NCEPOD overall care score following case note review.

Summary of learning/Description of Actions:

Good practice identified:

- Communication with family has been thorough and detailed in most areas.
- Referrals have been made to relevant community services for further support especially for patients who needed palliative care.
- The Dementia team have liaised with care homes to share good practice.
- Changes have been made to ensure that patients with autism are identified when they come into the hospital and are flagged on Nerve centre. All deaths in this group have come under the learning disability review.
- Handwritten documentation or discussions recorded in the electronic records are very clear and concise.
- Documentation of DNACPR discussion with patient and family very thorough in most areas
- Provision of hospital passports for patients with a learning disability has created clear pathways.
- Wedding vow renewal service arranged for terminally ill patients on St Bede's has been very welcome.
- Learning disability nurse involved in patient's care early in their journey, with implementation of reasonable adjustments has led to better care and awareness.
- Consent forms have been written in detail with risks and benefits clearly highlighted in most cases.

Learning themes identified:

- **Documentation**
    - Nerve centre is used in different ways in different specialties. A consistent method is required across the organisation.
    - Improvements in recording options discussed when taking consent are also required.

- **Clinical treatment**
    - Nasogastric tubes should be removed as soon as patients are able to eat and drink satisfactorily.
    - A gap was identified in terms the lack of written guidelines for the treatment of intermediate / sub-massive PEs. Particularly when there are cases where the risk of intracranial bleed or other secondary bleed can be as great as giving a high dose of tinzaparin. New guidelines were written for identification and management of this condition. These have been ratified by the VTE Committee and have been added to the guidelines.

- The AFLOAT tool will be used more uniformly in all clinical areas.
- Relevant neuro observations should be taken and recorded after a patient has fallen.
- Gap identified in terms of echo provision within 48 hours for inpatients
- Oxygen access in individual bathrooms on ward 2
- Pathway for urgent trauma and their prioritisation of admission needs to be developed.
- Clarification around the process to follow when patient is at risk of alcohol withdrawal.
- Guideline required for the management of neuro observations.

- **Organisational learning**

  - Ward moves should be recorded on Care flow as timely as possible.
  - Multiple wards moves contributed to communication issues
  - Consultant cover on wards 3 and 4 was not regular and some patients have been stepped down and did not have a senior review. (NOTE wards 3 and 4 are now closed)
  - Lack of level 1 care provision has been identified in several mortality council reviews and has been highlighted to the executive team.
  - Guidance required when supporting relatives when they are present at the time of a cardiac arrest.
  - Family expressed concern around ECHP not being followed. This was not within the patient's notes.
  - A pilot of the implementation of Treatment Escalation Plans had been carried out and these are now to be implemented across the organisation. There will be ongoing work to ensure that all patients have this documented in their records. This would assist with the prevention of patient's receiving treatment they do not necessary need or want.
  - Inpatients with learning disability, MCA 1 and 2 and DoLs application should be completed for each separate admission.
  - DNACPR discussions should be reviewed at each admission and clear documentation should be present in the paper or electronic forms.
  - There have been cases where the decision to manage fluid and electrolyte abnormalities have been delayed. Although this has improved significantly in the last two years, occasional cases have occurred where electrolyte imbalance has not been treated promptly. There is now an AKI (acute kidney injury) bundle where there is a protocol for raising any AKI abnormalities to the treating team.
  - Fluid prescription is still carried out on paper forms. This has led to inaccurate monitoring of intravenous fluid prescribing and fluid overload in a patient with low sodium.
  - Patients waiting for prolonged periods in the discharge lounge without monitoring or meals while they have been waiting.
  - Documentation of records made by the psychiatry liaison team are difficult to access because they use a different system used by CNTW. Clinical staff especially in A and E do not have easy access to this system.
  - The provision of emergency ERCP under general anaesthesia for patients with biliary stones is cumbersome. The endoscopists do not have easy access to emergency lists in theatres and must go through the on-call team who will have to ensure than there is no other emergency case in theatres. The anaesthetic team also must be informed, and the image intensifier arranged. The image

intensifier is often also used by other surgical teams. This has led to delayed and cancelled ERCP in patients with biliary sepsis.

- Lack of ownership of ICE requests and delayed action on results especially 'red flags' has caused delays in treatment or 'missed cancers. Each department has its own system of acting and filing of reports and therefore a single method will not be applicable. This has been highlighted to all the business units so that they can ensure that consultants take ownership of ICE requests.
- Transfer of unwell patients from Cragside Tranwell and Sunniside has been challenging as they are situated outside the acute hospital building, although in the same hospital compound. They must be discharged and then re admitted to the acute care setting. This has led to some delays in assessment.
- Delayed transfer of patients from A and E to the wards has created a back log in the 'front of house'. This is due to ward pressures and delayed discharges in the 'back of house' resulting in patients waiting in the acute wards for prolonged periods.

2.5 Seven Day Hospital Services

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

The Covid-19 pandemic delayed further work around this agenda and we had to temporarily adapt our ways of working considerably during this time. As we came out of the pandemic, we reviewed and changed our model of care, concentrating on patient flow especially around non-elective care. The original NHS England recommendations around seven-day hospital services are a number of years old and need to be reconsidered in light of new models of care (both locally and nationally). The priority for the Trust moving forward will be to improve the quality of care by improving length of stay through better use of clinical pathways. The original NHSE recommendations may need to be revised in this light and the standards redefined.

2.6 Freedom to Speak Up

As a result of Sir Robert Francis QC's follow up report to his Mid Staffs Report, all NHS Trusts are required to have a Freedom to Speak Up Guardian (FTSUG). Gateshead Health NHS Foundation Trust is committed to achieving the highest possible standards/duty of care and the highest possible ethical standards in public life and in all its practices. We are committed to promoting an open and transparent culture to ensure that all members of staff feel safe and confident to speak up. The FTSUG is employed by the Trust but is independent and works alongside Trust leadership teams to support this goal. The Trust is has shown their commitment to FTSU by supporting the role as a full time permanent position.

The FTSUG reports to the following Trust boards / Committees, Board and the People and Organisational Development Committee, Quality Governance Committee, and Trust Board twice per year, as well as continuing to report to the National Guardian Office on a quarterly basis.

Our FTSUG supports the delivery of the Trust's corporate strategy and vision as encapsulated in our ICORE values. As well as via the FTSUG, staff may also raise concerns with their trade union or professional organisations as per our FTSU Policy. When concerns are raised via the

FTSUG, the Guardian commissions an investigation with the most appropriate manager / leader and feeds back outcomes and learning to the person who has spoken up. The FTSUG is actively engaged in profile raising and education in relation to this role and is an active member of the Trust's Culture Board Program. The FTSUG now reports directly to the Chief Nurse / Deputy Chief Executive and can escalate to Chief Executive Officer when required and has regular meetings with the Director of People and OD and the Non-Executive Director (NED) responsible for FTSU.

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

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

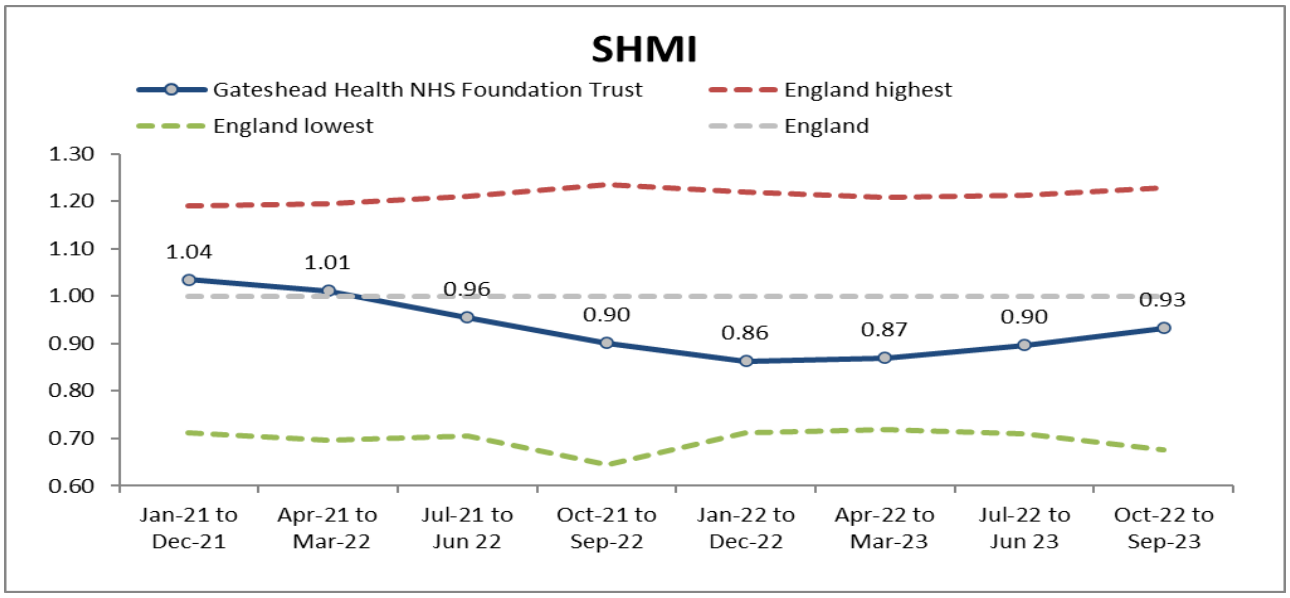
The Trust Board via the People and Organisational Development Committee receives an annual report from the Guardian of Safe Working which includes a consolidated report on rota gaps and actions taken by the Medical Workforce Group. This report is provided to the Local Negotiating Committee (LNC) by the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

The Medical Workforce Group meets monthly and reviews the developed medical workforce dashboard which summarises rota fill rates and staffing absences by service / specialty area and by business unit. The Trust Medical Staffing Team are now established and manage the medical staffing rosters on a day to day basis to ensure maximal roster fill rates and medical staffing cover. Gap management is proactive to ensure full rota compliance.

2.8 Mandated Core Quality Indicators

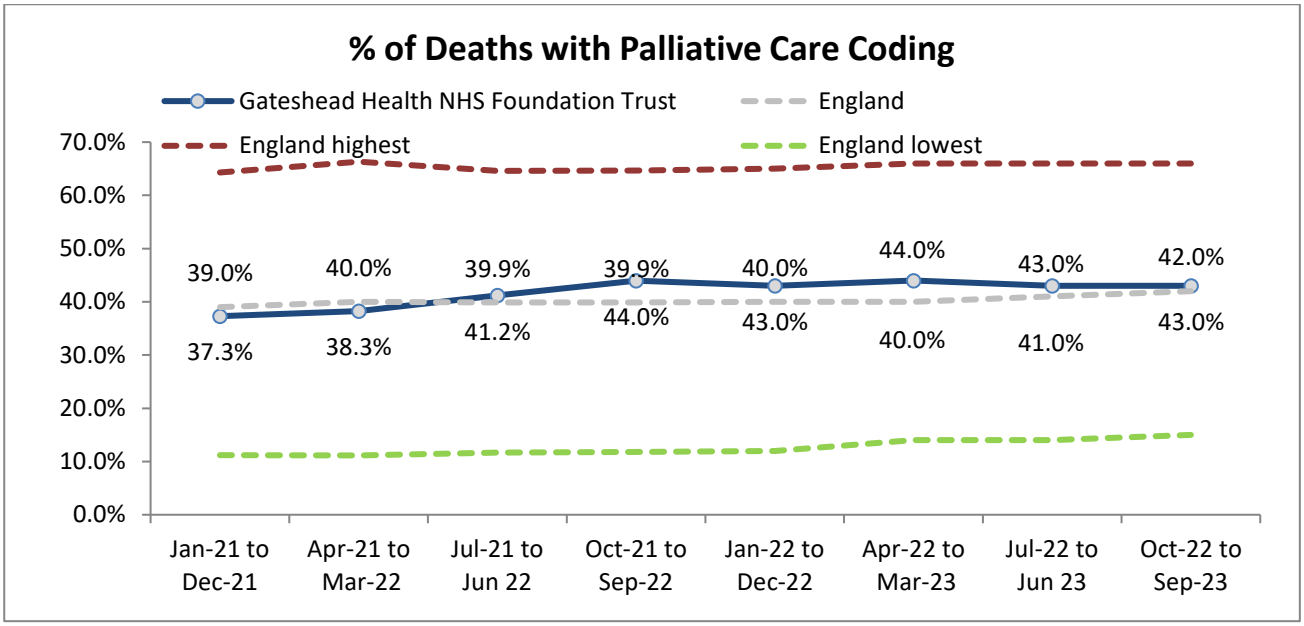
(a) SHMI (Summary Hospital-level Mortality Indicator)

SHMI	Jan-21 to Dec-21	Apr-21 to Mar-22	Jul-21 to Jun 22	Oct-21 to Sep-22	Jan-22 to Dec-22	Apr-22 to Mar-23	Jul-22 to Jun 23	Oct-22 to Sep-23
Gateshead Health NHS Foundation Trust	1.04	1.01	0.96	0.90	0.86	0.87	0.90	0.93
England highest	1.19	1.19	1.21	1.23	1.22	1.21	1.21	1.23
England lowest	0.71	0.70	0.70	0.65	0.71	0.72	0.71	0.68
Banding	2	2	2	2	3	3	2	2



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

% Deaths with palliative coding	Jan-21 to Dec-21	Apr-21 to Mar-22	Jul-21 to Jun 22	Oct-21 to Sep-22	Jan-22 to Dec-22	Apr-22 to Mar-23	Jul-22 to Jun 23	Oct-22 to Sep-23
Gateshead Health NHS Foundation Trust	37.3%	38.3%	41.2%	44.0%	43.0%	44.0%	43.0%	43.0%
England highest	64.3%	66.3%	64.6%	64.6%	65.0%	66.0%	66.0%	66.0%
England lowest	11.2%	11.1%	11.7%	11.8%	12.0%	14.0%	14.0%	15.0%
England	39.0%	40.0%	39.9%	39.9%	40.0%	40.0%	41.0%	42.0%



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

- The Summary Hospital-level Mortality Indicator (SHMI) reports death rates (mortality) at a Trust level across the NHS in England and is regarded as the national standard for monitoring of mortality.
- For all SHMI calculations since October 2011, mortality for the Trust is banded 'as expected', and more recently a period of 'Lower than expected' deaths was observed. For the latest period the SHMI is 'as expected'.
- The Trust reviews its SHMI monthly at the Mortality and Morbidity Steering Group. The model will be closely monitored as forthcoming changes to the SHMI calculation are being introduced in the May 2024 publication.
- Also. from May 2024 onwards the Trust will move from recording Same Day Emergency Care (SDEC) activity from its Admitted Patient Care dataset (APC) to the Emergency Care Data Set (ECDS) as Type 5 A&E activity. The SHMI is calculated using APC data. Removal of SDEC activity from the APC data may impact a Trust's SHMI value and may increase it.

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

- The Trust reviews cases for individual diagnosis groups where the SHMI & HSMR demonstrates more deaths than expected or an alert is triggered for a diagnosis group. The Trusts mortality review process can be used to review the Hogan preventability score & NCEPOD quality of care score and interrogate the narrative from the review to identify specific learning or learning themes.
- In response to a mortality alerts, and concerns from the medical examiner office, extraordinary Mortality Councils have been set up to review certain patient cohorts, for example heart failures death and frailty / end of life care.
- The Trust reviews the clinical coding for alerting diagnosis groups to determine whether the appropriate diagnosis was assigned and to refine the coding where appropriate.
- The Trust continues to review palliative care coding to ensure palliative care is recorded for all cases where this is appropriate. Palliative care coding is in line with the national level.

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

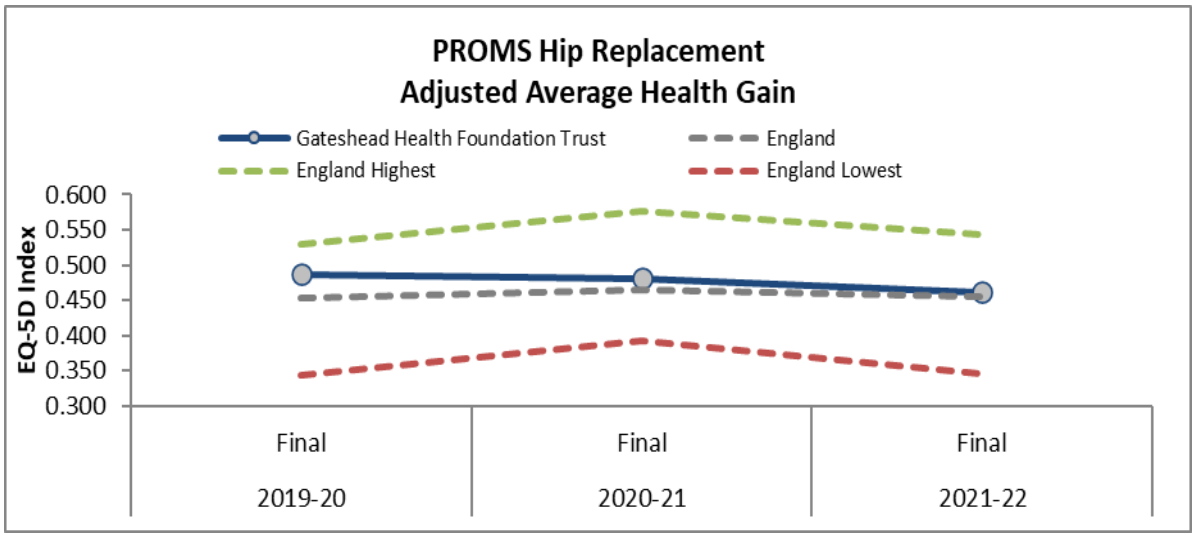
- In March 2020, the collection was suspended due to the coronavirus illness (COVID-19) and the need to release capacity across the NHS to support the response. This indicator is not included because of the suspension and has not yet been reinstated.

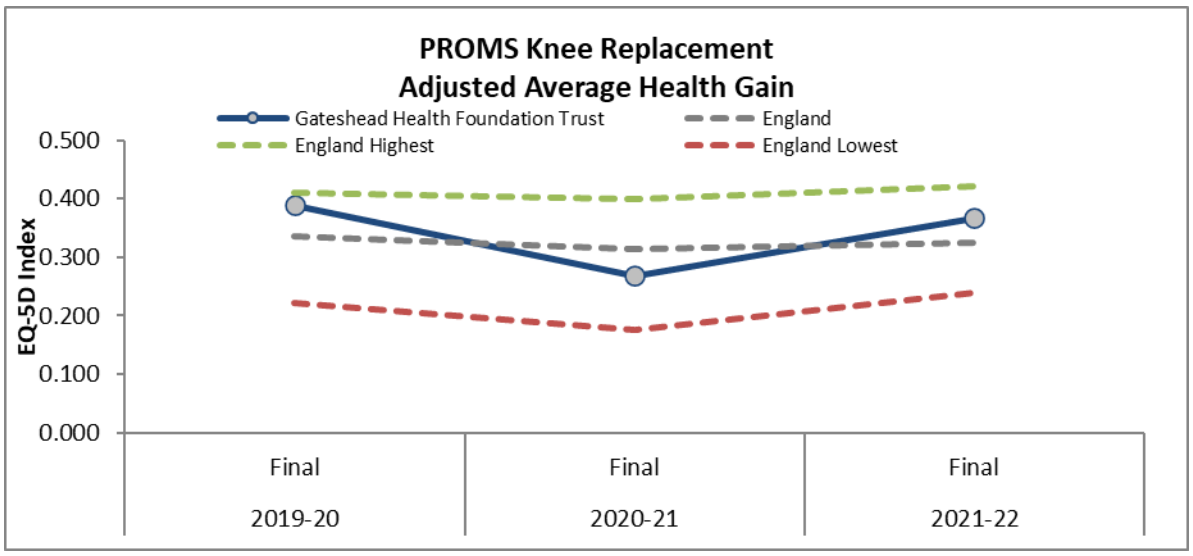
PROMs (Patient Reported Outcome Measures) for Hip Replacement and Knee Replacement:

Hip Replacement Adjusted average health gain EQ-5D index	2019-20 Final	2020-21 Final	2021-22 Final
Gateshead Health Foundation Trust	0.487	0.481	0.461
England	0.453	0.465	0.456
England Highest	0.529	0.576	0.544
England Lowest	0.344	0.392	0.346

Knee Replacement Adjusted average health gain EQ-5D index	2019-20 Final	2020-21 Final	2021-22 Final
Gateshead Health Foundation Trust	0.389	0.268	0.367
England	0.335	0.315	0.324
England Highest	0.409	0.400	0.421
England Lowest	0.221	0.176	0.239

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





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

- The Trust performance for PROMS score in 2021-22 remain above the national average for both hips and knees. The Trust scores are within common cause variation from the England average therefore neither statistically better nor worse.

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

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

Emergency Readmissions within 30 Days

- Aged 0 – 15yrs

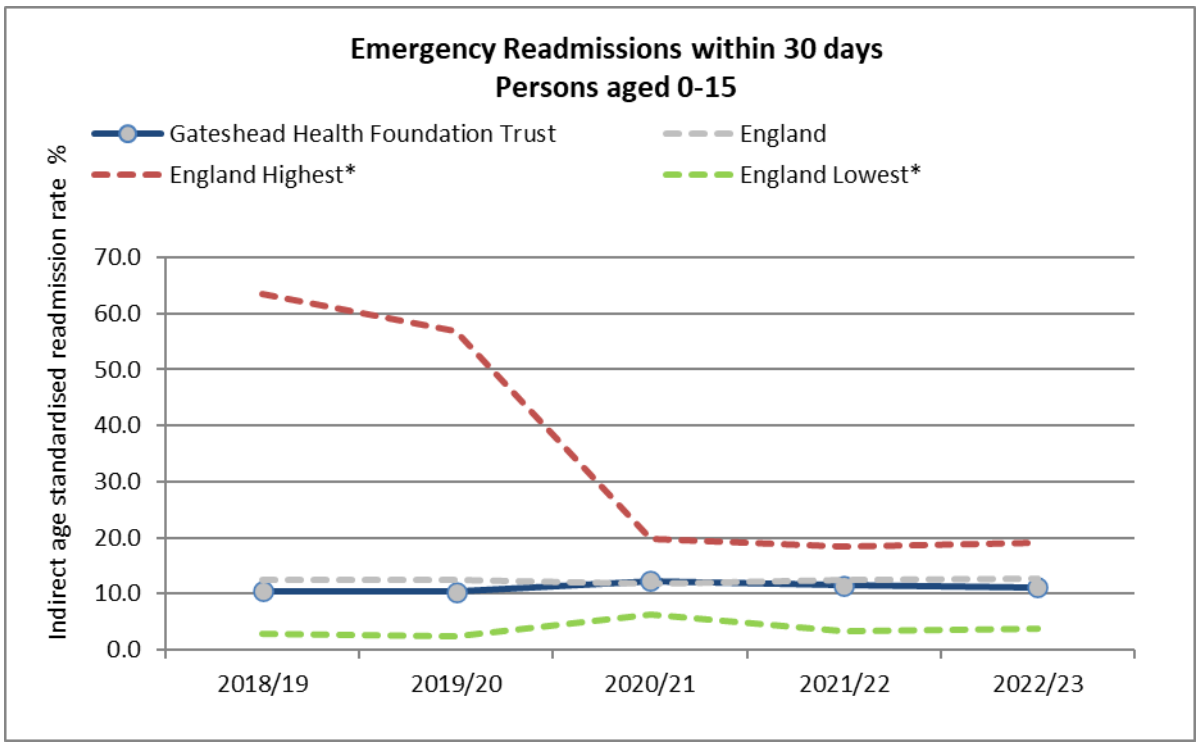
Emergency readmissions within 30 days of discharge from hospital Persons aged 0-15	2018/19	2019/20	2020/21	2021/22	2022/23
Gateshead Health Foundation Trust	10.5	10.4	12.3	11.5	11.2
Banding	B5	B5	W	W	W
England	12.5	12.5	11.9	12.5	12.8
England Highest*	63.5	56.8	19.7	18.4	19
England Lowest*	2.8	2.4	6.2	3.4	3.7

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

B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level

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

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



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

- Emergency readmission rates have decreased slightly in 2022/23, remaining broadly static over the last five years, tracking 'Significantly lower' or within than the national average in each of the last five years. The readmission rate remains within the expected variation from the national average.

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

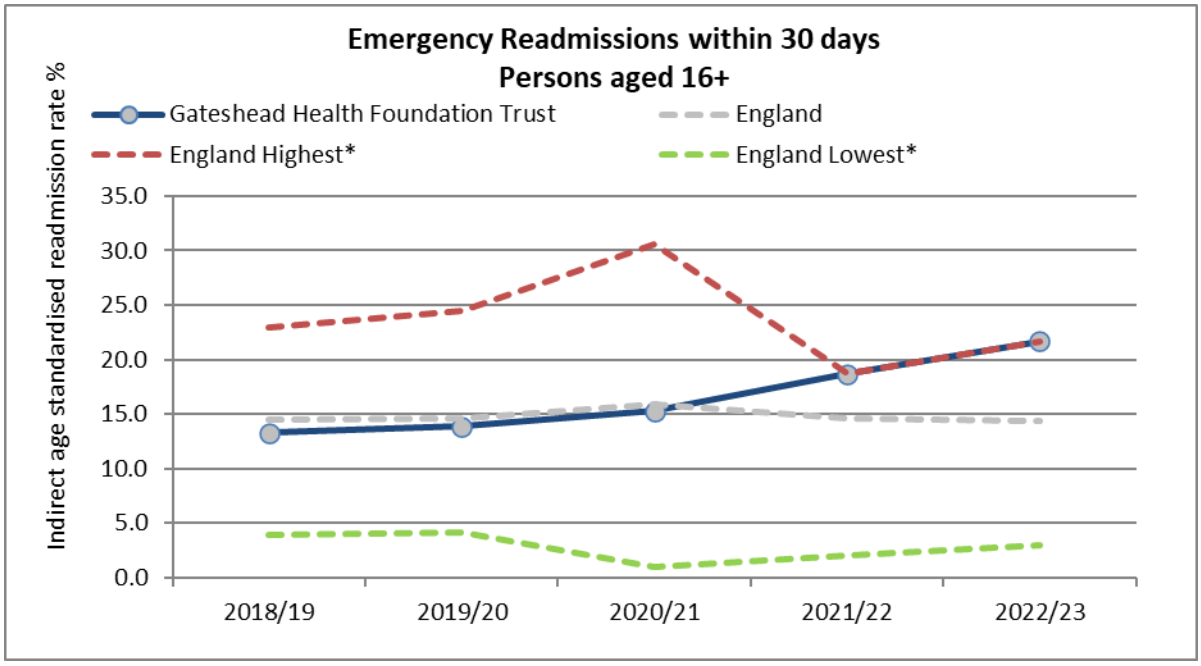
- The Trust will continue to monitor performance and undertake further investigations/actions should the rate increase.

- Aged 16 years or over

Emergency readmissions within 30 days of discharge from hospital Persons aged 16+	2018/19	2019/20	2020/21	2021/22	2022/23
Gateshead Health Foundation Trust	13.3	13.9	15.3	18.7	21.7
Banding	B1	B5	B5	A1	A1
England	14.5	14.6	15.9	14.6	14.4
England Highest*	22.9	24.5	30.6	18.7	21.7
England Lowest*	3.9	4.1	1	2.1	3.0

A1 = Significantly higher than the national average at the 99.8% level.
B1 = Significantly lower than the national average at the 99.8% level
B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level

W = National average lies within expected variation (95% confidence interval)
*excluding caution in interpretation of data records. Numbers of patients discharged too small for meaningful comparisons (i.e. below 200).



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

- Emergency readmission rates look to have risen significantly in 2021/22 and 2022/23 and are at a similar level to the highest nationally. However, this is largely due to a change in how the Trust records Same Day Emergency Care (SDEC). A new operating model was introduced in September 2021. Due to the data capture changes, an increase in readmissions was observed because of the follow-up care onto the unit. A further deep dive into the data revealed that the increase in readmissions is artificially inflated because of the clinical need of the SDEC reattenders. The true shift in average readmissions is circa 6 per month – the impact on percentage readmission rate is therefore minimal, demonstrating a slight drop in the average readmission rate overtime.

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

- Local monitoring of readmissions by ward and speciality to ensure that there is oversight of outlying areas.
- Reviews of readmissions that highlight failed / inappropriate discharges to better understand where practices can be improved and help ensure lessoned are learned.
- Successfully appointed a number of Discharge Coordinators across the Trust to improve discharge arrangements for patients and more robustly ensure patients' needs are met on discharge.
- Remodel SDEC Follow-ups, deduct from Non elective admissions to determine true readmissions rate, and continue to monitor. Develop integrated flow across the integrated care model.
- SDEC activity to be recorded as Type 5 A&E attendances from Wednesday 1st May 2024.

Trust's responsiveness to the personal needs of its patients

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

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

- Following the merger of NHS Digital and NHS England on 1st February 2023 we are reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed.

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

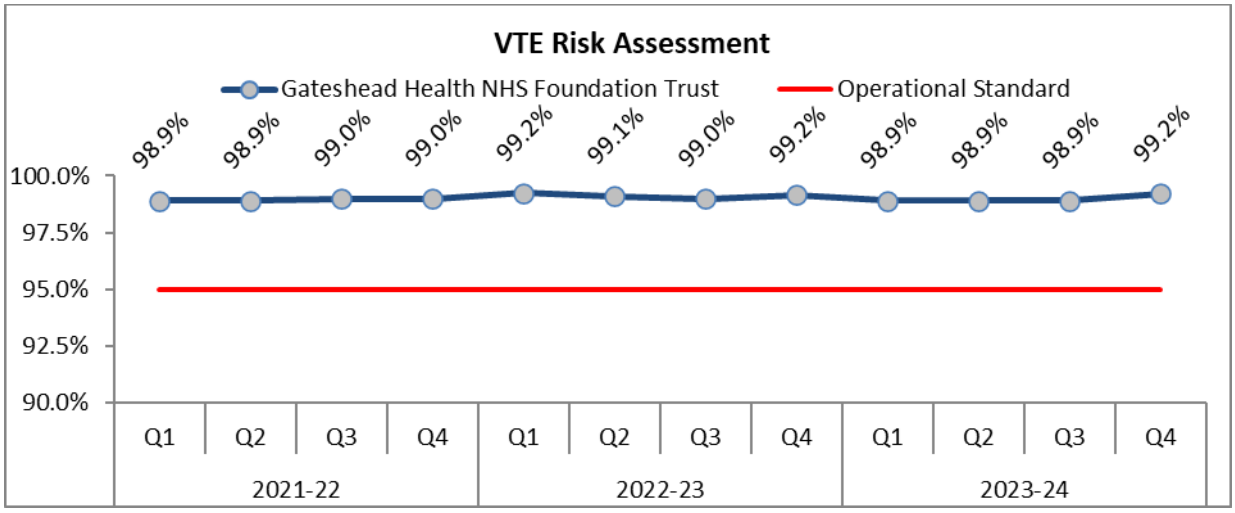
The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

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

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

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

Year	Quarter	Gateshead Health NHS Foundation Trust	England Highest Acute Trust	England Lowest Acute Trust	Acute Trusts	Operational Standard
2021-22	Q1	98.9%	No published data: National VTE Collection suspended to release capacity to manage COVID-19. This collection is to be reinstated in April 2024			95%
	Q2	98.9%				95%
	Q3	99.0%				95%
	Q4	99.0%				95%
2022-23	Q1	99.2%				95%
	Q2	99.1%				95%
	Q3	99.0%				95%
	Q4	99.2%				95%
2023-24	Q1	98.9%				95%
	Q2	98.9%				95%
	Q3	98.9%				95%
	Q4	99.2%				95%



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

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

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

- A Venous Thromboembolism Committee meet regularly to update all guidelines and raise awareness of deep vein thrombosis and pulmonary embolism and the impact on health.

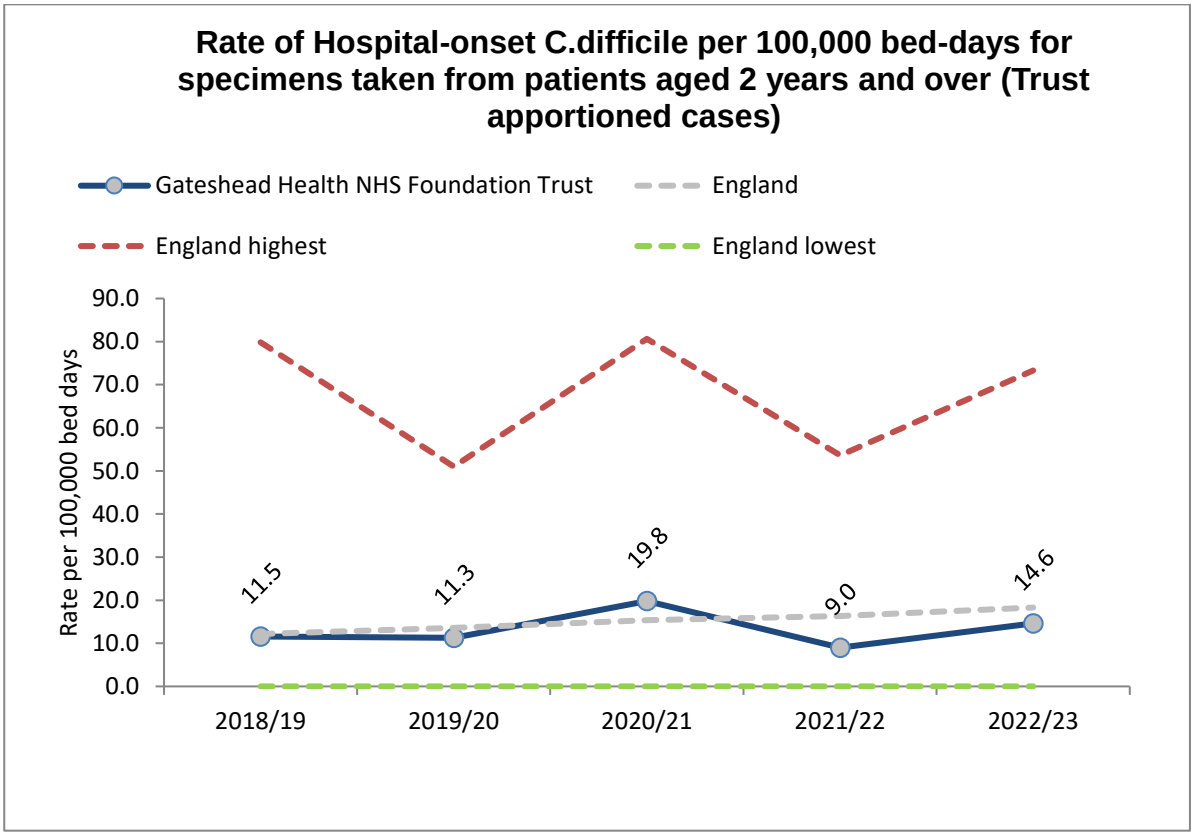
Education of junior doctors and nursing staff have been commenced with regular sessions in the Clinical Leads Nursing meeting and SafeCare meetings. The intranet has been updated with these guidelines and an e-learning module for this has been set up with the help of the Practice and Development Team.

- All new NICE guidelines are monitored on a monthly basis and the relevant updates sent to the respective teams.
- An abstract of the Trust's three-year audit on hospital acquired thrombosis has been accepted for presentation at the Thrombosis UK Conference and a poster has been submitted. This study has shown results which are at par with nationally agreed standards.
- The Trust hospital acquired thrombosis data is also shared with GIRFT.

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

Rate of Hospital-onset C.difficile per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	2018/19	2019/20	2020/21	2021/22	2022/23
Gateshead Health NHS Foundation Trust	11.5	11.3	19.8	9.0	14.6
England highest	79.8	51.0	80.6	53.6	73.3
England lowest	0.0	0.0	0.0	0.0	0.0
England	12.2	13.6	15.4	16.3	18.3

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



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

- Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal, infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety across the Trust, therefore ensuring preventative measures and reducing infection is very important to the high quality of patient care we deliver.
- The Trust reports Healthcare associated CDI cases to PHE via the national data capture system against the following categories:
    - Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1)
    - Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
- Nationally the financial sanctions for CDI have been removed and the 'appeals' process no longer in use, and the expectation that organisations will perform local review of cases.
- The Trust is required under the NHS Standard Contract 2022/23 to minimise rates of Clostridioides difficile (C. difficile) so that it is no higher than the threshold level set by NHS England and Improvement.
- For 2023/24 we reported thirty-seven (37) cases of healthcare associated CDI against the threshold of twenty-three (23). Twenty-seven (27) hospital onset healthcare associated, and ten (10) community onset healthcare associated cases.
- The Trust has reported a yearly reduction in CDI cases of 7.5% for 2022/23 in spite of increased activity compared to 2021/22. The threshold for CDI's, which is calculated by Public Health England (PHE) from November to October was reduced by 28% for 2022/23 which made a challenging target.

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

- An internal review is held for all healthcare associated CDI cases, supported by the PSIRF framework and internal safety triangulation review as necessary, where good practice and lessons learnt can be identified. The learning is then linked, if appropriate, to the key themes of sample submission, antimicrobial prescribing, documentation, patient management and human factors. The good practice and lessons learnt are then cascaded back through the internal safe care mechanisms.
- (PHE) publish thresholds for each trust on a yearly basis calculated from the previous twelve months from November to the following October for 2022/23 the trust was asked to reduce the cases of CDIs by nine (9) cases against the previous year, a reduction of 28%. An action plan was devised to help with this ambitious target, these included; education and awareness around hand washing, increased audit surveillance on clinical areas, clearer definitions on cleaning terminology, clearer signage on wards, refresh of IPC intranet page and implementation of PSIRF.
- Where there is an increased incidence of CDI associated with a particular clinical area, a multidisciplinary meeting will review all the cases collectively, consider if any cross infection may have occurred then formulate and enable an action plan to address any shortcomings identified.
- When there is an increased incidence of CDI cases associated with a particular clinical area Ribotyping can be arranged with the Clostridium difficile Ribotyping Network (CDRN) to determine if cross infection has taken place.

- The Diarrhoea Assessment Management Pathway (DAMP) tool provides guidance for clinical staff managing those patients experiencing loose stools, and has been assimilated into the suite of electronic documents available on Nerve Centre
- Enhanced personal protective equipment is worn when caring for patients with suspected infective diarrhoea.
- Patients are risk assessed and prioritised, ensuring those patients requiring a level of isolation are identified.
- To enhance antimicrobial stewardship Trust guidelines are developed to reflect the national five-year antimicrobial resistance strategy.

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

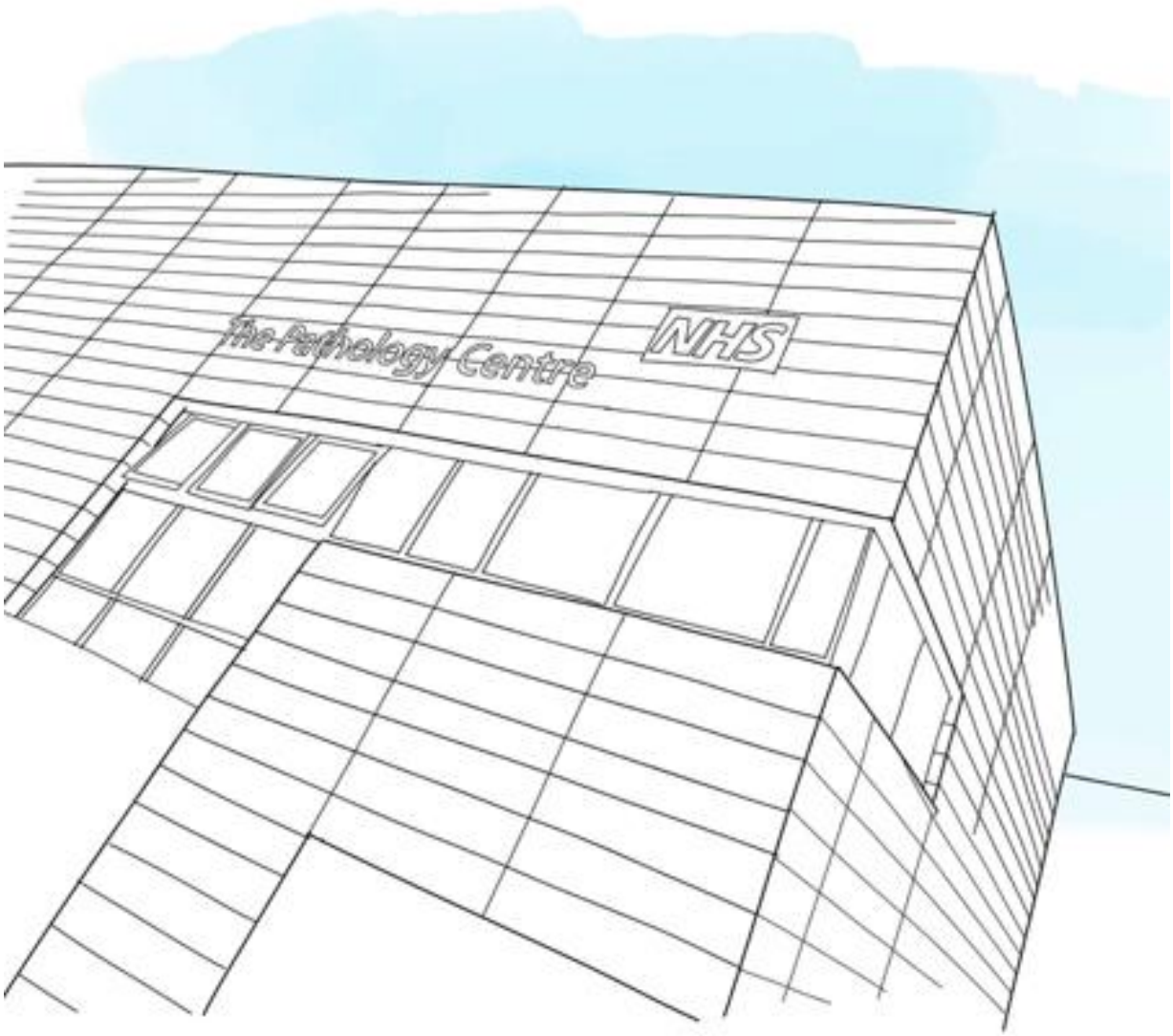
The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

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

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

Part 3

Review of Quality Performance



Review of quality performance

2023/24 has been a successful year in relation to the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

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

The following sections provide details on the Trust's performance on a range of quality indicators. The indicators themselves have been extracted from NHS nationally mandated indicators, and locally determined measures. Trust performance is measured against a mixture of locally and nationally agreed targets. The key below provides an explanation of the colour coding used within the data tables.

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

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

3.1 PATIENT SAFETY

Reducing Harm from Deterioration:

Safe Reliable care	2021-22	2022-23	2023-24	Target
HSMR Period	Apr-21 to Mar-22	Apr-22 to Mar-23	Feb-23 to Jan-24	
HSMR	114.4	100.6	110.6*	<100
SHMI Period	Apr-21 to Mar-22	Apr-22 to Mar-23	Dec-22 to Nov-23	
SHMI	1.01	0.87	0.96	<=1

SHMI Banding	As Expected	Lower than expected	As Expected	As expected or lower than expected
SHMI - Percentage of provider spells with palliative care coding(contextual indicator)	2.1%	2.2%	2.3%	N/A
Crude mortality rate taken from CDS	1.83%	1.75%	1.79%	<1.99%
Number of calls to the CRASH team	164	176	134	N/A
Number of calls to the CRASH team that were cardiac arrests	164	61	51	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	40.2%	34.7%	38.1%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.41	0.35	0.28	N/A
Hospital Acquired Pressure Damage (grade 2 and above)	87	127	183	Year on year Reduction
Community Acquired Pressure Damage (grade 2 and above)	1451	1469	1432	N/A
Number of Patient Slips, Trips and Falls	1525	1589	1344	N/A
Rate of Falls per 1000 bed days	9.51	9.03	7.77	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm	335	382	464	N/A
Rate of Harm Falls per 1000 bed days	2.09	2.17	2.68	Reduction (Less than <2.25)
Harm Falls Rate Change	10.3% Reduction	3.8% Increase	23.6% Increase	N/A
Ratio of Harm to No Harm Falls (i.e. what percentage of falls resulted in Harm being caused to the patient)	22.0%	24.0%	34.5%	Year on Year reduction

Reducing Avoidable Harm:

Reducing Avoidable Harm		2021-22	2022-23	2023-24	Target
Medication Errors	No Harm	620	738	671	N/A
	Minimal Harm	84	129	139	N/A
	Moderate Harm	4	8	2	<8
	Severe	1	3	0	0
	Death	0	0	0	0
	Total	709	878	812	N/A
Never Events		0	0	1	0
Patient Incidents per 1,000 bed days		38.9	38.3	37.0	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.15	0.13	0.11	N/A

Source: Trust incident reporting systems Datix & inPhase

Infection Prevention and Control:

Infection Prevention & Control	2020-21	2021-22	2022-23	2023-24	2023-24 Threshold
MRSA bacteraemia apportioned to acute trust post 48hrs	0	0	0	0	0
MRSA bacteraemia rate per 100,000 bed days	0	0	0	0	0
NB: **Healthcare Associated** *Clostridium difficile* Infections (CDI) post 72hr cases	40	32	40	37	<23
Healthcare Associated *Clostridium difficile* Infections (CDI) rate per 100,000 bed days	29.59	19.68	24.56	22.84	-

Infection Prevention & Control	2020-21	2021-22	2022-23	2023-24
Hospital Onset Healthcare Associated C.difficile count	31	22	27	27
Hospital Onset Healthcare Associated C.difficile per 100,000 occupied overnight beds	23.6	14.15	17.37	17.32

Infection Prevention & Control	2020-21	2021-22	2022-23	2023-24
Community Onset Healthcare Associated C.difficile count	9	10	13	10
Community Onset Healthcare Associated C.difficile per 100,000 occupied overnight beds	5.99	5.53	7.19	5.52

Other Indicators:

Other Indicators	2021-22	2022-23	2023-24	Target	Benchmark
Percentage of Cancelled Operations from FFCE's†	0.55%	0.41%	0.29%	0.80%	1.12%*
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	4.89%	5.00%	4.21%	Improve Year on Year	N/A
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	92.7%	90.1%	91.9%	90%	N/A
Proportion of patients who are readmitted within 28 days across the Trust**	14.33%	14.06%	13.78%	Improve year on year	N/A
Proportion of patients undergoing knee replacement who are readmitted within 30 days**	6.21% 10 Patients readmitted	8.43% 15 Patients readmitted	7.94% 15 Patients readmitted	Improve Year on Year	N/A

Proportion of patients undergoing hip replacement who are readmitted within 30 days**	9.83% 17 patients readmitted	8.49% 18 patients readmitted	9.13% 22 patients readmitted	Improve Year on Year	N/A

† 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.
* Q3 2023-24 national position www.england.nhs.uk/statistics/statistical-work-areas/cancelled-elective-operations/
** Figures taken from Healthcare Evaluation data (HED) and provide full financial years for 2020-21, 2021-22, 2022-23, and April to December 2023

Safeguarding Children and Adults

- The Adult and children's safeguarding teams are committed to ensuring that effective safeguarding arrangements are in place, to prevent and protect adults, young people and children from harm or abuse. Safeguarding is firmly embedded within the organisation as being everyone's responsibility. Leads for both adults and children ensure that a think family approach is evident across the Trust.
- Both safeguarding teams have worked in partnership with key partners to address safeguarding priorities in Gateshead.
- Within the quarterly Safeguarding Committee, we bring the lived experiences of service users by sharing patient stories and any learning at every meeting.
- The children and adult teams have worked together to further raise awareness of the trusts Safeguarding Exploitation Grooming and Risk Identifier tool (SEGRI) to include both vulnerable adults and children at risk sexual exploitation, criminal exploitation, and modern-day slavery.
- In response to what staff have told us the safeguarding children team have facilitated on site level 3 safeguarding training. This has been well received and compliance has improved. Training has been targeted at domestic abuse, county lines, substance use in children and knife crime.
- From the 1st February 2024 the safeguarding children team now use careflow and docstore to record children's safeguarding information. This allows pertinent information to be available to practitioners at the point of need.
- The Adults team continue to prioritise and deliver capacity training in line with Mental Capacity Act legislation.
- During the past twelve months the children and adult safeguarding teams have continued to deliver a comprehensive safeguarding service. Despite staffing pressures, the team have continued to support staff to safeguard some of the most vulnerable people in society.
- The joint adult and children Safeguarding Link Meetings have been successful and continue via MS Teams with an emphasis on promoting a "Think Family" approach to Safeguarding. This has proved to be a successful forum for education, sharing knowledge, and for staff to discuss individual safeguarding case studies.
- The adults and children's safeguarding teams continue to provide regular news bulletins within the QE Weekly providing valuable updates on current safeguarding issues and promoting training opportunities.
- The adult and children team have been working closely with patient safety to ensure a smooth migration from DATIX to InPhase, and we are now live on InPhase.
- Adult safeguarding concerns have continued to increase during the last 12 months with the main categories being Domestic Abuse, Neglect and Self-Neglect. This reflects the information shared from partner agencies. These concerns also include the community teams, where we continue to offer support and advice by telephone.

- The adult team continue to receive several provider concerns in relation to care homes and domiciliary care providers. These are currently shared with the Quality Lead nurse for ICB, Local Authority and within the provider Information sharing meetings.
- The adult team continue to receive high levels of complex domestic abuse referrals, including staff members. The team continue to work with departments and partner agencies to support and safeguarding people who are at risk of domestic abuse. This includes staff members, where they work closely with managers and HR to ensure the safety and wellbeing of staff.

3.2 CLINICAL EFFECTIVENESS

Getting it Right First Time (GIRFT)

One deep dive visit took place during 2023/24, the outcome of which is below:

Adult Orthopaedic Trauma – Deep Dive Visit February 2024

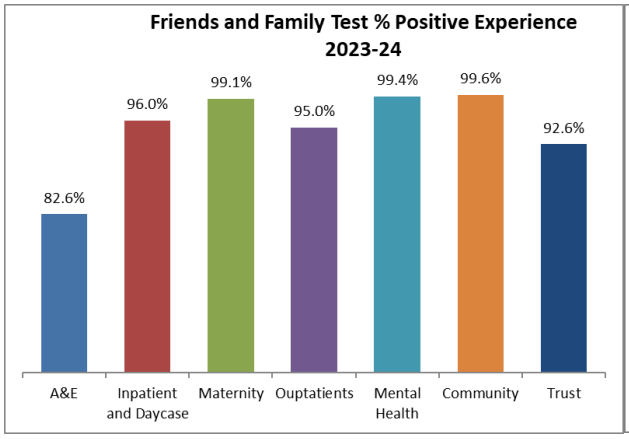
Good practice identified
- Early discharge planning
- Efforts to ensure theatre efficiency
- Communication
- Achievement of neck of femur Best Practice Tariff
- Rationalisation of kit/equipment

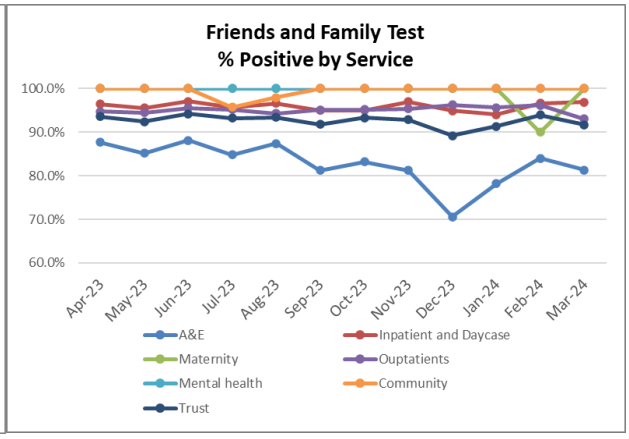
Opportunities
- Provision of total hip replacement
- Theatre start times
- Consistent weekend trauma co-ordinator cover

Recommendations
- There should routinely be an appropriate multidisciplinary representation at M&M and other meetings for all orthopaedic trauma patients.
- Management of pain in the orthopaedic trauma patient.
- Fracture prevention: I. Inpatient falls II. Secondary fracture prevention
- Orthogeriatric provision and medical cover for the injured frail.
- Continuity of care

3.3 PATIENT EXPERIENCE

Friends & Family Test



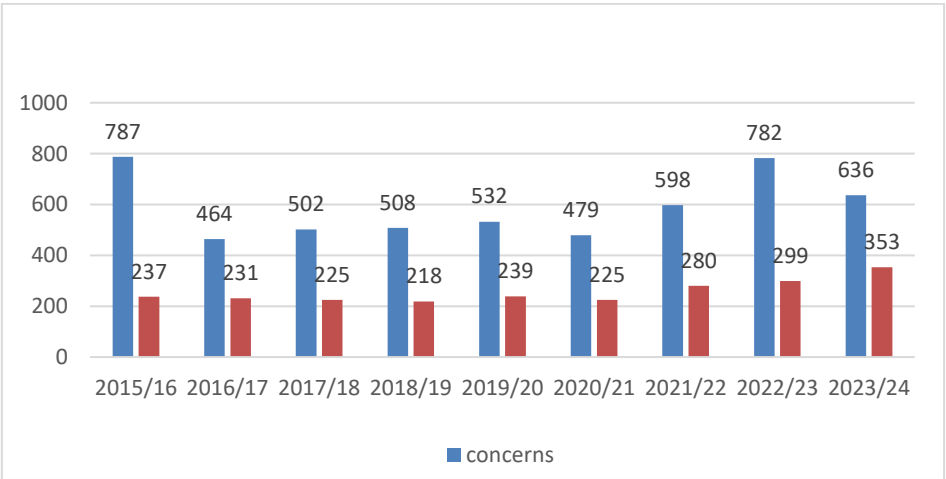


Listening to Concerns and Complaints, Compliments

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

For the year 2023/24 we received a total of 353 formal complaints. Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment when inpatients or outpatients of the Trust. It also involves apologising and explaining what happened to staff or visitors who have suffered harm. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers, staff and visitors and makes sure that openness, honesty and timeliness underpins responses to such incidents. The Patient Advice and Liaison Service (PALS) offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers.

Complaints and Concerns 2015 to 2024



Complaints Performance Indicators	Total 2022/23
Complaints received	353
Acknowledged within three working days	353
Complaints closed	353
Closed within agreed timescale (eight weeks)	175
Number of complaints upheld	301
Concerns received by PALS	636

Complaints Indicators	Total 2022/23
Number of closed complaints reopened	53*
Number of closed complaints referred to Parliamentary & Health Service Ombudsman	16

Outcome of complaints referred to Parliamentary & Health Service Ombudsman (PHSO)	Total 2022/23
Considering whether to investigate	4
Currently investigating	2
Complaints upheld	0
Part upheld	1
Declined to be investigated	9
Agreed actions with Trust (incl as a result of learning)	0

***Number of closed complaints reopened.**
In the year 2022/23 53 closed complaints were reopened. This compares to 34 in 2022/23. Reasons for reopening cases include where the complainant has additional questions/concerns.

During 2023/24 the top five main reasons to raise a formal complaint were in relation to:

- Communications
- Clinical Treatment – General Medical Group
- Values & Behaviours (Staff)
- Clinical Treatment – Surgical Group
- Clinical Treatment – Accident & Emergency

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

In response to a complaint relating to Ward 25 Care of the Elderly:
Following the concern raised regarding the administration of the patient's nebuliser, we have discussed this with staff and now recognise we have a training gap. We have since implemented further training and development for our staff to ensure all qualified staff are competent in the administration of nebulisers.

In response to a complaint relating to A&E:
As a result of this event, doctor will feedback to the wider medical team, your mother's case details, (in an anonymised way), to allow learning, especially around the themes of communication and complex drugs and where to find policy/ information regarding these drugs to aid with assessment and care.

Doctor has also contacted A&E Sister to communicate the wider feedback around staff commentaries about other patients. Doctor is aware that Sister has already done some work with the non-medical staff to highlight the importance of keeping conversations in the staff area professional. Doctor has also included the medical teams in this, as well as part of the learning theme regarding professionalism and especially as part of the wider Trust's ethos about getting back to doing basics well.

In response to a complaint relating to Medical Examiner:
We are setting up a session for the Matrons and Ward Managers to meet with the Medical Examiners and discuss their role so that other families do not find themselves in the same situation with incorrect information being given to families. We will also be monitoring our communication with families to see if there are other ways, we can improve our services.

ME explained she will develop an internet page to help signpost families on how to contact the Medical Examiners. Information is included in the bereavement pack and ME, together with the Bereavement Office Team will review the information to see how clear it is.

The team have sent out information on the Medical Examiner role to the nursing teams (including sisters and matrons) and PALS to make sure they are all aware of who the team is and how to contact them.

In response to a complain relating to General Surgery
Unfortunately, it is apparent that you were not sent a reminder for the liver reduction diet when you were then sent a date for surgery in November 2023. As a result of this, when information is collated and provided to patients prior to their surgery, we are looking to develop a checklist which will include checks to see if any information is required for pre-operative diets to ensure that this will not be missed moving forward. We have also shared your experience with the team in General Surgery in order that there are lessons learned, and so that the importance of communicating this information is emphasised.

3.4 Good News Stories

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

Teams recognised with awards

Children's unit becomes the first in the region to hit the gold standard for caring for neurodivergent children

The Children's department at the Queen Elizabeth Hospital in Gateshead has been awarded the 'Gold Standard for Autism Acceptance' from the North East Autism Society (NEAS). Gateshead Health is the first children's department in the region to receive this honour after tailoring care for neurodivergent children.

Awarded for commitment to patient safety by the National Joint Registry

Gateshead Health is celebrating after being named as a National Joint Registry (NJR) Quality Data Provider after successfully completing a national programme of local data audits.

Improving Quality in Liver Services – Deferred status

The Liver service is close to being accredited and has some actions we must take to meet the standards. We have up to 6 months to do this.

Gateshead Health NHS wins Pastoral Care Award for international recruitment

The international recruitment team at Gateshead Health NHS Foundation Trust has been awarded the NHS Pastoral Care Quality Award as part of NHS England International Recruitment Programme.

The award recognises commitment to providing high-quality pastoral care and the positive impact this has on staff wellbeing. The number one priority for embedding new people into the NHS is to provide safe onboarding, induction and pastoral support for new international recruits.

Gateshead Health staff awarded Chief Nursing Officer awards

Three Gateshead Nurses receive special national recognition with Silver Chief Nursing Officer for England awards alongside nursing colleagues who have successfully become Professional Nurse Advocates.

New initiatives implemented

Frailty Virtual Ward offers patients an alternative to a hospital stay

The Frailty Virtual Ward at Gateshead Health NHS Foundation Trust first opened in September 2023. The ward aims to help patients who are frail to stay at home during a period of acute illness such as chest infections, urine infections or constipation alongside conditions such as dementia or delirium.

Building work underway on new community diagnostic centre

Work to develop a new community diagnostic centre (CDC) at Metrocentre in Gateshead is now underway. Gateshead Health NHS Foundation Trust and Newcastle Hospitals are working in partnership on this exciting project which will create a modern, state-of-the-art environment for patients, carers and staff.

Partnered with Seating Matters….

To become the first trust in Europe to collaborate with Seating Matters to create an innovative and award winning device to support critical care patients.

Helping families make the most of diabetes care

Gateshead Health NHS Foundation Trust is supporting a partnership project which is helping young people and their families to make the most of technological innovation in diabetes care. New technologies have been proven to improve the health and quality of life outcomes of children and young people living with diabetes; however, as technology increasingly needs patients to have access to smartphones and laptops, this can be a barrier to people in more deprived communities.

Local School supporting Organ Donation

Consultant and Clinical Lead for Organ Donation, Andy Lowes has been working closely with schools in the local community to produce artwork promoting organ donation and working at Gateshead Health.
Today we unveiled an incredible bespoke piece of artwork by XP School entitled ‘Being Human’. The year 8 children have created artwork of different organs to help raise awareness of donation alongside a QR code that explains their learning experience.

3.5 Focus on staff

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

2023/24 continued to be a challenging year for our people as the Trust continued to manage the impact of Industrial action from our nursing, junior doctors, consultants and ambulance colleagues.

We understand how challenging this has been personally and professionally for our colleagues - for those colleagues who took part in the strike, the colleagues helping to keep services running and keep patients safe during these periods and for those involved in the complex and dynamic planning and risk assessments for every strike period. We recognise that the dispute has not been directly with the Trust and we remain supportive of all of our people who have exercised their legal right to strike.

We continue to look to improve the health and wellbeing of our workforce via various ways. During the past year, the health and wellbeing team has become more embedded within Occupational Health team, helping provide a more holistic and comprehensive support offer to staff.

During the last year, targeted work has been done to support colleagues impacted by the cost of living crisis – ranging from new partnerships and offers to the provision of free sanitary products for staff. The #GHMoneyMatters Guide to Financial Wellbeing brings together all of the benefits, savings, freebies, discounts, support offers, grants and more available to help colleagues manage their finances, and continues to be updated regularly.

Elsewhere and after colleagues told the organisation they'd like to see more physical wellbeing support offers, the organisation has worked to introduce staff health checks, physical activity groups, an on-site fruit & veg stall and more. Mental health also continues to be an active area of focus, with a newly-trained network of Mental Health First Aiders set to continue growing throughout 2024.

Key headlines – recruitment, retention and absences

Recruitment, retention, and absence remain a key priority, with the board setting a target of group sickness absence of less than 5%, and a vacancy rate of less than 5% also by the end of the 23/24 financial year.

In March 23 our vacancy rate was 4.7% and sickness absence was 5.3%, by March 24 the vacancy rate had dropped to 2.3% which is a fantastic achievement however, the sickness absence increased to 5.6%.

International recruitment was a focus throughout 22/23 in which the first 50 internationally recruited nurses were appointed. Our international nurses are supported by a dedicated International Nursing Team. The nurses have a broad on boarding and pastoral programme before attending wards with the team supporting access to the hospital computer systems. The team help them with many of the practical things for settling into a new country, such as opening bank accounts and finding accommodation. There is an extensive comprehensive teaching programme, delivered by the practice development team We were successful in a bid to recruit a further 100 which took place throughout 23/24. To date, the programme has been a success, recruiting 150 international nurses, and retaining 100% of those recruited. As the nursing headcount has reached stable levels, this programme of work will conclude in March 24.

As part of our domestic recruitment we are engaging with local schools and colleges to educate young people about the different career opportunities available to them in the Trust, as outlined earlier in the report. We have also supported 116 colleagues through apprenticeship programmes, with around 38 different types of apprenticeship available across the Trust and QE Facilities.

During 2023/24 we have been working with our partners at place on the development of Gateshead development opportunities for a variety of the local population. This involves collaborative working with Gateshead Council, CBC Health, local colleges and other partners. There have been successful cohorts of Getting in to Care programmes, as well as 2 summer schools, that saw a number of young people from the local areas attending programmes to help develop their understanding of the health and care sector, with exciting simulation sessions ran within the Queen Elizabeth Hospital. The Gateshead Cares Workforce partnership continues to work collaboratively, and further opportunities are being scoped into 24/25.

We believe that retention is just as important as recruitment and have taken a number of steps to support our colleagues and encourage them to continue their careers with us. This includes increasing our health and wellbeing offering, as described at the beginning of this section, as well as enhancing our learning offerings. During 2023/24 we introduced legacy mentors, we were observing a high turnover of Nursing and Midwifery colleagues at the 18-24 months of service stage, legacy mentors provided an opportunity to discuss progression, itchy feet conversations etc on a one to one basis, this scheme saw turnover with this group reduce by 8% Throughout 24/25 we want to expand the success of these scheme to other staff groups.

As mentioned above our target for sickness was for this to be below 5%, unfortunately by March 24 sickness was sat at 5.6%. Our continued focus on health and wellbeing is an important part of supporting our colleagues to be well enough to remain at work. We undertook some focussed work between People and OD colleagues and our business units to support colleagues in appropriately managing absences. It is identified that there is further work to do in this area to reduce sickness throughout 24/25 to bring sickness absence down to a manageable level.

Information on sickness absence is collated nationally by NHS Digital and can be found at the following link https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

The latest information about our staff turnover can also be found on the NHS Digital website: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff equality, diversity and inclusion

At Gateshead Health we are passionate about equality, diversity and inclusion (EDI) and we have continued to take steps to ensure that EDI considerations are part of everything that we do. Our Board Members are committed to equality, diversity and inclusion.

We operate within a legislative framework which is underpinned by the Equality Act 2010, which means we need to comply with a range of different requirements, including but not limited to:

- Public Sector Equality Duty;
- Human Rights – Mental Health Code of Practice;
- Equality Delivery System (EDS2);
- Workforce Race Equality Standard (WRES);
- Workforce Disability Standard (WDES);
- Gender Pay Gap; and
- Accessible Information Standard.

Ensuring equality for all is a core part of our organisational culture and compassionate leadership approach. Our policies help us to ensure that we embrace equality, diversity and inclusion both in service delivery and employment with the Trust. As part of policy review and development, all policies must be accompanied by an equality and quality impact assessment (EQiA). The EQiA is reviewed by the Trust's dedicated Policy Review Group and signed off by the EDI and Engagement Manager prior to a policy being approved. This ensures that there are no unintended negative consequences of a policy for anyone with a protected characteristic.

We have four staff networks in place within the Trust – GEM network, D-Ability network, Women's network and LGBT+ network. The Networks help to raise the concerns of members of staff who share an affiliation with a protected characteristic to ensure that concerns are listened to and inform our continued development.

Our four staff networks provide an invaluable space for mutual peer support, networking and opportunities for personal and professional development of members. Our networks provide a safe space where information, knowledge and experiences can be shared. Their activity helps us to support organisational and cultural development in positive and innovative ways.

Our staff networks played an integral role in helping us to promote and celebrate key occasions with events, celebrations and training. Our D-Ability network supported a number of different national awareness weeks with stalls in our canteen:

- Eating Disorders Awareness Week and Neurodiversity Celebration Week.
- LGBT+ network supported the Transgender Day of Remembrance and Non-Binary Peoples' Day.
- The LGBT+ network has also been undertaking work with our clinical teams to develop transgender and non-binary policies.

Workforce Disability Equality Standard (WDES)

The WDES was developed to help NHS organisations make a positive impact for all disabled colleagues working in the NHS. The WDES aims to inform year-on-year improvements in reducing those barriers that impact most on the career opportunities and workplace experiences of disabled staff.

The D-Ability network has been integral to this work and has helped us to develop a greater understanding of the experiences of disabled staff. A detailed action plan for the Trust has been developed and this will enable us to measure our progress in this area.

Our latest staff survey results shows that three out of five questions that have a year-on-year comparison have improved in respect of the WDES, with work still to do in relation to bullying and harassment at work, and feeling pressure from managers to come to work. This will form part of our cultural development work with our people to ensure that we provide a supportive and inclusive workplace for all our colleagues.

Our D-Ability Group and the Trust's Human Rights and EDI Programme Board continue to be focussed on the WDES results and improvement actions, but we recognise that it is the responsibility of every member of staff to embrace this.

We are a Disability Confident Level 2 employer which means that we are recognised for actively attracting and recruiting disabled people to help fill opportunities, providing a fully inclusive and accessible recruitment process and we offer guaranteed interviews to disabled people who meet the minimum criteria for roles. We are flexible when assessing applicants to give disabled applicants the best opportunity to demonstrate that they can fulfil the role and we commit to proactively offering and making reasonable adjustments.

Workforce Race Equality Standard (WRES)

The WRES was developed with similar principles in mind, helping to ensure that NHS organisations make a positive impact for colleagues from a Black, Asian or Minority Ethnic (BAME) background.

In respect of the four WRES indicators in the NHS staff survey 2023 in respect of our BAME staff:

- Percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public in the last 12 months saw an increase - up from 20.3% to 25.6%.
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months also an increase from 19.1% to 29.4%
- Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues rose from 11.4% to 14.6%

On a positive note, the figure for our staff believing that the Trust provides equal opportunities for career progression, increased from 47% to 52.5%. Detailed analysis is being undertaken to understand why there has been an increase from the previous year. Discussions are taking place as to the best way of incorporating our Cultural Ambassadors into the disciplinary and grievance processes.

Collectively on a regional basis there are discussions around running a recruitment fair for BAME and Disabled communities, to help members of these communities feel comfortable to work in NHS organisations. We routinely capture information around who has been successful in applying and being recruited within the Trust and are using this information to address and understand how we are reflective of the diverse communities we serve.

We have implemented practices to assess where the pitfalls are for candidates in respect of their protected characteristics using the data available. We tackle conscious and unconscious bias in the recruitment process within the recruitment and selection training that is offered to our managers. We are also reviewing the assessment methods and scoring systems used by hiring managers to ensure reasonable and fair decisions are being made during the selection process.

In terms of gender pay gap reporting, in 2022/23 77.6% of our workforce was female. Women occupied 73.8% of the highest paid jobs and 73.8% of the lowest paid jobs. The gender pay median was 12.7% which is consistent with the previous year.
Further information on gender pay gap reporting can be found on the Cabinet Office website: Find and compare gender pay gap data - GOV.UK (www.gov.uk)
Further information on our approach to EDI can be found on our website via the following link: https://www.gatesheadhealth.nhs.uk/about/trust/equality-diversity

Communicating, consulting and engaging with our colleagues

We actively encourage our colleagues to become involved in identifying improvements and shaping our performance and operations.
We have several consultative forums in place within the Trust. Our Joint Consultation Committee and Local Negotiation Committee are the most formal arenas for consultation with staff side colleagues. They are also supported by several sub-committees (such as policy sub-committee and working groups for example the Medical Workforce Group). In addition, there are forums such as Junior Doctor Forum. Staff side colleagues are involved in our staff network groups.
There has been further development and progression of the transformation programme and portfolio during the year which was referenced in last year's report following its relaunch. The delivery of transformation programmes involves collaboration and key contributions from those colleagues who work in and understand these areas the most. Our transformation team facilitate a wide range of improvement and support activity including:

- Improvement and transformation advice and support;
- Training and development (project, programme management, Lean leaders);
- Kaizen events; and
- Rapid Process Improvement Workshops (RPIWs).

Recent RPIWs have included recruitment processes, endoscopy and occupational health. In addition to leading RPIWs the team have trained a further eight colleagues as Lean leaders to further enhance our capacity to increase our improvement activity across the organisation.
Further RPIWs are planned for 2024/25 and we aim to train more colleagues to be certified leaders, further increasing our capacity to facilitate these important engagement and improvement events as well as increasing the capability and resilience of the organisation, supporting an improvement culture.

We communicate with our colleagues using several different channels. The key tools that we use to ensure information is cascaded is through Gateshead Health Weekly (a weekly staff newsletter), an internal staff Facebook group, Team Brief (managers' briefing), and the intranet (Staff Zone) plus other ad-hoc briefings that are distributed as required. Our Chief Executive, Trudie Davies, also sends out a personalised weekly update to all colleagues and we have recently introduced Facebook Live events, where colleagues can ask questions of our Executive Directors and Senior Management Team.

Occupational Health & Wellbeing

The Occupational Health and Wellbeing team began the year with a RPIW (Rapid Process Improvement Workshop), that focused on ways to improve our Management Referral process. The outcomes of this have included improved use of the current estate, a new online referral form, streamlined report processes and an improved welcome for clients. All of these improvements are aimed at enhancing our offer to staff and ensuring the best possible service is available to all those who work at Gateshead. The team once again successfully delivery the 2023-24 flu and covid booster vaccination programme and whilst we saw lower than expected take-up rates, this was a common theme across the region and work is underway to

understand the reasons why, which will be incorporated into the 2024-25 campaign plan, which is currently underway.

Our Physiotherapy service continues to go from strength to strength, with over 500 colleagues being referred into the service in the last 12 months. Client feedback remains extremely positive, with both the EQ5D and OREBRO scores demonstrating the positive impact the service is having from a clinical effectiveness perspective and on long-term absence.
Demand on all services continues to rise, with 8-12 week waits for many of our services. The team continue to look for ways to support those colleagues in most need, as quickly as possible, whilst also considering longer term solutions. It is hoped that service demand may be helped by the Occupational Health and Wellbeing Scaling Up programme, of which the team are active members, and see's Occupational Health and Wellbeing teams from across the region come together to find ways to work more collaboratively.

The Health & Wellbeing team achieved the Better Health at Work Gold standard this year, which highlights the work being done to support the health and wellbeing of colleagues at Gateshead. The team are also closely involved in the development of a post-incident support hub for those who experience bullying, harassment, discrimination, and abuse. This forms part of the Trust wide, zero-tolerance programme, supporting the 'It's Not Ok' campaign.

As we move into the new year, the team are preparing for the SEQOHS revalidation, which assesses the services against 6 key domains; Governance & Finance; Resources and Processes; Outputs and Outcomes; Information and Communication; Quality Assurance and Improvement; and Sector Specific Standards.

Health and safety performance

We are committed to ensuring the health, safety and wellbeing of our people, patients, contractors and members of the public who are in any way affected by the activities of the Trust or QE Facilities across all locations. We ensure the provision of appropriate resources, including staff, finance and equipment in a timely manner so as to conduct our activities in accordance with all statutory and regulatory requirements, seeking to exceed such requirements wherever reasonably practicable. Our key objectives are to:

- prevent accidents and cases of work-related ill health;
- manage health and safety risks in our workplace;
- provide clear instructions and information, and adequate training, to ensure our people are competent to do their work;
- provide personal protective equipment;
- consult with our people on matters affecting their health and safety;
- provide and maintain safe plant and equipment;
- ensure safe handling and use of substances;
- maintain safe and healthy working conditions;
- implement emergency procedures, including evacuation in case of fire or other significant incident;
- review and revise the Health & Safety Policy on a regular basis;
- maintain a culture of co-operation, communication, competency and control for health and safety; and
- protect patients and people other than those at work against risks to their health and safety arising out of work activities.

The Board has identified and assigned roles and responsibilities to management, specialist support subject matter experts and individual staff members including bank and volunteering colleagues across the Group's organisational structure, to ensure the aims and objects of our Group Health & Safety Policy are achieved and maintained.

In delivering these aims, we expect all staff, bank staff, students and contractors to always conduct themselves in line with the policy and to fully engage in all identified health & safety initiatives to deliver continual health & safety improvements.

Assurance on all matters relating to health & safety continues to be achieved through the Group Health & Safety committee meetings and team structure.

As part of the Trust's drive for continued improvement we continue to run our Safer Working Practices Groups which provide additional assurance and governance into the Group Health & Safety Committee. They include the Water Safety, Medical Gas, Violence Reduction, Medical Devices Steering Group, Infection Prevention Control, CERA, Internal Compliance Auditing, PLACE Auditing & Radiation Protect groups.

The Group Health & Safety Committee is well attended across the year, with members representing staff from across the Group, our union colleagues across all locations and all levels of management including our Trust Board accountable Health & Safety lead.

We continue to promote and drive a safe working culture by providing additional education and awareness of shared learnings via internal communications, newsletters and staff social media forums.

Staff Survey Report

The 2023 Staff Survey saw a completion rate of 50% across the Group, with the largest increase in participation seen within QE Facilities who achieved a 59% completion rate overall. We have seen year on year increase across all 7 People Promises, with Morale and Engagement also seeing an improving picture.

One of the Trust's Leading Indicators focuses on Staff Engagement, and seeing an improvement in this score aligns with our strategic direction. This continues to be an area of focus for 2024-25 and our aim is to see this increase again in 2024.

Areas of Focus from 2022 Staff Survey

The results of the 2022 survey saw us focus on 3 key areas; Freedom to Speak Up; Appraisal Quality and Bullying & Harassment. In each of these 3 areas we have seen encouraging movement, with freedom to speak up maintaining its position at 67% for the Trust and increasing by 3% for QE Facilities to 64%.

Appraisal completion for the Trust reported at 88% and 81% for QEF. Both are significantly above the Picker average and demonstrate the targeted work, particularly within QE Facilities on the importance of the appraisal conversation. We have also seen a positive trajectory in those questions relating to the quality of the appraisal process. The Trust continues to score positive in relation to instances of bullying, harassment, and physical violence at work however, when we examine this through the lens of our Staff Networks, we can see that the experiences differ for GEM colleagues, those who report a disability and our LGBTQ population. This will be picked up in more detail, along with the WRES and WDES results, within the EDI section, but it's worth noting that this has triggered an organisational focus on zero-tolerance and the creation of our It's Not Ok campaign. We have also seen a slight reduction in the reporting of incidents, and this is being addressed through the zero-tolerance working group.

Some of the activity that has taken place as a result of the 2022 staff survey results can be seen below:

Priorities Areas for 2024-25

Areas of priority following the 2023 Staff Survey include:

- Continued focus on bullying, harassment, discrimination and abuse via the Zero-Tolerance Working Group.
- Appropriate reporting of incidents.
- Developing the 'We Are a Team' People Promise through the promotion of civility and respect and living in line with our values.
- Continuing to promote a culture of speaking up and taking action as a result of feedback from colleagues. This is being championed by our new Freedom to Speak Up Guardian.
- Continue with our commitment to the NHS Equality, Diversity and Inclusion Improvement Plan, using this to enhance the experience of those who identify with our staff networks.
- Increasing opportunities for conversation between our Staff Networks and the Board, to encourage better understanding through the sharing of lived experiences and challenges.
- A continued focus on flexible working and making this an option for everyone.
- Continuing to increase clinical engagement on results, themes and actions, helping to ensure we are truly clinically led, and management supported.

3.6 National targets and regulatory requirements

The following indicators are all governed by standard national definitions

Indicator		2021/22	2022/23	2023/24	Target	National Average / Benchmark
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		78.6%	73.0%	**68.8%**	92.0%	58.1%*
A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		81.6%	73.3%	**71.1%**	76.0%	72.1%
Cancer Faster Diagnosis Standard	Faster diagnosis standard (FDS): Maximum 28-day wait to communication of definitive cancer/not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	N/A	76.4%	**77.3%**	75.0%	72.5%*
	Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients	N/A	98.8%	**99.6%**	96.0%	89.9%*
	Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening	N/A	61.4%	**66.5%**	70.0%	89.9%*
Maximum 6-week wait for diagnostic procedures		70.6%	81.3%	**90.9%**	99.0%	79.2%**

*2023-24 YTD February 2024 position

** February 2024 position

Annex 1: Feedback on our 2023/24 Quality Account

4.1 Gateshead Overview and Scrutiny Committee

Based on Gateshead Care, Health, and Wellbeing OSC's knowledge of the work of the Trust during 2023-24 we feel able to comment as follows:

Quality Priorities for 2024-25

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

Progress Against Quality Priorities for 2023-24

OSC expressed its thanks to all the Trust's staff and volunteers for its excellent work in continuing to make some real improvements in quality and safety whilst still facing significant challenges. The OSC felt there were no omissions from the report.

Health and Wellbeing of Staff
OSC commended the Trust's support of its staff, and stated that it was unacceptable that staff faced intolerance and abuse in the workplace. The Trust continues to support its staff and is aiming to tailor its staff health and wellbeing initiatives further so that staff can get the most from them.

4.2 Northeast and North Cumbria Newcastle Gateshead Integrated Care Board

Commissioner Statement from
North East and North Cumbria Integrated Care Board (NENC ICB)
Gateshead Health NHS Foundation Trust
Quality Account 2023/24

The North East and North Cumbria Integrated Care Board (NENC ICB) is committed to commissioning high quality services from Gateshead Health NHS Foundation Trust (GHFT). NENC ICB is responsible for ensuring that the healthcare needs of the patients they represent are safe, effective and that the experiences of patients are reflected and acted upon. The ICB welcomes the opportunity to review and provide comment on the 2023/24 Quality Account for GHFT.

Firstly, the ICB recognises that 2023/24 remained a challenging year across the system due to increasing service demands and the impact of industrial action, with GHFT being no exception. The ICB acknowledges and appreciates the combined effort of all staff to deliver safe and effective care during this period, and their ongoing commitment to improve patient experience and drive to deliver continuous quality improvement to the services offered.

The ICB would like to thank the Trust for welcoming their attendance at a variety of committees and meetings to gain assurance and seek insight into the Board level oversight, challenge, safety culture and transparency within the organisation. These meetings will provide the ICB with assurance that the Trust provides safe, high quality health care and has effective internal review and governance processes in place.

The Trust's Quality Account provides an honest, comprehensive, and transparent appraisal of the quality improvements made over the past year and the aspirations for the coming twelve months. The ICB welcomes that safe and high quality-care has remained a priority and progression has been made towards achieving the 2023/24 quality priorities.

The Trust has made good progress in its quality priority to work with the Volunteer Service to develop new roles, which was partially achieved. It is positive to note that funding has been secured for a volunteer coordinator post. The initial discussions with People at The Heart and the drug and alcohol team about appointing volunteers with lived experience, demonstrates a proactive approach to diversifying roles. The ICB fully supports the Trust's plans to progress this work, including the intention to develop a Volunteer Strategy in consultation with patients, the public, and staff. Additionally, aligning volunteer initiatives with the organisational strategic model, with a particular focus on women's health services, the Community Diagnostic Centre, and supporting patients with long-term conditions, demonstrates a clear direction for future volunteer engagement.

The Trust has made good progress with the quality priority to improve the way they learn and make improvements following complaints. The implementation of the feedback module on Inphase reflects a proactive approach towards capturing and addressing patient concerns. The remodelling of the Patient Advice and Liaison Service (PALS) will hopefully result in an improved experience for patients and their families. Additionally, the review and amendment of the complaints policy and process demonstrates a commitment to refining internal procedures for better resolution outcomes. The allocation of funding for complaints training from an external provider is a positive step towards equipping staff with the necessary skills for effective complaint management. The planned dissemination of this training across the organisation demonstrates the Trust's commitment to fostering a culture of continuous improvement and excellence in complaint handling practices.
The Trust has made good progress with the quality priority to strengthen partnership working with collaborative patient forums to enhance patient engagement and involvement. The re-engaging with Gateshead Carers Partnership and representatives from Gateshead Council, and subsequently inviting them to forums, reflects a proactive approach towards enhancing patient engagement. The 15 Steps Challenge is a powerful tool which highlights the importance of understanding what good quality looks and feels like from a patient and carer perspective. It is positive to see this was relaunched in January 2024 and visits have been planned for the whole year. The ICB supports the Trust's continued focus on this work and the next steps as outlined in the report, which will further enhance patient engagement and involvement.

The Trust is commended for the excellent progress made in the staff experience quality priority to improve the way they listen, act upon, and learn from concerns. Key achievements include updating the Freedom to Speak Up (FTSU) policy in line with national guidance and appointing a full-time permanent FTSU Guardian. Notable initiatives also include the relaunch of the FTSU service, increased education and training, the establishment of the Trust Culture Board Program, and improved data collection methods. The increased FTSU concerns reported in Quarters 3 and 4 indicates staff are increasingly more aware of this process and feel more confident in raising their concerns. The ICB acknowledges the Trust's continued commitment to this important work and fully support that this is continued as a quality priority in 2024/25.

The Trust has made good progress in the quality priority to listen to staff experience in relation to waste and duplication, including increasing the number of staff who are trained in improvement and lean approaches. It is positive to see the wide range of service improvements introduced as a result of the Rapid Process Improvement Workshops. The Well Organised Hospital Programme is an excellent initiative, with plans underway for its

wider implementation. It is encouraging to note the next steps outlined in the report, including planned service improvement events, ongoing staff training and the activation of a dedicated website to foster staff engagement in sharing ideas and identifying areas for improvement. This is to be commended as it demonstrates the Trust's commitment to fostering a culture of quality and service improvement, aimed at reducing waste and duplication.

The Trust is congratulated for the excellent progress made in its quality priority to focus on safe staffing, including reducing movement between clinical areas. The successful improvement in the nurse staffing position, reducing the overall vacancy rate from 9.0% to -1.3%, is a significant achievement. The recruitment of 171 internationally educated nurses is particularly welcomed, as they make a significant contribution to patient care in the NHS, with organisations benefitting from their expertise and the new knowledge and skills they bring. The learning opportunities offered by the Trust are commendable, including a four-year apprentice scheme for school leavers to become qualified registered nurses and the support for Healthcare Support Workers to advance to Nurse Associates or registered nurses. The ICB recognises and supports the Trust's ongoing commitment to this priority continuing in 2024/25, particularly in retaining experienced staff post-retirement and enhancing safe staffing monitoring in non-inpatient areas.

The Trust is commended for achieving its quality priority of reducing the overall length of stay, which decreased from 4.96 days to 4.83 days. This success is notably attributed to the collaborative efforts across the hospital, community services, social care, and GPs, which were integral to the Winter governance structure. It is positive to note the initiatives introduced to support earlier discharge, including increased social care availability, virtual ward arrangements, and weekly stranded patient meetings. The ICB fully supports the Trust's commitment to further reducing length of stay to 4 days of less as part of their quality improvement work in 2024/25.

The Trust has made significant progress with the implementation of the Patient Safety Incident Response Framework (PSIRF), with further workstreams on falls and civility. The Trust formally transitioned to PSIRF on 1 November 2023, following agreement with the ICB. Enhancing engagement within the Falls Strategic Group, including broader stakeholder participation, and developing the System Improvement Plan are positive achievements. The integration of the Civility Saves Lives initiative into the Culture Transformation Programme aligns well with national Patient Safety Strategy principles. The ICB fully supports the quality priority for 2024/25 to implement the Patient Safety Incident Response Plan and progress the agreed programmes of work for each of the six workstreams. The ICB looks forward to continuing to receive regular updates from the Trust as they continue to fully embed these programmes of work.

In 2023/24 there was a notable reduction in the overall incidence of patient falls per 1000 bed days, decreasing from 9.03 to 7.77. Whist this indicates progress, it is a concern that there has been an increasing trend in falls resulting in harm. Specifically, there has been a 23.6% increase in the harm falls rate, with the rate of harm falls per 1000 bed days rising from 2.17 to 2.68 and the number of patient falls resulting in harm increasing from 382 to 464. Falls remain one of the leading causes of harm in the hospital setting and it is important that every effort is made to mitigate all falls, particularly those leading to harm. The ICB expects to see a further reduction in inpatient falls, particularly those which result in harm, as the Trust continues to implement their falls reduction improvement priorities during 2024/25.

Additionally, it is a concern to note the upward trend in the incidence of hospital acquired pressure damage (Category II and above). The number of cases has steadily increased over the past three years, rising from 87 in 2021/22, to 127 in 2022/23 and to 183 in

2023/24. Preventing pressure ulcers is an important patient safety issue and a key marker of good quality care. The ICB therefore expects to see a significant reduction in cases in 2024/25 as the Trust continues to implement and embed the agreed pressure damage improvement programme of work.

The Trust made good progress with its quality priority to undertake improvement work in the processing of clinical results, which was partially achieved. It is positive to note that an RPIW was held, resulting in Trust and departmental standard operating procedures being developed. It is acknowledged that compliance with the management of ICE results is difficult to monitor as reports are not easily accessible and difficult to interrogate, and work is ongoing to improve this. The ICB notes the future developments including moving to a newer version of ICE in the short term, and in the longer-term, procurement of a fully integrated Electronic Patient Record. The ICB fully supports this continuing as a quality priority in 2024/25, including implementing and monitoring the standard operating procedure, raising awareness of the new process, and auditing its effectiveness.

The Trust has made good progress in implementing the maternity and neonatal plan quality priority, which was partially achieved. This included monthly reporting of agreed data in the Maternity Integrated Oversight Report to the Trust Board, which is now fully embedded into reporting processes. It is positive to see that the Midwifery Strategy is in the final stages of development and plans are in place to complete and publish this. The ICB congratulates the Trust on achieving an overall rating of *'good*' following the CQC inspection of Maternity Services in February 2023, which highlighted a number of outstanding practices. The Trust is also commended for the excellent results achieved from the CQC Maternity Services Survey (2023), which ranked GHFT as fifth best out of 61 Trusts in England, and only one of eight Trusts nationally who performed in the 'better than expected' category. This is an outstanding achievement and demonstrates the dedication and compassion of the maternity team in providing excellent care to pregnant women and their babies.

The ICB recognises the progress made with the quality priority to embed a culture of research in the Trust and make *'Research Everyone's Business',* which included continued promotion of research and awareness raising with staff. It is positive that in the last year over 1,600 participants were recruited into more than 50 studies and the Patient Research Experience Survey showed that 98% of participants would consider taking part in research again. Clinical Research is a major driver of innovation and is central to NHS practice for maintaining and developing high standards of patient care and the Trust is commended for their continued commitment to this.

The Trust has made good progress with its quality priority of strengthening learning from deaths and expanding the Medical Examiner system to include non-coronial deaths outside of the Acute Trust. Notably, the Lead Medical Examiner Officer has engaged with the 28 GP practices in Gateshead to explain the new process. It is encouraging to note that 20 GP practices are now regularly referring into the service and the number of referrals received is increasing. It is noted that the confirmed 'go live' date is 9 September 2024 and all GP practices will be required to send completed Medical Certificate for the Cause Death to the Medical Examiner's Officer for sign off before submission to the Registrar.

The ICB recognises the progress made with the quality priority to improve the experiences of people with a learning disability, mental health, or autism, through education, training and promoting the role of the Learning Disability Nurse. It is encouraging to note that the Learning Disabilities Clinical Nurse Specialist Team is to be expanded to ensure the needs of patients and service users are met. Discussions are ongoing between the ICB and Trust partners to understand how the national requirement to introduce ‘Oliver

McGowan' training will be rolled out across the region. The ICB acknowledges the Trust's ongoing commitment to improving the health outcomes and reducing health inequalities for people with a learning disability or neurodiversity and fully supports the continuation of this quality priority in 2024/25.

The emphasis the Trust gives to national clinical audits and confidential enquiries demonstrates that they are focused on delivering evidence-based best practice, noting participation in 91% of national clinical audits and 100% of national confidential enquiries. The ICB commends the Trust for their continued commitment to clinical research and for remaining a research active organisation to ensure patients have access to the latest treatments and technologies.

It is noted that in early April 2024, 1,205 case record reviews and 23 investigations had been carried out in relation to 1,227 patient deaths within GHFT during 2023/24. The ICB commends the Trust's commitment to learning from patients' deaths and applying learning from these difficult experiences to drive future improvements in high quality care, as highlighted in the report.

Despite extensive improvement work across the Trust, compliance with the nationally assigned C. Difficile threshold was not met. GHFT reported 37 cases (27 hospital onset healthcare associated and 10 community onset healthcare associated cases) against the national threshold of 23. The continued focus on reducing harm associated with health care associated infections remains central to patient safety and it is essential that a system wide focus is maintained, as the increasing rates of C. Difficile infection remain a significant challenge both nationally, regionally and within the Trust. The Trust's quality improvement approach to infection, prevention, and control in line with PSIRF, will hopefully result in a reduction in cases.

The Trust reported one never event in 2023/24 and the ICB is assured that appropriate learning will be identified as a result of this incident. All never events are managed through the Trust's internal patient safety incident investigation processes. The ICB will continue to work with the Trust to identify learning and appropriate actions in response to never events, gaining assurance through the attendance at the Trust's monthly Patient Safety Learning Panel.

The ICB acknowledges and wholeheartedly supports the Trust's approach to and continued commitment to caring for its workforce and the various initiatives to support staff wellbeing, as highlighted in the report. The Trust is congratulated on the positive results from the NHS Staff Survey which showed a year-on-year increase across all seven people promises, with morale and engagement also seeing an improvement. It was positive to note that 74.4% of staff said they would be happy with the standard of care provided if a friend or relative needed treatment, and 67.4% of staff would recommend the Trust as a place of work, both of which were both improved scores compared to the 2022 survey.

However, as highlighted in the Chief Executive's statement, it is concerning that the staff survey showed a worrying number of staff had been exposed to abuse at work. The ICB is reassured to see that the Trust has identified a number of priority areas to address this. The ICB fully supports the three staff quality priorities for 2024/25, particularly the implementation of the culture programme to introduce a zero-tolerance campaign and empowering staff to report incidents of aggression and incivility.

It is fully acknowledged that ongoing system pressures and industrial action have continued to impact on the Trust's performance across several key national. However, it is positive to note that the Trust achieved two of the three cancer targets: the 28 day faster diagnostic standard and 31-day decision to treat. Consequently, the ICB fully supports the

new quality priority for 2024/25 to reduce waiting times for patients, with a specific emphasis on reducing waiting times for those needing an elective operation so that no one waits more than 52 weeks, reducing waiting times in the emergency department and achieving the 62-day time to treatment cancer target.

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

The Quality Account clearly defines the key priorities for 2024/25, which are aligned to the four domains of clinical effectiveness, patient safety, patient experience, and staff experience. They include detailed explanation of how progress will be measured to deliver safe, clinically effective services and to improve patient and staff experience. The ICB welcomes and fully supports these quality priorities as appropriate areas to target for continuous evidence-based quality improvement, which link well with the commissioning priorities.

The ICB can confirm that to the best of their ability the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2023/24. It is clearly presented in the format required and contains information that accurately represents the Trust's quality profile and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The commissioners look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2024/25.

Richard Scott
Director of Nursing (North)
NENC ICB

May 2024

4.3 Gateshead Healthwatch

Response from Healthwatch Gateshead
Gateshead Health NHS Foundation Trust
Annual Quality Account 2023/24
10th June 2024
Healthwatch Gateshead welcome this year's Quality Account as it shows that Gateshead Health NHS Foundation Trust (GHFT) have continued to focus their approach and they

are working to achieve their ambitions. We welcome the continual review they are undertaking to ensure that resources are used effectively, and we support their continued vision to deliver outstanding and compassionate care to our patients and communities.

We welcome the endeavours taken by GHFT to achieve the priorities it set for 2022/23. Healthwatch Gateshead especially welcomes the work done following on how they learn from deaths, improving the safe procession of clinical results, strengthening collaborative patient forums and listening to staff's experiences. Healthwatch Gateshead would like to commend GHFT for their work in this year Healthwatch Gateshead welcomes the priorities chosen by GHFT for 2024/25 that cut across all the four quality domains.

- Clinical effectiveness

  Healthwatch Gateshead welcomes the activities that GHFT are developing to embed the safe processing of clinical results and to use quality metrics to drive improvements in patient care.

- Patient experience

  Healthwatch Gateshead supports the implement of the Patient Safety Incident Response Plan and the aim to improve the safety of patients with mental ill health in the acute setting.

- Patient safety

  Healthwatch Gateshead supports the priorities to reduce the waiting times for patients, improve the experiences of people with a learning disability, mental health or autism and strengthening the carers passport.

- Staff experience

  Healthwatch Gateshead supports GHFT priority to improve the way they listen, act upon and learn from concerns, and intend to increase staff engagement.

Overall we welcome the priorities for 2024/5 and the clear focus on service user experience throughout. Alongside patient experience, we strongly encourage the trust to continue to improve how families and carers views are heard and involved.
We encourage the trust to work with partners, such as Healthwatch, to understand the experience of patients, families, carers and the wider community, in addition to the internal mechanisms you are implementing. Patients tell us that it is the holistic view of their care and support that is important to them.

We know timely care is a key priority for our residents and they are increasingly concerned about delays within the NHS. This applies across all services including urgent and emergency care services as well as community and clinical pathways. Waiting times continue to be highlighted as a particular concern from our residents. A key element of this is communications with those on waiting lists so that they don't 'feel forgotten about'. This includes timely sharing of test results.

We have heard concerns from residents about the transition between different services and are surprised that this isn't more of a focus within your priorities. This includes handovers between ambulances to the emergency department, GP referrals and

handovers to social care/community support when people are leaving hospital. Patients tell us that it is the holistic view of their care that is important to them.

The inclusion of strengthening the Carers Passport within the Trust as a priority is most welcomed. As the identification of carers and connecting carers to appropriate support is also an issue we hear a lot about, particularly connecting carers to support in their local communities.

Healthwatch Gateshead thank you for sharing the draft quality account for our comment. We would like to thank everyone at GHFT for their continuing commitment to provide a quality and safe service to the communities and we look forward to further working in partnership with GHFT over the next twelve months.

Michael Brown
Chair of Healthwatch Gateshead

The role of Healthwatch Gateshead.
Healthwatch Gateshead is an independent, not-for-profit service. We help people of all ages and from all backgrounds have their say about social care and health services in Gateshead. This includes every part of the community, so we give a voice to people who sometimes struggle to be heard. We also offer free, confidential and independent information about social care and health services in the area.

Healthwatch Gateshead is one of 153 Healthwatch groups in England and each local authority is linked to a Healthwatch for their area. We have statutory powers under the Health and Social Care Act 2012, including the ability to:

- Request information from commissioners and service providers (they have to respond within 20 days).

- Visit publicly funded health or social care services to see how they are working (known as 'enter and view' visits).

- Represent the views of the public on the Gateshead Health and Wellbeing Board.

Healthwatch Gateshead works to make sure that the people who plan and run social care and health services are listening to their service users. When people's voices can be heard, we can make positive change. Together, we can create services that cater to what real people actually need and want.

4.4 Council of Governors

The Council of Governors had the opportunity to partake in two dedicated workshops on the development of the Quality Account and quality priorities on TBC and TBC. In addition, the completed draft of the Quality Account was shared with all Governors as part of the consultation process. We have used our knowledge of the Trust gained through attendance at meetings and other engagement opportunities during 2023/24 to determine whether the content of the document presents a fair reflection of the achievements, challenges, risks and opportunities experienced during the year, as well as whether the quality priorities for 2024/25 are focussed on what we feel are the key areas.

In general, we believe the document is well presented, concise, comprehensive and informative. However, we do feel that it is difficult to provide a full comprehensive feedback on the draft document as there is some data missing particularly within the priorities for 2024/25.

We also shared a number of specific points for consideration:

- Inclusion of the Council of Governors and their role within the organisation would be welcomed; we understand this has subsequently been added to the Glossary of Terms.

- Volunteers Service development is positive, however would like to see further roles developed as many areas of the hospital would benefit from the support of volunteers;

- A number of last's year priorities are still ongoing, with the addition of the new priorities, concerned whether all of these are achievable;

- Addition of further positive initiatives that have taken place throughout the year e.g. Improvement Quality in Liver Services 'deferred' status and engagement with local schools in the promotion of Organ Donation would be welcomed.

We also expressed concern around the tight deadline that was given to provide feedback on such a comprehensive document.

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

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

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

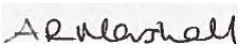
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2023 to March 2024
    - papers relating to quality reported to the board over the period April 2023 to March 2024
    - feedback from Northeast and North Cumbria Newcastle Gateshead Integrated Care Board dated – 22/05/2024
    - feedback from governors dated – 15/05/2024
    - feedback from local Healthwatch organisations dated – 10/06/2024
    - feedback from Overview and Scrutiny Committee dated – 07/06/2024
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – not yet published
    - the 2023 national patient survey – March 2024
    - the 2023 national staff survey – March 2024
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated – May 2024
    - CQC inspection report dated CQC Inspections and rating of specific services dated – 14/08/2019
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts

regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Date: 26.06.24 Chairman: 

Date: 26.06.24 Chief Executive: 

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Research
Clinical research and clinical trials are an everyday part of the NHS and are often conducted by medical professionals who see patients. A clinical trial is a particular type of research that

tests one treatment against another. It may involve people in poor health, people in good health or both.

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

Special Review
A special review is carried out by the Care Quality Commission. Each special review looks at themes in health and social care. They focus on services, pathways, and care groups of people. A review will usually result in assessments by the CQC of local health and social care organisations as well as supporting the identification of national findings.

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

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