



Quality Account 2009-10



Chief Executives Statement

As Chief Executive I can confirm that the Trust Board is fully committed to ensuring that the Trust provides the highest quality care to our patients in a safe, clean environment.

Quality and safety of patient care are identified within our main corporate priorities. Following its launch in 2007, our SafeCare Programme, which is aimed at improving the safety and quality of patient care, has become firmly embedded within the organisation. The SafeCare Programme has been driven by the Board, and staff have actively engaged in the challenge of making quality and safety the Trust's top priority.

2009/10 has seen many independent acknowledgements of our focus on the quality of the services we deliver for our patients:

- We were awarded a double 'Excellent' by the Care Quality Commission in the latest Annual Health Check process
- We were acknowledged as one of the top 25 trusts in the country for reporting and submitting patient safety data by the national Patient Safety First Campaign
- We achieved full marks in an assessment by the NHS Litigation Authority – one of only 10 Trusts in the country to achieve this. The Trust achieved full compliance across all 50 areas examined at level 3 -which is the highest level of assessment possible.

We have continued our robust management of Healthcare Associated Infections which, through the combined efforts and commitment of staff, has resulted in a further 50% reduction year on year in Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia – representing a 75% reduction over the past two years.

It is important to acknowledge that the NHS has undergone a significant shift with regard to the delivery of quality, safety and clinical effectiveness with a greater emphasis on measurable outcomes of care. This is set against the background of a tighter financial climate in future years. The Trust will therefore be working even harder to secure further improvements in these areas.

The text which follows provides an update on our key priorities for 2009/10 and for quality improvement during 2010/11.

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



Signed: Ian Renwick, Chief Executive Date: 19 May 2010

1. Priorities for Improvement

2.1 Review of Quality Performance in 2009/10

The Trust published its first Quality Report in 2008/09 in which it identified 4 priority areas for improvement in 2009/10. The following section provides an update of performance against these priorities and a summary of work undertaken.

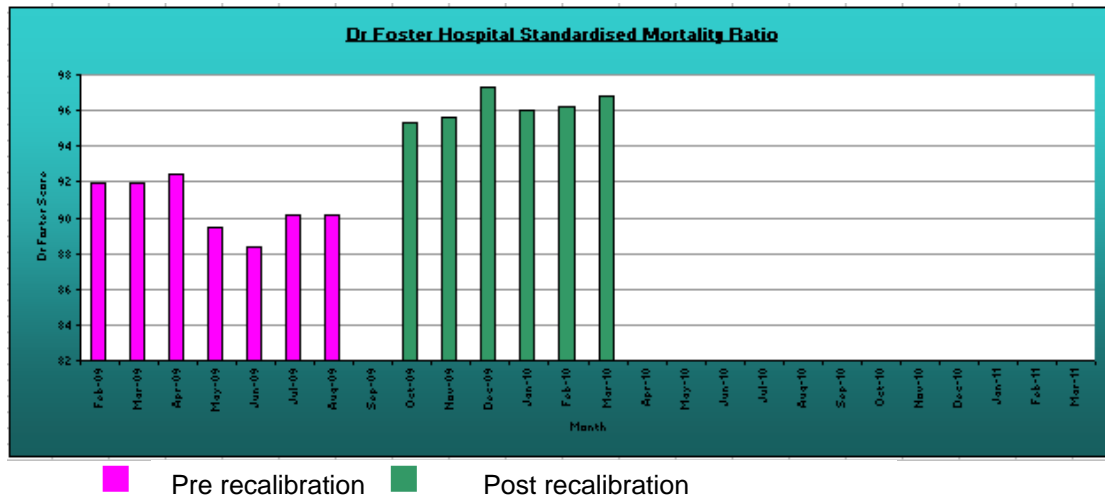
Priority 1: To reduce avoidable mortality.

The Trust's overall aim is to reduce avoidable harm and deaths within the hospital. A recognised indicator of safe and clinically effective care is the Hospital Standardised Mortality Ratio (HSMR). It is a measure of a Trust's actual number of deaths during the year compared to how many would be expected. The prediction calculation takes into account factors such as age, sex, diagnosis and presence of other diseases. The national average is 100, therefore if a Trust has a HSMR of less than 100 this means that the number of deaths is less than would be expected, a HSMR of more than 100 indicates more deaths than would be expected.

Aim/Goal set for 2009/10

To reduce our 1 year Hospital Standardised Mortality Ratio (HSMR) as defined by Dr Foster from 92.43 to 90 in 2009/10

Performance in 2009/10



The table above shows the Trust's performance. In 2009, Dr Foster made a number of adjustments to their calculation of HSMR including a process of recalibration, or setting the average, rather than using a rolling average. As a result the numbers become less useful other than as a measure of performance against the average. This has therefore made direct year on year comparison of the Trust's performance very difficult. However despite the many changes the Trust's HSMR remains below 100 i.e. less deaths than expected.

	2007/08	2008/09
HSMR	90	89
Recalibrated HSMR	92	96

The Trust has used an additional measure, crude mortality, to assess mortality on an ongoing basis. Crude mortality is calculated using actual deaths divided by the spells. The data below represents the Trust's mortality ratio for all admissions and for emergency admissions.

Baseline Comparison	2007/08	2008/09	2009/10
Crude mortality (all admissions)	3.03%	2.94%	2.74%
Crude Mortality (emergency admissions)	4.16%	3.94%	3.71%

It indicates a reduction in mortality between the two years, which is contrary to the findings published by Dr Foster.

The Department of Health has established a Working Group that will review the use of HSMRs and their value within the NHS. They will provide more detailed advice about how Trusts can monitor and benchmark using hospital mortality data in the future. In the meantime, the North East Quality Observatory System will provide reports, advice and support to Trusts and PCTs in NHS North East to look at hospital mortality. This will supplement our internal arrangements.

Initiatives implemented in 2009/10

The Trust was proactive in implementing a comprehensive programme of action aimed at reducing the HSMR.

- Continued programmes of improvement work related to :
 - Further reducing Health Care Associated Infections
 - Rescuing the deteriorating patient.
 - Medications safety
- Implemented the World Health Organisation Surgical Safety Checklist to reduce the risk of errors during surgery.
- Developed and piloted a framework to facilitate structured multidisciplinary mortality case note review that facilitates the identification of sub optimal practice and adverse events, action planning and a reporting system for sharing lessons learned as well as highlighting good practice from the ward to the board.
- Implemented Quality and Safety Executive walkabouts conducted by executive directors and senior clinicians. These enable staff and patients to identify any concerns re quality and safety of care. As a result specific actions are taken to address these concerns.
- Maintaining a safe hospital at night programme of work.
- Utilisation of Global Trigger Tool in identifying areas for improvement in 2010/11.

Priority 2: Further reduction in our Healthcare Associated Infection Rates

Further reduction of Healthcare Associated Infection was a high priority in 2009/10.

Aim/Goal set for 2009/10

Each year the Trust is given an improvement target from the Department of Health for both MRSA and Clostridium Difficile. Within last year's Quality Report the Trust set more challenging local targets for achievement as detailed below. The Department of Health (DOH) targets are indicated in brackets.

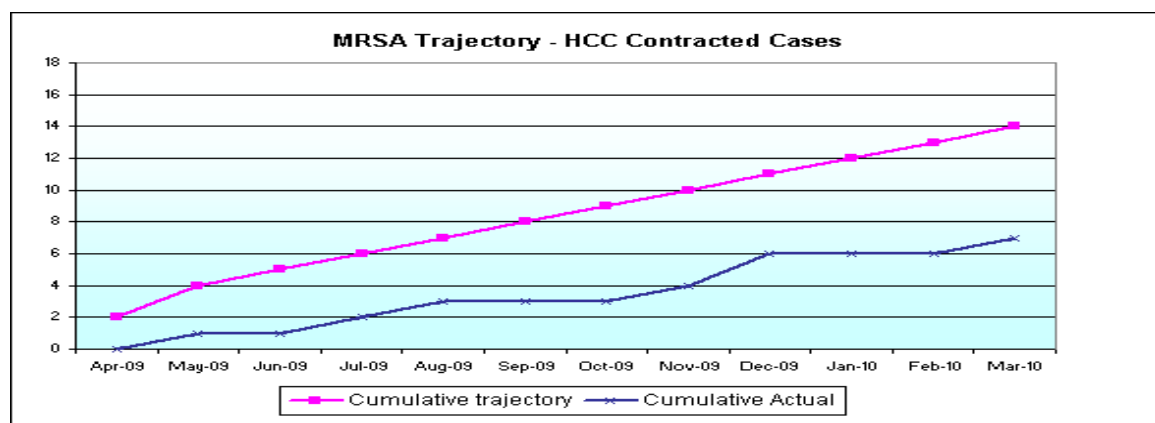
1. To reduce the number of MRSA bacteraemia from 16 in 2008/09 to 12 (14 DOH Target) in 2009/10
2. To reduce the number of Clostridium Difficile from 107 in 2008/09 to 100 (128 DOH Target) in 2009/10

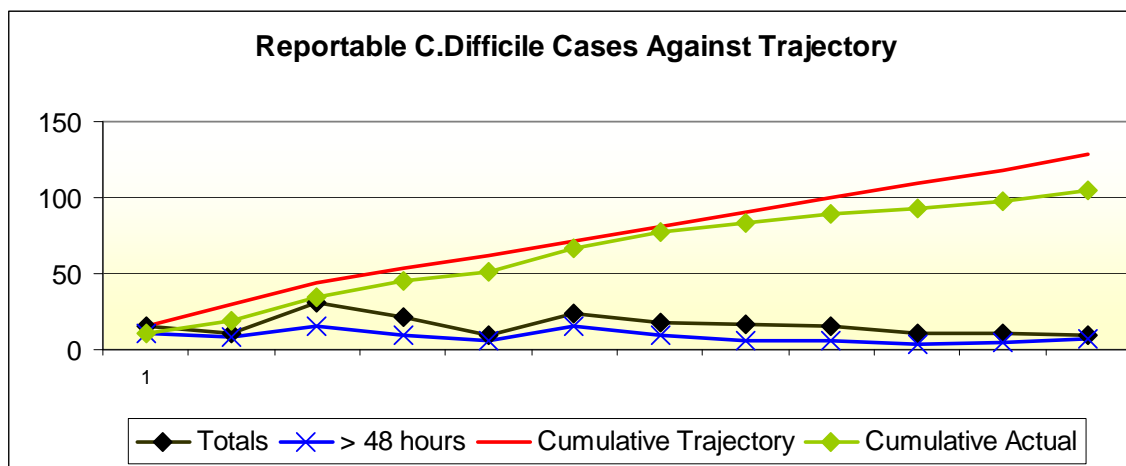
Performance in 2009/10

For 2009/10 we reported a total of 8 MRSA bacteraemia against a target of 14 (representing a reduction of 50% on 2008/09 levels). During 2009/10 the Department of Health directed that cases occurring within 48 hours of admission should be attributed to the PCT. Of our year end total, 7 are attributable to the Trust and 1 to the PCT. As a consequence of this split, our target for 2010/11 has been split to reflect 5 for the Trust and 2 for the PCT. We reported 105 Clostridium Difficile occurring post 72 hours from admission meeting the DOH target.

Performance in 2009/10

For 2009/10 we reported a total of 8 MRSA bacteraemia against a target of 14 (representing a reduction of 50% on 2008/09 levels). During 2009/10 the Department of Health directed that cases occurring within 48 hours of admission should be attributed to the PCT. Of our year end total, 7 are attributable to the Trust and 1 to the PCT. As a consequence of this split, our target for 2010/11 has been split to reflect 5 for the Trust and 2 for the PCT. We reported 105 Clostridium Difficile occurring post 72 hours from admission meeting the DOH target.





Initiatives implemented in 2009/10:

MRSA

MRSA related bacteraemia rates have fallen during 2009-10 to 8, against a trajectory of 14. Robust root cause analysis has been invaluable in supporting ward staff across the health economy to maintain best practice.

- The programme of work has ensured the continued use of the five performance indicators of hand hygiene, uniform/work attire compliance, intravenous therapy management, urinary catheter management and equipment monitoring for cleanliness and repair. With practice embedded within this weekly monitoring initiative expansion of the new programme for 2010/11 will encompass other significant alert organisms and infections associated with medical devices.
- The continued use of blood culture kits which are supplied in house by the Sterile Supplies Department and are available on a 24 hour basis has directed staff towards compliance with policy.
- To support both the reduction of MRSA bacteraemia or blood infections and the reduction in MRSA colonisation the Trust has adopted the use of a body wash for all elective surgery. In 2010/11 this initiative will be rolled out to the whole Trust.
- MRSA screening for elective patients has been in place since April 2009.
- In February 2010 the Trust was invited by the NHS Institute for Improvement and Innovation to be one of 10 national field test sites to review patient and public perceptions for healthcare associated infection. Pre assessment work, which was particularly proactive in the implementation of MRSA screening for elective patients, was particularly commended by the NHS Institute for Improvement and Innovation.
- Ahead of Department of Health requirements the Trust has initiated emergency screening for some recognised higher risk groups and will continue the programme to ensure it meets screening targets for both elective and non elective patients by December 2010.
- Implementation of a laboratory system to enable progress of MRSA screening swabs as a separate entity within Microbiology services with support from an identified group of lab/infection control staff.

It is important to recognise for patients the difference between:

1. MRSA colonisation, or carrying MRSA bacteria in your nose, throat or on your skin/in a wound when, unless swabbed, the individual would be totally unaware; and
2. MRSA infection –which will be obvious to clinical staff by the clinical signs and symptoms of infection *and* a positive swab for MRSA. For example the patient will have a growth of MRSA which maybe associated with possibly a wound, medical device, urine, chest or a blood infection or bacteraemia commonly called a blood infection. Antibiotics will be taken to treat this illness.

Clostridium Difficile

Clostridium Difficile infection rates acquired post admissions have remained within the national trajectory of 128 with 105 cases notified. The Infection Prevention and Control Team have followed national recommendations for Clostridium Difficile control and introduced a multidisciplinary team approach to management and control of symptomatic patients. Further activity has included:

- Exception reports to Divisional teams on a weekly basis to ensure ownership of issues at ward level and of subsequent actions.
- Further use of the patient surveillance system to allow for shared data entry against patient management.
- Support and engagement of the link persons across the Trust to audit practice.
- Use of an RCA checklist to measure performance and inform any potential links between patients.
- RCA education and training for Matrons participating in validation of practice for patient management.
- Engagement of a gastroenterologist to give immediate input when patients are not responding to treatment or may have other reasons for their continued diarrhoea.

The 2010/11 programme will aim to further embed ownership of national requirements against the Clostridium Difficile objectives which will be finalised shortly to give Trusts an opportunity to reduce their current rates. Work with the primary care trust will continue to ensure that every opportunity is taken to minimise episodes of infection.

Priority 3: To increase the percentage of patients reporting a positive experience

If quality is to be at the heart of everything we do, it essential that it is understood from the perspective of the patient.

Aim /Goal set for 2009/10

The Trust chose the methodology used by the DOH to monitor patient experience against a group of indicators (Vital Sign VSB 16). The Department of Health tool selects a wide range of metrics from the annual inpatient survey, staff satisfaction survey and complaints procedures and combines the metrics to produce an aggregate score/trajectory. The Trust agreed the performance target below to use as the chosen measurement tool for reporting positive patient experiences.

		2008/09	2009/10
VSB16/01	Focus on the person score	76.0	88.0
VSB16/02	Focus on dignity and respect score	90.0	95.0
VSB16/03	Focus on improving as an organisation score	47.0	59.0
VSB16/04	Overall score	71.0	80.7

Performance 2009/10

The Department of Health has not yet released the tool kit to produce the composite scores against the vital sign methodology. In the absence of the national data, the table below represents an attempt to (where possible) track the changes in measures which combine to produce the aggregate score.

Focus on the Patient	2008/09	2009/10
Percentage of written complaints about services resolved locally within the 25 day limit	92%	81%
Patients family or someone close have the opportunity to talk to a doctor if they needed to	57%	54%
Patients found a member of hospital staff to talk to about worries & fears	53%	51%
Whilst in an emergency department, were patients able to get a member of staff to help if they needed attention?	Not available	Not available

Organisations that learn from experience	2008/09	2009/10
Percentage of staff who reported that in the last month they had not seen any errors, near misses or incidents that could have hurt patients/service users	80%	82%
During their hospital stay, patients were asked to give their views on the quality of care	26%	23%
Whilst in hospital, patients saw posters or leaflets explaining how to complain about the care or treatment they received	59%	64%

Dignity Privacy & Compassion	2008/09	2009/10
When first admitted, patients did not share a sleeping area with a member of the opposite sex	90%	87%
Patients did not have to use the same bathroom or shower area as patients of the opposite sex	86%	87%
Patients were given enough privacy when discussing their condition or treatment	82%	77%
Whilst in the Outpatients Department, patients were given enough privacy when discussing their condition or treatment	89%	83%
Whilst in the Outpatients Department, patients were given enough privacy when being examined or treated	92%	93%

Initiatives implemented in 2009/10

Organisational Learning

- Promotion of a culture of open communication and the development of structures and frameworks to enable this. Consultation and feedback on safety and quality issues is through the SafeCare meetings that are held at ward, specialty, divisional and Trust level. These provide an opportunity for sharing learning gained from a range of sources such as incident investigation, complaints, audit, national guidance, policy and practice development.
- Within services, mechanisms have been developed for ensuring that where lessons can be learned, these are shared with relevant staff so that staff understand the reasons for any changes that are implemented.
- Internal media has been utilised to promote safety awareness through the issue of SafeCare Alerts and Good Practice Bulletins, Newsletters, SafeCare web site, posters.
- The Trust has supported local and Trust wide SafeCare half days where good practice and lessons learnt have been shared.
- Implementation of multidisciplinary mortality case note review.

Privacy and Dignity

Review of training and education

- Work has been undertaken throughout the year to raise the profile of privacy and dignity through induction and mandatory training, other education programmes and the Privacy and Dignity Annual Conference. The Trust now has a robust system in place supported by divisional SafeCare events and collaborative working with Higher Education Institutions. It is hoped that this work will be progressed in the coming year through an e-based learning tool.

Delivering Same Sex Accommodation

- Following a major programme of work the Trust has been able to declare compliance with Delivering Same Sex Accommodation. The work included estates refurbishment on some of the wards, converting some of the wards to all same sex, adjustments to patient flow in MAU, changes to the bed management documentation and process of escalation in the event of a potential breach. Work was also done to raise awareness of the principles of DSSA with staff. An extensive communications exercise using posters and leaflets ensured that patients' expectations were managed. Patient opinion was sought on all wards by the Patient Panel who undertook a questionnaire with current patients relating to their experience of single sex accommodation within the organisation – the outcome of which was very positive.
- The Strategic Health Authority Peer Review, which took place in December 2009, gave very positive feedback on the whole package of work delivered.

Patient's and users can find out more by accessing the Trust's website homepage and clicking on the appropriate icon.

Audit programme

- A coordinated programme of audit and assessment is completed on an annual basis. In addition the Steering Group undertook a bi-annual privacy and dignity self assessment using the NHS Institute for Innovation and Improvement documentation. The outcome indicated a high level of compliance in all areas.

Complaints, Patient Advice and Liaison Service and Datix incident reports

- The PALS manager presents a quarterly report to the Steering Group which collates complaints, PALS and incidents where privacy and dignity was identified to be an issue.
- A mandatory field was added to the Datix incident reporting form in December 2009 to make it easier to identify the incidents that had a privacy and dignity element.
- During 2009/10 there were:
79 PALS issues raised regarding privacy and dignity
21 Datix forms completed
14 complaints

Many of the issues were dealt with successfully through discussion and local resolution and some common themes were identified:

- Lost property in particular dentures
- Lack of assistance with personal needs
- Lack of accessible wheelchairs
- Lack of privacy/confidentiality such as being overheard at reception or being given information in an unsuitable place

In response to the common themes identified, the Trust has taken the following action:

- To make sure that the appropriate documentation is completed in relation to property, in particular on transfer between wards or if a patient attends another department for a procedure
- Feedback is given to individual wards by the PALS officers and is picked up by the Matron in that area. Matrons in medicine have adopted a drop in session for patients and relatives to allow them to voice any concerns
- Work is being undertaken in outpatients around self service check-in to allow patients greater privacy when registering. All wards have a designated quiet area to enable private conversations to take place

Enabling Technology

- We have introduced a system of real time patient satisfaction monitoring, using a package developed by Dr Foster Intelligence. This involves the collection of data based on 5 questions using a combination of hand held and static devices. Over time, the Trust will be able to measure its own progress at an organisational and departmental ward level with further potential to benchmark externally. Over 1,100 patients provided feedback within the first month of its use, March 2010. An organisational score of 92% was achieved

Priority 4: To implement a Strategy to improve medication safety

Medication errors can cause unnecessary pain and harm to patients and can even lead to death. Safer medication is everybody's business and small changes can make a real difference in reducing harm to patients.

The fourth report from the Patient Safety Observatory – 'Safety in doses: medication safety incidents in the NHS', identifies seven priority areas for action for NHS organisations.

Aim /Goal in 2009/10

We will develop and implement a strategy to improve medication safety using these seven key themes as a framework. From the seven key themes we prioritised two key areas for improvement in 2009/10:

1. Increase reporting and learning from medication incidents

Objective - To improve the quality of medication incident reports by:

- increasing the number of reports which include the medicine name
- reducing the number of medication errors classified as "other"

Within the Trust all medication incidents reported through the Datix system are reviewed quarterly through the Trust Medicines Governance Group. However, the quality of these reports has the potential for improvement, especially related to the level of detail recorded. Improving the quality of reporting will enable greater learning and identify the key areas to be addressed to improve medication safety.

2. Improve staff skills and competencies

Objectives – To improve staff knowledge and skills related to high risk medicines through:

- the assessment of health care professionals' practice and understanding of medication safety
- the delivery of education and training programmes focusing on high risk medications
- the development of user friendly protocols and policies in key areas

The Trust provides various education and training opportunities related to medicines including a safe prescribing module to F1 doctors and a training day for preceptorship nurses. However, ongoing competency assurance is a challenge and is a key requirement for NHSLA levels 2 and 3.

Performance and Initiatives implemented in 2009/10

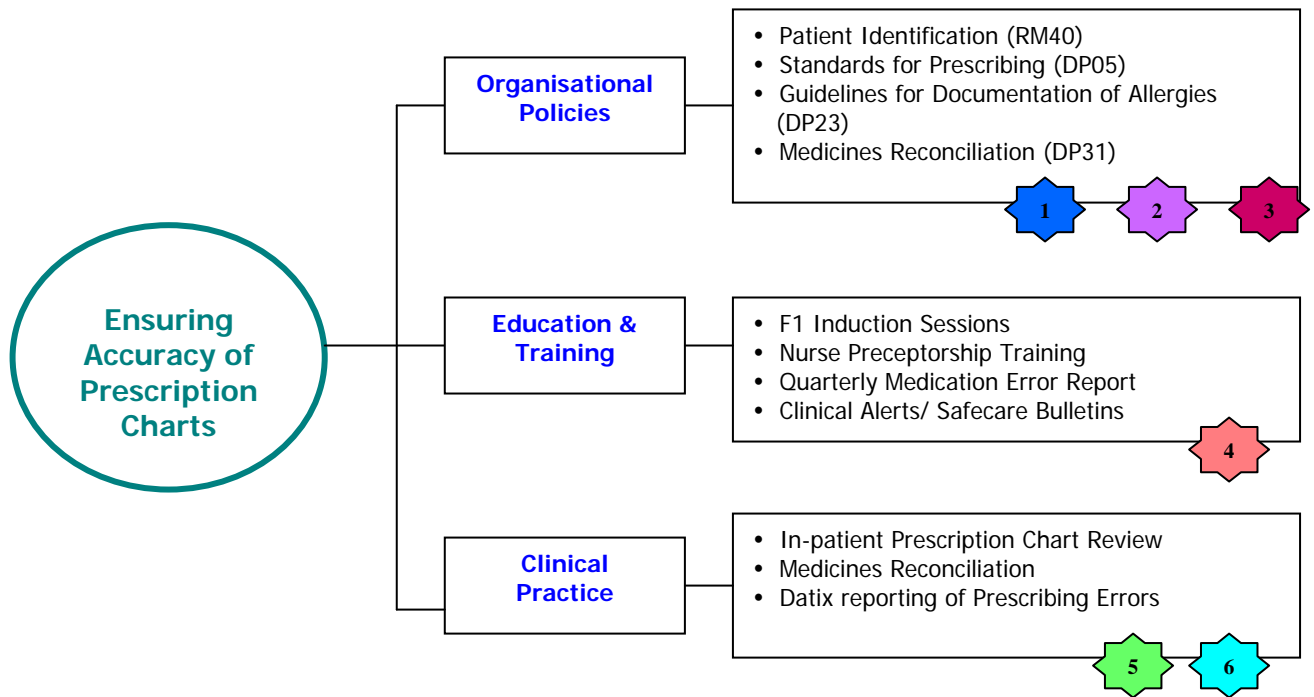
- **Development of the Datix reporting system and user guidance**
The Datix system is constrained by the requirements of the National Patient Safety Agency which has resulted in "other" being the most frequently selected error classification. Work is ongoing with the Datix management

team to increase the range of error types linked to each stage in the process. More positively the drug name is now a mandatory field as National Reporting and Learning System feedback had indicated that the drug name was often missed off medication error reports

- **Implementation of a programme of audit to identify areas for improvement**

The audit of medicines management during 2009/10 enabled the Trust to attain NHSLA Level 3. This required development of a portfolio of evidence to assure the accuracy of in-patient prescription charts. Documentation of the processes undertaken to support medicines reconciliation were formalised through a new formal drug policy and a review of the standards for prescribing as described by an existing policy. A driver diagram approach was adopted to bring the evidence together in a single document for presentation to the assessors. Six measures were identified and baseline data was collected for each of these. This will provide a framework to ensure audit data is captured in a consistent manner to facilitate the monitoring of change over time.

Driver Diagram: Ensuring the Accuracy of In-patient Prescription Charts



Metrics



Annual audit of Standards of Prescribing - F1 Doctor



Quarterly audit of Patient Identification on In-patient Prescription Chart – Health Records



Quarterly audit of Allergy Status Recording on In-patient Prescription Chart – Health Records



Quarterly audit/report of Medication Errors reported via Datix System – Pharmacy



Quarterly audit of in-patient prescription chart pharmacist review – Pharmacy



Quarterly audit of medicines reconciliation – Pharmacy

- **Utilisation of the Global Trigger Tool medication module to identify harm events**

Even in the highest reporting organisations it is recognised that many incidents are not reported. A proactive method of data capture has been explored utilising the Global Trigger Tool medication module to track use of medication antidotes, flumazenil, glucagon and glucose 25%. All ward stock has a travelling card attached and nurses are requested to return this to pharmacy when used with the patient identification number. Each case where flumazenil has been used is reviewed and any learning shared with relevant staff. This has led to improved prescribing of midazolam within the Trust.

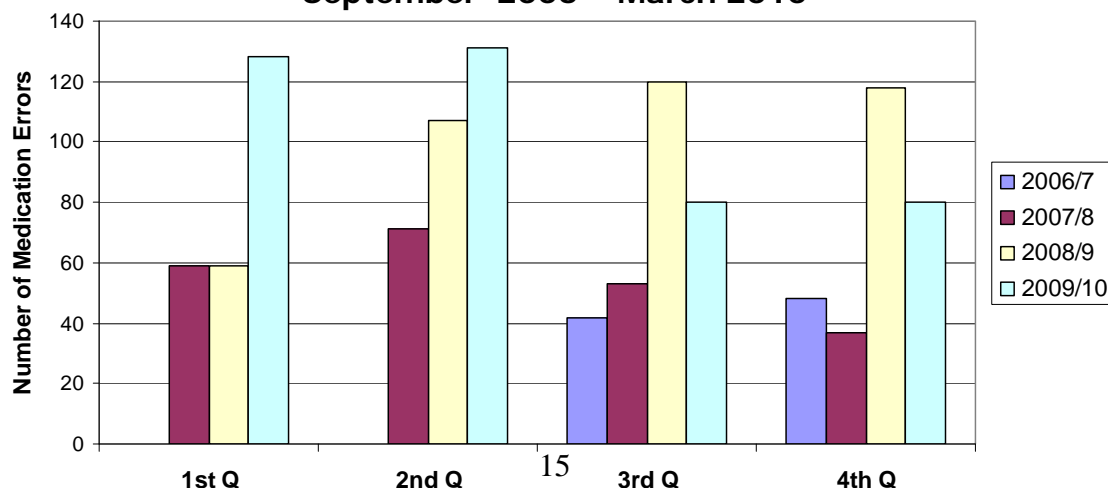
- **Support health care professionals in developing their skills and competencies in medicine management through the delivery of education and training programmes focusing on high risk medicines with an initial focus on Insulin**

E-learning has been agreed as the way forward to support health care professionals in developing their skills and competencies in medicine management. An external package has been identified but adaptations are required to meet the needs of this organisation.

- **Develop more detailed feedback reports to staff at all levels related to medication incidents**

Pharmacy has continued to analyse all reports through Datix classified as a medication incident. A summary report is presented quarterly to the group to identify key issues and actions to improve patient safety. A number of medication incidents are avoidable. The National Patient Safety Agency (NPSA) recognises that organisations that report more incidents, especially near miss or those with no adverse outcome on that occasion, usually have a better and more efficient safety culture. To promote learning and encourage further reporting the main points are disseminated and shared Trust wide through the combined Complaints, Litigation, Incidents, PALS and Audit report (CLIPA) and a section in the SafeCare newsletter. Incident reporting has more than doubled since the introduction of the Datix reporting system and for the period 1 October 2008 to 31 March 2009, this Trust was the 3rd highest reporter of medication incidents reported to the National Reporting and Learning System (NRLS) in our cluster group which reflects a good culture of reporting.

**Medication Error Reporting
September 2006 – March 2010**



- **Quantify baseline of omitted doses, contributory factors and clinical relevance to shape our strategy for improvement**

This work was delayed waiting for the anticipated NPSA alert. In preparation the algorithm to describe the appropriate actions when medicines are unavailable was reviewed. This was distributed to all ward areas to raise awareness of the detrimental impact missed doses can have on patient outcomes and to encourage ownership at ward level to reduce the medication incidents of this type.

- **Undertake an assessment of practice of health care professionals through a series of initiatives to gather information on current safety issues**

Focus groups were undertaken seeking the views of nursing staff on current medicines management supply services. The results are currently being analysed.

2.2 Quality Improvement Priorities for 2010/11

Following Board consideration of our analysis, this year the Trust has identified 6 priority areas for quality improvement:

- Priority 1: To reduce avoidable mortality
- Priority 2: To further reduce our Healthcare Associated Infection Rates
- Priority 3: To improve medication safety
- Priority 4: To reduce harm from falls
- Priority 5: To reduce the prevalence of grade 2 and above pressure damage
- Priority 6: To increase the percentage of patients reporting a positive experience

To determine these priorities we considered:

- Each Division's SafeCare plans and identified priorities
- Internal and external data sources and reports including Care Quality Commission standards, NHSLA standards, NPSA alerts, local and external audits and analysis of complaints and incident reports.
- Feedback from our patients.
- Existing quality improvement work and priorities identified in the 2009/10 accounts. The Trust views the Quality Report/Accounts as a means of accounting and communicating to the public on our continuous quality improvement work. The reports will build on each year's work, hence a number of the quality improvement priorities identified in this year's report have been continued into 2009/10 to ensure actions and improvements are fully embedded.
- Alignment with our SafeCare Strategy 2010/13.
- Issues of concern to our Governors, our workforce and our local health care partners.

Each of the priorities for 2010/11 and proposed initiatives are described in detail on the following pages including how these will be measured, monitored and reported.

Priorities for 2010/11

Domain: Clinical Effectiveness

Priority 1: To reduce avoidable hospital mortality

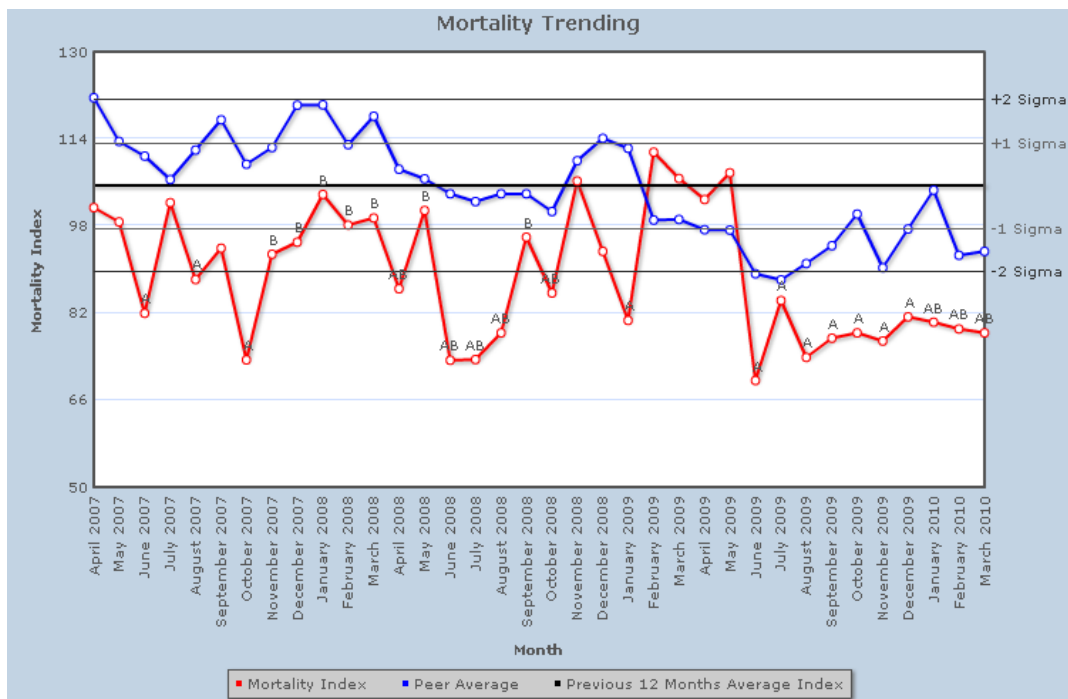
Description of issue and rationale for prioritising

Reducing avoidable mortality and harm to patients is at the centre of our SafeCare programme of work. The Trust will use the CHKS risk adjusted mortality index and crude mortality rate to monitor hospital mortality. The rationale for this is that it will link with other information provided within the region by the Strategic Health Authority. Also the Department of Health are presently undertaking a review of the national mortality indicators and once this work is concluded CHKS will replicate these indicators for use within their current programme.

Current Status

The crude mortality rate has fallen from 3.03% in 2007/08 to 2.74% in 2009/10. A similar pattern is found in the risk adjusted mortality index (RAMI).

The graph below shows the recalibrated RAMI index for three financial years and provides a comparative to the Trust's chosen peer group. For 2007/08 the annual index was 94 and was falling, in 2008/09 the annual index at 91 was lower but it increased towards the year end. However the annual index for 2009/10 was 82 and showed significant decreases which has been maintained.



Aim/Goal

The Trust aims to achieve year on year reduction in avoidable mortality utilising CHKS crude mortality rate and RAMI.

Initiatives to be implemented in 2010/11

- Continue to utilise combination of data to monitor mortality over time. The North East Quality Observatory System will provide the Trust with reports, advice and support to supplement our own internal arrangements.
- Further develop service level mortality reporting.
- Continue to implement multidisciplinary mortality case note review and mechanisms for sharing learning.
- Continue to focus on improvement work streams and interventions addressing key areas that are known to contribute to mortality .
- Utilise Global Trigger Tool to continue to identify and address sources of harm.
- Work with PCT to encourage improvements to community-based care for patients at the end of their lives and prevent inappropriate admissions to hospital and subsequent death.
- Pilot the use of Schwartz rounds - a multidisciplinary forum where caregivers discuss important emotional and social issues that arise in caring for seriously ill patients. Participants engage in an interactive discussion about the issue presented and share their experiences, thoughts and feelings. Rounds enhance communication and promote teamwork among caregivers.
- Quarterly reports to SafeCare Council and 6 monthly to Patients, Quality, Risk and Safety Committee.
- Monthly reports to Trust Board via dashboard.

Domain: Patient Safety

Priority 2: Further reduction in our Healthcare Associated Infection Rates

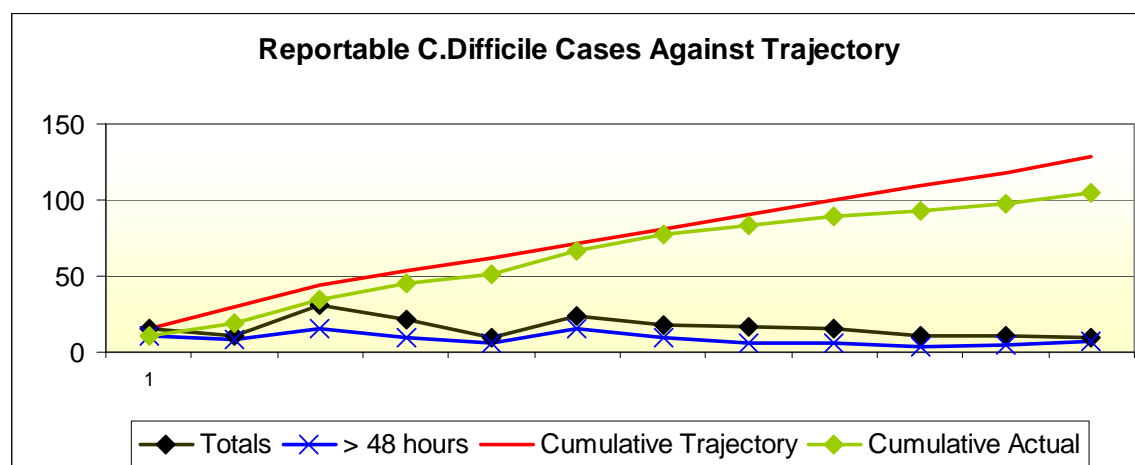
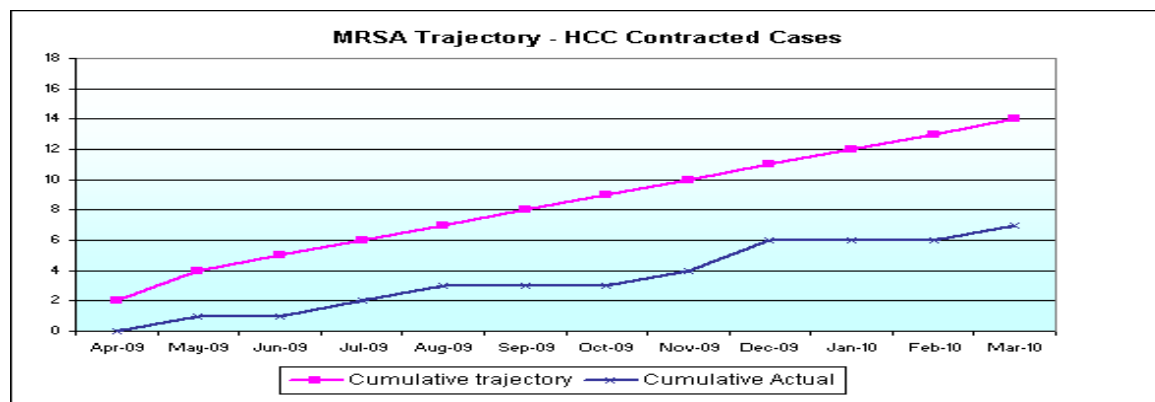
Description of issue and rationale for prioritising

Ensuring that the health of our patients is not compromised by healthcare associated infections is a key strategic priority. A significant improvement has been made over the past two years in reducing MRSA Bacteraemia and Clostridium Difficile, however, further reduction remains a high priority for the Trust.

Aim/Goal:

1. To reduce the number of MRSA bacteraemia from 8 to meet the DOH target which is split at 5 for the Trust and 2 for the PCT.
2. To reduce the number of Clostridium Difficile from 105 in 2009/10 to 90 in 2010/11. The DOH target for 2010/11 is 108, but in 2011/12 will transfer to a bed day rate for the Trust.

Current Status



Initiatives to be implemented in 2010/11:

- Continue to incorporate MRSA bacteraemia related programmes of work into the Annual Forward programme 2010/11 for infection prevention and control.
- MRSA screening compliance.
- Use RCA from MSSA bacteraemia to examine the risk factors and assist across South of Tyne and Wear by correlating results within the Health Protection Agency Healthcare Associated Infection (HCAI) data capture system.
- Use Board to Ward assurances to measure practice against performance for the 5 clinical measures. Develop web based dashboards.
- Validate performance with South of Tyne and Wear health economy by presenting root cause analysis (RCA) outcomes in conjunction with the Primary Care Trust.
- Measure blood culture contaminants which are an indicator of poor practice in blood culture technique.
- Maintain continuous surveillance for MRSA/MSSA bacteraemia and Clostridium Difficile Infection Microbiology department, Consultant Microbiologists, IPCT, Specialist Registrar for IPC, Data coordinator, Administration staff, and specimen generators.
- Measure success and exceptions against the programme of work at weekly local Infection Prevention and Control meetings.
- Monthly progress and exceptions to the Trust Board within the Healthcare associated infection progress report.
- NHS South of Tyne and Wear monthly meetings alternating between performance and developments sessions. Practice and performance IPC meeting.
- Development of an HCAI dashboard to be presented at the bi monthly strategic HCAI committee.
- Work has begun in 2010/11 to expand the Surgical Site Surveillance data set from orthopaedic hip and knee only to include a programme for both local and national data comparison across several specialities in 2011/12. The initial programme will be structured for two years to enable meaningful comparable data.

Priority 3: To improve medication safety

Description of issue and rationale for prioritising

The National Patient Safety Agency reports continue to identify unnecessary pain and harm to patients caused by medication incidents, a number of which could have been prevented. The Trust has an approved strategy to improve medication safety across the organisation based on the fourth report from the Patient Safety Observatory – “Safety in doses: medication safety incidents in the NHS”. This identified seven priority areas for action for NHS organisations.

Aim/Goal

We will continue to build on our established work, based on the 7 themes strategy. We will focus particularly on themes 2,3,5,6 and 7 as detailed below.

Initiatives to be implemented in 2010/11

Theme 2 Implement NPSA safer medication practice recommendations

- To ensure actions are progressed to new NPSA alerts issued involving medicines.
- To engage with NE Strategic Health Authority anticoagulant group as part of Safer Care NE initiative.
- To demonstrate implementation of the care bundle, incorporating the 4 elements described in the Safer use of intravenous gentamicin for neonates.
- To implement needle free device Trust wide to ensure completely closed system of IV drug delivery.

Theme 3 Improve staff skills and competence

- To progress the second e-learning module which will be focussed on drug administration.
- Overhaul and consolidate all trust drug policies into clearer themed documents to facilitate healthcare professionals' access to required information to support safe prescribing, supply and administration of medicines.

Theme 5 Ensure medicines are not omitted

- Between September 2006 and June 2009 the NPSA received reports from Trusts nationally on 27 deaths, 68 severe harms and 21,383 other patient safety incidents relating to delayed or omitted medication. Of all the issues reported to the NPSA across all categories, this is the second largest. There is further concern as it is believed this type of incident is under reported. An alert was issued in February with a one year deadline for Trusts to identify a list of critical medicines in their hospitals and ensure medicines management policies provide guidance on the timeliness of prescribing, supply and administration of these medicines.
- In 2010/11 a programme of work will be developed and implemented that will focus on ensuring medicines are not omitted.

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

- Reduce errors occurring on patient discharge. Work will focus initially on the nurse discharge check list and identifying when/how patient compliance sheets should be issued.
- Manage demand for medicines to be supplied in compliance aids. There is increasing demand for discharge medicines to be supplied in Monitored Dosage Systems (MDS)/compliance aids. This requires huge quantities of tablets to be repackaged, the blister packs used by the Trust are tedious and difficult to fill and as the majority of requests fall outwith the requirements of disablement, disability is unfunded. A recent high profile study of medication errors in care homes identified 40% of doses were not in the MDS. Some designs had inadequate space for all required labels resulting in higher dispensing error rates than for standard containers. The study concluded that dispensing in MDS imposes high demands on pharmacy time yet its contribution to safety is unclear. It is proposed that a tool is developed which must be completed before any new patients are provided with medicines in MDS.

Theme 7 Document Patient's Medicine allergy status

- To consolidate the Model for Improvement methodology piloted on one medical ward and roll out to other wards across the organisation.

Performance will be monitored by and reported to the Medicines Governance Group bi monthly, SafeCare Council 6 monthly and an annual report to the Board.

Priority 4: To reduce harm from falls

Description of issue and rationale for prioritising

Across England and Wales, approximately 152,000 falls are reported in acute hospitals every year, with over 26,000 reported from mental health units and 28,000 from community hospitals. A proportion of these falls result in moderate, major and catastrophic consequences for the patient. Falls are consistently our top reported incidents in the Trust with approximately 50% of these resulting in some form of harm to the patient.

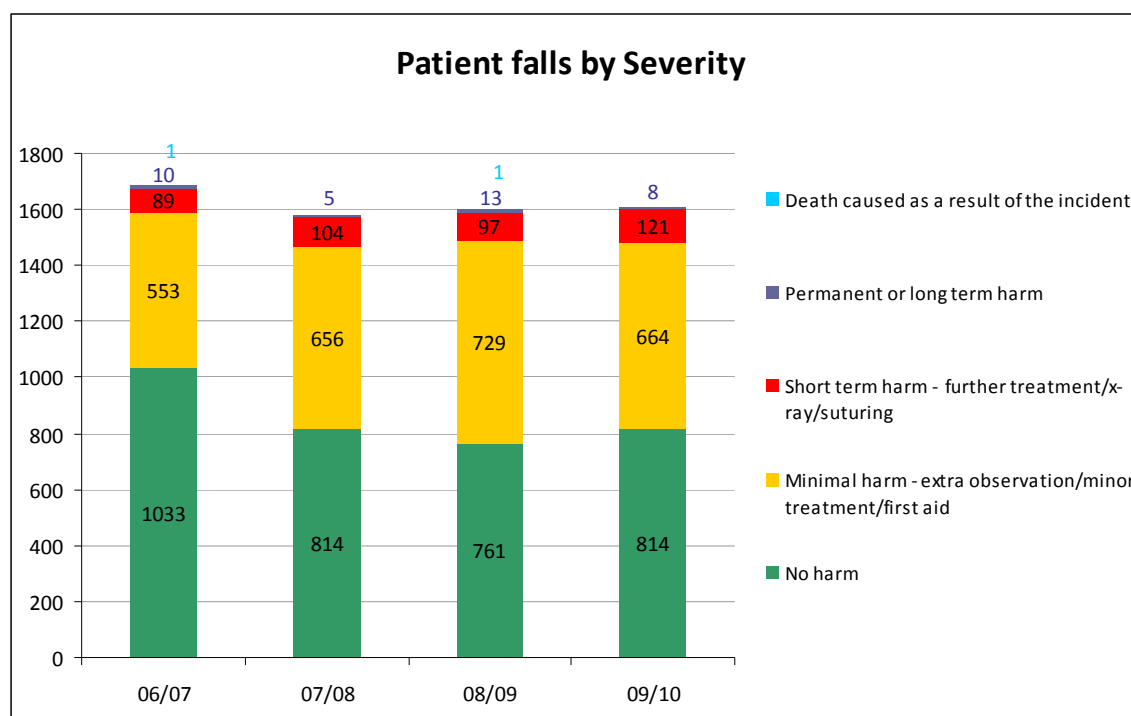
Aim/Goal

To reduce the incidence of falls by 10% and the number of incidents resulting in harm by 10% in 2010/11.

Current Status

The graph below shows the incidence of falls by degree of harm. Minimal and short term harm are the most frequently occurring with the numbers having remained relatively static for the past three years.

Whilst the number of falls remains static, over the past 3 years there has been an increase of 4.2% in Trust activity from the baseline of 2006 to 2009/10 and this should be taken into consideration. In the future this will be calculated at a rate of falls per 1,000 bed days which will take activity into account.



Current Initiatives

- Gateshead has had an established falls team for several years. Work has been undertaken in line with the National Service Framework for Older people (2001) and NICE guideline 21(2004).
- All clinical areas use the Trust risk assessment tool, which is audited regularly.

- A quarterly report is produced via the Datix incident reporting system. Data is broken down by ward and allows identification of "hot spots". Targeted work can then be designed for and implemented for a specific area.
- A training needs analysis has been undertaken and we are working to coordinate training across the South of Tyne and Wear compiled by falls specialists working collaboratively.

Initiatives to be implemented in 2010/11

- Study available data sources to better understand and identify what interventions and programmes of work are required.
- Based on the above, develop and roll out to relevant areas a 'Reducing Harm from Falls' work programme.
- Review findings of recent training needs analysis to identify staff requiring and receiving training in the prevention, reporting and management of falls.
- Develop and implement a plan for falls prevention training that recognises the varying needs of different groups of staff, including doctors, registered nurses, healthcare assistants, porters etc. We will consider various ways of delivering training, including e-learning and ward based teaching utilising 'falls champions' within the services.
- Measure and monitor compliance with falls risk assessment within 24 hours of admission for appropriate patients via monthly health records audit.
- Measure and monitor compliance with implementation of care plans for those patients with a score of 17 or more.
- Consider measurement and monitoring compliance with implementation of 'the 'four basics' in targeted areas utilising the model for improvement methodology.
 1. Ask patients on admission if they have fallen recently
 2. Avoid unnecessary hypnotic and sedative medications
 3. Ensure patients have appropriate footwear
 4. Ensure call bells are in reach
- The Falls Strategic group will monitor progress on a monthly basis and report to SafeCare Council throughout the year.
- Annual report to the Board.

Priority 5: To reduce harm from hospital acquired pressure damage

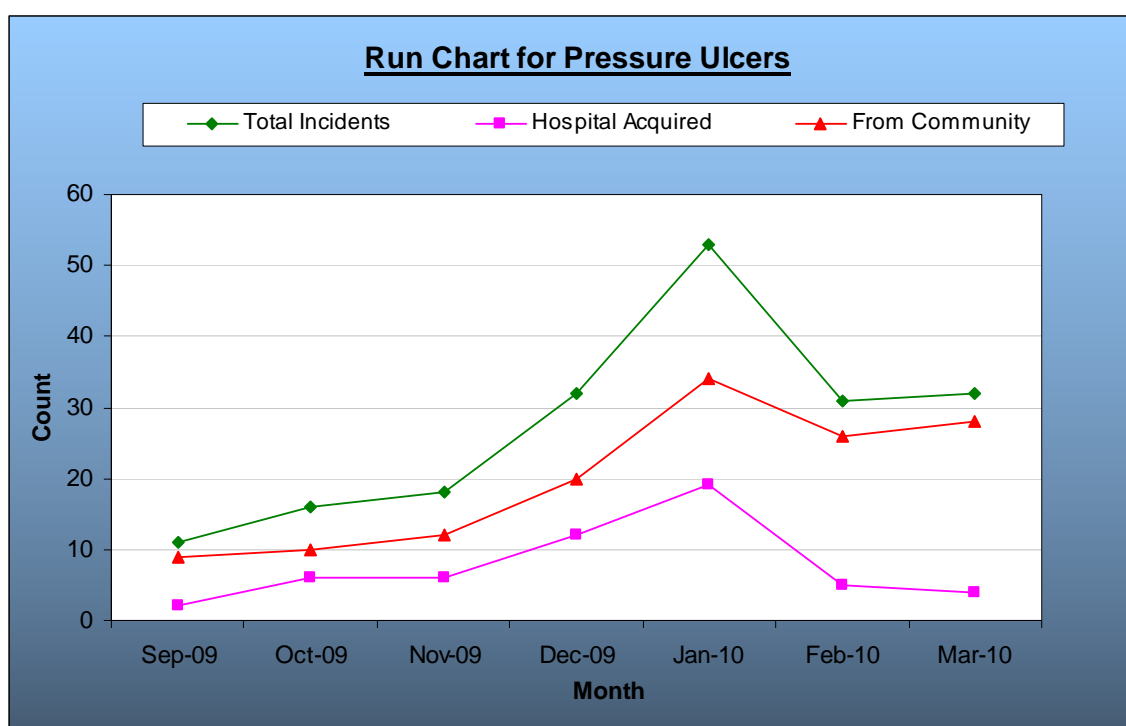
Description of issue and rationale for prioritising

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

Aim/Goal: To reduce the incidence of hospital acquired pressure damage of Grade 2 and above by 30% in 2010/11

Current Status

The Trust monitors the prevalence of pressure damage through both the Datix reporting system and through undertaking six monthly point prevalence studies across the Trust. Until recently, September 2009, the Datix reporting system did not differentiate between patients who had sustained pressure damage before admission to the hospital and patients developing pressure damage during their hospital stay. Therefore prior to September it was difficult to gauge how many patients were sustaining pressure damage within the hospital.



Initiatives to be implemented in 2010/11

- Roll out the rapid improvement programme focusing on key hot spots within the organisation with linked metrics for monitoring improvement.
- Implement a proactive multidisciplinary review of Datix incidents reports and patient follow up using weekly Mattress Hire Company data - Tissue Viability Nurses, Practice Development Team, Infection Prevention and Control Nurses.
- Root cause analysis for all Grade 4 pressure damage with a measure of deterioration through 1-4 damage. RCA will inform risk factors for

deterioration and unavoidable pressure damage which, if all policy has been followed, may be unavoidable.

- Monitoring and reporting will be through a variety of mechanisms at strategic and operational level.
- Initiate formal monitoring for deterioration in pressure damage via proactive patient review and amendments to the data entry set within Datix. This will provide a data set for acute Trust related reduction in 2011/12 when the established data set for pressure damage performance indicators will also be used to measure unavoidable deterioration.

Domain: Patient Experience

Priority 6: To increase the percentage of patients reporting a positive experience

Description of issue and rationale for prioritising

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

Aim/Goal

To improve performance across a range of patient experience measures which affect patient satisfaction. We will focus on the areas of patient experience agreed within our CQUIN scheme. These comprise:

- **A composite of 5 indicators of responsiveness to personal needs that have been identified nationally as requiring improvement :**
 - Q1** Were you as involved as you wanted to be in decisions about your care?
 - Q2** Did you find someone to talk to about your worries and fears?
 - Q3** Were you given enough privacy when discussing your condition or treatment?
 - Q4** Were you told about medication side effects to watch out for when you went home?
 - Q5** Were you told who to contact if you were worried about your condition after you left hospital?
- **The provision of written information for patients on what to do after leaving hospital**

Current Status

Patient Experience	2003	2005	2006	2007	2008	2009	Target
Composite score based on the CQC Inpatient survey	71	71	67	66	73	73	75
The provision of information for patients on what to do after leaving hospital	-	-	-	51	59	56	63

Initiatives to be implemented in 2010/11

- Implementation of privacy and dignity work programme for 2010/11. The action plan has been developed following a group work session of the Steering Group and has specifically considered the quality and patient experience agenda, the national drivers and the 2009/10 work streams that need to be carried forward.
- Monitor patient satisfaction from the patient experience tracker devices and implement action where necessary.
- Roll out of standard discharge information for all inpatients at discharge.
- Implementation of the in patient and out Patient Picker report action plans.
- Monitoring and reporting will be via Patient Carer and Public Involvement Group, SafeCare Council and annual report to Board.

2.3 Statements of Assurance from the Board

Review of services

During 2009/10 Gateshead Health NHS Foundation Trust provided and/or sub-contracted 58 NHS services. Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2009/10 represents 100 per cent of the total income generated from the provision of NHS services by Gateshead Health NHS Foundation Trust for 2009/10.

Participation in Clinical audits and National Confidential Enquiries

During 2009/10 21 national clinical audits and 5 national confidential enquiries covered NHS services that Gateshead Health NHS Foundation Trust provides.

During 2009/10 Gateshead Health NHS Foundation Trust participated in 95% national clinical audits and 80% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust was eligible to participate in during 2009/10 are as follows:

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust participated in during 2009/10 are as follows:

Eligible Audit	Trust Participating
Neonatal Care	Yes
National Diabetes Audit	Yes
ICNARC Adult Critical Care Units	Yes
PROMS	Yes
NLCA Lung Cancer	Yes
NBOCAP Bowel Cancer	Yes
MINAP	Yes
Heart Failure Audit	Yes
NHFD Hip Fracture	Yes

TARN Severe Trauma	Yes
NHS Blood & Transplant: potential donor audit	Yes
National Sentinel Stroke Audit	No this is a biannual audit participated in 2008/09 and signed up to participate in 2010/11
National Audit of Dementia	No this is a biannual audit participated in 2008/09 and signed up to participate in 2010/11
National Falls and Bone Health Audit	No this is a biannual audit participated in 2008/09 and signed up to participate in 2010/11
National Comparative Audit of Blood Transfusion	Yes
National Comparative Audit of Fresh Frozen Plasma	Yes
British Thoracic Society: respiratory diseases	No – Trust were unaware of these audits, however have plans to take part in 2010/11
College of Emergency Medicine Pain in Children	Yes
College of Emergency Medicine Asthma	Yes
College of Emergency Medicine Fractured Neck of Femur	Yes
National Mastectomy and Breast Reconstruction Audit	Yes
National Oesophago-gastric Cancer Audit	Yes
RCP Continence Care Audit	Yes

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

- National Inflammatory Bowel Disease Audit
- National Carotid Endarterectomy Audit
- National Care of the Dying Audit – Hospitals 2nd round
- PbR Assurance Framework Clinical Coding Audit
- Sloane Project
- Surgical Site Infection

National Confidential Enquiry	Trust Participating
NCEPOD - Elective & Emergency Surgery in the Elderly	Yes
NCEPOD – Surgery in Children	Yes
NCEPOD – Parenteral Nutrition Study	No
CMACE – Perinatal Deaths	Yes
CMACE – Maternal Deaths	Yes

The national clinical audits and national confidential enquiries that Gateshead Health NHS Foundation Trust participated in, and for which data collection was completed during 2009/10, 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.

National Audit	Number of cases submitted	Number of cases required	Percentage
Neonatal Care	9	N/A	N/A
ICNARC CMPD: Adult Critical Care Units	1436	N/A	N/A
National Elective Surgery PROMS	670	1091	61%
NCLA Lung Cancer	217	N/A	N/A
NBOCAP Bowel Cancer	108	N/A	N/A
NHFD Hip Fracture Database	299	N/A	N/A
TARN Severe Trauma	190	N/A	N/A
NHS Blood & Transplant: potential donor audit	88	N/A	N/A
National Comparative Audit of Blood Transfusion – Bedside Transfusion	26	40	65%

National Comparative Audit of Blood Transfusion - Fresh Frozen Plasma	36	N/A	N/A
College of Emergency Medicine Pain in Children	50	50	100%
College of Emergency Medicine Asthma	48	50	96%
College of Emergency Medicine Fractured Neck of Femur	50	50	100%
National Mastectomy and Breast Reconstruction Audit	114 patients registered 95 patients operative data submitted	N/A	N/A
RCP Continence Care Audit	58	40	145%
National Diabetes Audit	76 – clinical audit 31 – patient experience surveys	N/A	N/A
MINAP	20	20	100%
Heart Failure Audit	113	20 new cases per month = 240	47%

Additional to the Department of Health List:-

National Audit	Number of cases submitted	Number of cases required	Percentage
National Carotid Endarterectomy Audit	23	N/A	N/A
National Care of the Dying Audit – Hospitals 2 nd round	14	30	47%
PbR Assurance Framework Clinical Coding Audit	300	N/A	N/A
Sloane Project	57	N/A	N/A
Surgical Site Infection	644	644	100%

National Audits that the Trust are participating in that data collection remains ongoing:-

- Sentinel Stroke Audit

- National Audit of Dementia
- National Audit of Falls and Bone Health
- National Pain Audit
- National Cardiac Arrest Audit

National Confidential Enquiry	Number of cases submitted	Number of cases required	Percentage
NCEPOD Elective & Emergency Surgery in the Elderly	2 1 could not be completed 5 2 could not be completed	7 from surgeons 7 from anaesthetists	29% 71%
NCEPOD Surgery in Children	There were no eligible cases for submission to the study	N/A	N/A
CMACE Maternal Deaths	There were no maternal deaths	N/A	N/A
CMACE Perinatal Deaths	21	N/A	N/A

National Confidential Enquiries that the Trust are participating in that data collection remains ongoing:-

- NCEPOD - Peri-Operative Care Study
- CMACE - Child Head Injury

The reports of 10 national clinical audits were reviewed by the provider in 2009/10 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

- **National Comparative Audit for the use of Fresh Frozen Plasma**
 - All requests for Fresh Frozen Plasma to go through the Haematologist on call.
 - The use of beriplex and vitamin k in life threatening bleeding to be adopted.
- **National Comparative Audit of Blood Transfusion**
 - Training to continue with further emphasis on documentation of start and end time of transfusions and clinical observations.
 - E-learning module for transfusion to be promoted.
 - A second transfusion nurse to be employed to help promote education, training and competency etc in transfusion.
- **College of Emergency Medicine Asthma**
 - To educate both nurses and medical staff on the importance of performing both initial and repeat Peak Expiratory Flow by presenting the findings from the audit at a SafeCare Meeting.

- Explore the possibility of introducing nurse-led prescribing of salbutamol on asthma patients.
- **Trauma Audit and Research Network (TARN)**
 - Filter back good and bad practice, audit results and present trauma related education to multidisciplinary audience via the revamped bi-monthly SafeCare Sessions.
- **National Diabetes In-Patient Audit**
 - Implement a care plan administered by ward nurses so that the feet of every patient with diabetes is examined and appropriate protection offered to lower the risk of foot ulceration and particularly for patients nursed in bed.
 - To educate ward staff that involvement of the person with diabetes in their diabetes care is very important. To incorporate this concept within Diabetes Study Days.
- **National Care of the Dying Audit – Hospitals 2nd Round 2009-2010**
 - Agreed national template of version 12 of Liverpool Care Pathway and agreement to use this document within the Trust and PCT.
 - Continue Trust wide roll out and education sessions regarding Version 12 Liverpool Care Pathway.
- **National Sentinel Stroke**

A detailed action plan has been agreed and includes:-

 - Work with Information Department to ensure patients coded correctly
 - Review Stroke Pathway
 - Raise profile of nutritional assessment with nursing team
 - Provide documented evidence of assessment
 - Provide training for staff ensuring 80% of workforce have skills to assess swallow
 - All medical and nursing staff to be aware of recommendations in stroke strategy
 - Scan results and treatment plan to be documented within 24 hours of admission
 - Physio, Speech and Language, OT and Social Worker assessments will be documented in MDT notes
 - A review of referral systems between disciplines
 - Evidence of use of appropriate continence assessment tool
 - All discussions with patient documented regarding risk factors
 - Identify appropriate tool for mood assessment and ensure use is documented
- **National Lung Cancer Audit**

A detailed action plan has been agreed and includes:-

 - Use MDT meetings to capture all cases discussed
 - Aim to record cases in real time/near real time
 - Identify key to QA data prior to submission
 - Work with data inputters to understand clinical implications of data

- Ensure all histological diagnoses are submitted to the audit
 - Review specialist nurse services
 - Ensure all surgical resections are submitted to the audit
 - Ensure that all anti-cancer treatments are submitted to the audit
- **National Bowel Cancer Audit**
A detailed action plan has been agreed and includes:-
 - Identify electronic mechanisms for capture of weight and height
 - Review specialist nurse services and ensure clear referral processes exist
 - Ensure all relevant pre-operative cases are submitted to the audit
 - Review protocols for availability of CT scanning
 - Review of nodal harvest process for resection specimens
 - **National Audit of Falls and Bone Health**
The Falls Team have developed a detailed action plan based on the outcomes of the audit. This includes:-
 - Reassessment of inpatient falls assessment
 - Review of Falls Policy in line with NPSA guidelines and information regarding bedrails
 - Review of routine assessment of falls risk in Accident and Emergency
 - Education and Training for pharmacists and social workers

The reports of **250** local clinical audits were reviewed by the provider in 2009/10 and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The themes that have been identified from the review have enabled us to develop action plans to address these.

Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2009/10 that were recruited during that period to participate in research approved by a Research Ethics Committee was 245 participants in Portfolio Research Trials and 55 participants in Non-Portfolio Research Trials.

Best Research for Best Health – A new national health research strategy - outlines the direction that NHS research and development needs to take over the next five years to ensure a vibrant, world-class environment for conducting and using NHS health research. The aim is to improve the health and wealth of the nation through research.

The Research & Development service within Gateshead Health NHS Foundation Trust continually promotes research. The service also supports, encourages, educates and develops the research activities of both staff and students within the Trust. Doubling recruitment within the Trust is a major priority for the Research & Development service and this will be facilitated by targeting studies that are under-recruiting and actively managing these studies, maximising portfolio adoption and creating an environment where research can flourish. By adopting these approaches Gateshead Health, as part of the Northumberland Tyne and Wear Comprehensive Local Research Network, can play its part in contributing to National Institute of Health Research Comprehensive Research Network delivering the research-related goals of the NHS Operating Framework.

The Operating Framework for the NHS in England (2009/2010) states – “High Quality Care for All made it clear that innovation must be central to the NHS if we are to improve constantly the quality of care. To achieve this, the NHS must play its full part in supporting health research. NHS Trusts and NHS Foundation Trusts have a statutory duty to support education and training. All providers of NHS care will need to increase their participation in research. The national ambition is to double the number of patients taking part in clinical trials and other well-designed research studies within five years.”

The Trust will also be employing additional Research Support staff (Research Nurse/Research Facilitator/Stroke CTO) as a direct result of feedback gained from the Research & Development Researchers Event held in October 2009. The level of participation in clinical research demonstrates Gateshead Health NHS Foundation Trust’s commitment to improving the quality of care that is offered to all patients.

	Project Applications	Active Projects	NIHR Portfolio Trials	Non-Portfolio Trials
2008/09	30	123	56	67
2009/10	41	153	84	69

CQUIN framework

A proportion of Gateshead Health NHS Foundation Trust's income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between Gateshead Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from SafeCare Department, Queen Elizabeth Hospital, Sheriff Hill, Gateshead NE9 6SX. Telephone number 0191 445 2934.

A monetary total of £781,400 of the Trusts' income in 2009/10 was conditional upon achieving quality improvement and innovation goals, which was achieved.

Registration with the CQC and periodic /special reviews

Gateshead Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration from 1st April 2010 is registered without conditions. The Trust provides the following regulated activities in the stated locations.

Regulated Activity	Location
1. Assessment of medical treatment of persons detained under the Mental Health Act 1983.	Dunston Hill Hospital. Whickham Highway, Gateshead, NE11 9QT Queen Elizabeth Hospital, Sheriff Hill, Gateshead, NE9 6SX
2. Treatment of disease, disorder or injury	Dunston Hill Hospital. Whickham Highway, Gateshead, NE11 9QT Queen Elizabeth Hospital, Sheriff Hill, Gateshead, NE9 6SX
3. Surgical Procedures	Queen Elizabeth Hospital, Sheriff Hill, Gateshead, NE9 6SX
4. Diagnostic and Screening Procedures	Queen Elizabeth Hospital, Sheriff Hill, Gateshead, NE9 6SX
5. Maternity and Midwifery Services	Queen Elizabeth Hospital, Sheriff Hill, Gateshead, NE9 6SX
6. Termination of Pregnancies	Queen Elizabeth Hospital, Sheriff Hill, Gateshead, NE9 6SX
7. Family Planning	Queen Elizabeth Hospital, Sheriff Hill, Gateshead, NE9 6SX

The Care Quality Commission has not taken any enforcement action against Gateshead Health NHS Foundation Trust in 2009/10.

Gateshead Health NHS Foundation Trust is not subject to periodic review by the Care Quality Commission.

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

Quality of Data

Gateshead Health NHS Foundation Trust submitted records during 2009/10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 98.8% for admitted patient care; 98.9% for outpatient care and 85.6% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was: 100% for admitted patient care; 98.9% for outpatient care and 100% for accident and emergency care.

Gateshead Health NHS Foundation Trust's score for 2009/10 for Information Quality and Records Management, assessed by the Information Governance Toolkit was 83%.

Gateshead Health NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:-

- Primary Diagnoses Incorrect 8%
- Secondary Diagnoses Incorrect 5%
- Primary Procedures Incorrect 6%
- Secondary Procedures Incorrect 7%

These results should not be extrapolated further than the actual sample audited which included the following services:

- General Medicine
- Gynaecology
- JA Breast procedures and disorders
- PB02Z Minor neonatal Disorders

3. Review of Quality Performance

In 2007 the Trust launched its long term strategy '**SafeCare – A Responsibility we ALL share**'. We adopted the term 'SafeCare' to describe our clinical governance programme in order to enable all staff, both clinical and non clinical, to understand their contribution to reducing harm and improving the safety and quality of patient care. Our SafeCare Strategy 2010/13 builds on our previous work and sets out a framework for how we will reduce harm and improve quality and safety of patient care. The framework consists of 6 key domains that further develop Lord Darzi's dimensions of quality:

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

Our SafeCare improvement map provides an overview of the key areas within the Strategy and the programmes of work linked to these. The strategy is underpinned by quality management systems and an accountability framework that ensures ward-to-board assurances regarding our quality improvement activities and outcomes.

All Clinical and Non-Clinical Divisions submit their Annual SafeCare plan in April each year with subsequent presentation to the SafeCare Council followed by a 6 monthly progress report.

Divisional SafeCare Teams are well established and work with frontline staff to develop a culture that supports and develops good clinical governance through "SafeCare" initiatives and local risk management systems within their area.

Our ward-to-board quality dashboards are constructed utilising the 6 key domains. They provide valuable and important information that we are able to use to track improvements across a range of safety and quality measures that are aligned to our corporate SafeCare priorities and Trust objectives.

Delivering SafeCare

Our Vision



Trust Strategic Priorities



SafeCare Strategy 2010-13

SafeCare Improvement Map



Quality Dashboard

BOARD MEASURES				PERFORMANCE			
Board Measures	Criteria	Definition	Performance				
			This month	Last month	YTD	Target	
1 Visible Leadership for Safety & Culture	Number Of Quality & Safety Walkabouts Undertaken	Monthly count of quality and safety walkabouts undertaken					
	Cumulative Quality & Safety Walkabouts Undertaken	Financial year to date, total number of quality and safety walkabouts undertaken					
	Cumulative Number of Actions Identified from Walkabouts	Financial year to date, total number of actions identified from quality and safety walkabouts					
	Cumulative Number of Actions Implemented from Walkabouts	Financial year to date, total number of actions implemented from quality and safety walkabouts					
2 Team Effectiveness/Efficient/Innovative	Mandatory Training Compliance	Staff attendance at mandatory training [% - uptake on offered places]					
	PDP Compliance - YTD figure	Staff with PDP completed timely [%]					
3 Safe Reliable Care / No Harm	Hospital Standardized Mortality Ratio (1 year)	Latest Dr. Foster rating from Dr. Foster Website					
	Hospital Standardized Mortality Ratio (3 year)	Latest Dr. Foster rating from Dr. Foster Website					
	Unadjusted Raw Mortality Rate [%]	Deaths against discharges					
	Rate of Adverse Events / 1000 patient days using Global Trigger Tool	Rate of Adverse Events / 1000 patient days using Global Trigger Tool					
	Never events	Number of events per month					
	Medication Errors Per Month	Number of medication errors					
4 Right Care, Right Place, Right Time	Deobitus Ulcers > Grade 2 Per Month	Number of deobitus ulcers					
	Percentage Of Falls Against Admissions	Percentage of falls on Ward, coded falls against admissions, [%]					
	MRSA Bacteremia YTD position	Numbers of MRSA bacteremia against projected number for YTD					
	C-DFP:48 hrs YTD position	Numbers of C-DFP:48hrs against projected number for YTD					
5 Positive Patient Experience	Number of Boarders	Total number of boarders for month					
	Unplanned Transfers To Critical Care	Percentage of unplanned transfers from all transfers to ITU/HCU					
6 Safe, Effective Environment, Appropriate Equipment & Supplies	Did the patient receive the information they needed from the staff about their care?						
	Was the patient given enough privacy when discussing their condition or treatment?						
	Did the patient think the ward/department was nice and clean during their stay/visit to hospital?						
	Were the staff courteous to them and their family/carer?						
Complaints	Would the patient recommend the hospital to family and friends?						
	Overall Trust Score	Aggregated Patient Experience Tracker Score for the Trust across all 5 questions					
	Complaints	Number of formal complaints received					
Maximiser results	No Harm To Staff - Needle Stick Injury	Staff with needle stick injury					
	No Harm To Staff - RIDDOR Reportable Injury	Staff with RIDDOR reportable injury					
	Maximiser results	Aggregated Maximiser results for all wards and departments					

Effective Culture and Inspirational Leadership

Leadership is the critical element in the Trust's SafeCare programme. The Chief Executive Officer and Board are key to establishing the value system, setting goals and aligning efforts to achieve these goals. The Board has demonstrated its commitment to SafeCare in a number of ways:

- The successful implementation of Executive Quality and Safety Walkabouts.
- Patient stories at Board meetings to aid understanding of the nature and sources of hazards in a complex healthcare organisation, and the impact on patients, families and staff.
- Strengthening the integration of quality and patient safety into the routine Board agenda and increasing the proportion of time spent on this.
- Regularly reviewing the Board Quality and Safety dashboard that comprises key system level measures.
- Supporting the development of safety and improvement knowledge and capability within the organisation.
- Continued sign up to 'Safety First', the National Patient Safety Campaign.
- Continuing to promote an environment that is respectful, fair and just, that takes a systems approach to incident investigation and realises the potential for learning.

The Trust is committed to building the capacity and capability across the organisation to enable us to further develop clear and deliverable organisational plans for patient safety and quality improvements that take a proactive and transformational approach. The development of leadership and management capability is therefore paramount and this has been supported through the provision of a framework for leadership and management development that has included the following programmes:

- Leading Empowered Organisations
- RCN Leadership Programme
- Clinical Lead Development Programme
- Senior Nurse Development Programme
- Coaching for improved Job Performance
- Supporting and sustaining clinical engagement

Efficient, Effective and Innovative Teams

The delivery of high quality and respectful care is dependent upon a skilled and effective workforce. The Trust supports the principle of lifelong learning as the key to delivering knowledge-based, high quality patient centred services. We have continued to ensure that advances are made in education and training to ensure that staff have the knowledge and skills necessary to perform their role within the organisation through

- effective training needs analysis
- access to appropriate training and line management support to succeed;
and
- knowledge and skills framework/appraisal system.

Individual staff appraisal and personal development plans have been a key vehicle to ensuring that all staff within the organisation understand their contribution to patient safety improvement and quality outcomes.

Learning lessons from mistakes, patient safety and untoward incidents is key to ensuring that incidents do not repeatedly occur. Systems are in place that enable timely feedback to staff on the outcome and learning from investigations and case reviews.

In addition to local divisional events, a number of SafeCare Trust wide events have been held to share good practice and raise areas for improvement and debate. The topics have included:

- Keeping Patients Safe in Our Care;
- SafeCare Showcase Workshops;
- Providing Quality Care for patients with Physical and Learning Disabilities;
- Learning from Patients' Experiences; and
- Reducing Harm from Venous Thromboembolism.

Listening to our staff through the NHS Staff Survey 2009

The NHS Survey is one of the main ways in which we gain staff feedback on how we are doing as an employer. By investing in a census of all staff in October 2009, the Trust received views from 1,522 staff via the NHS National Staff Survey, making our response rate 48%, which is the same as last year. The Trust is constantly striving to be a model employer by improving the quality of working lives for staff, which directly impacts positively on the quality of care to users of our services.

Measured against 40 Care Quality Commission key indicators, Gateshead Health came out most favourably compared to other acute trusts in the UK in the following areas:

- Percentage of staff experiencing harassment, bullying or abuse from patient/relatives in the last twelve months (14%);
- Percentage of staff feeling there are good opportunities to develop their potential at work (55%);
- Fairness and effectiveness of incident reporting procedures (73%); and
- Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell (18%)

The Trust's lowest ranked scores were:

- Percentage of staff agreeing that their role makes a difference to patients (87%);
- Percentage of staff witnessing potentially harmful errors, near misses or incidents (38%)

In terms of staff satisfaction, ratings show that we are in the top 20% of acute Trusts for 22 key scores; 13 better than average; 4 average and 1 in the lowest 20% of acute Trusts.

Key priorities to address through action plan in the coming year:

- Raise awareness of hand washing facilities available;
- Decrease physical violence towards staff;
- Further reduce incidence of harassment and bullying;
- Continue to tackle causes of work-related stress;
- Develop an overarching Health and Well-being Strategy;
- Increase annual staff appraisal; and
- Make more explicit links between contribution of all staff to patient experience.

Investors in People

Following a rigorous 6 day Investors in People assessment in September 2009, the Trust not only retained its Investor in People status for another three years, but gained silver recognition against the extended "Your Choice" framework which goes beyond the basic standard which we have held since 1999. IiP is a national quality standard for people management and development and confirms the Trust's commitment to continue to be a Good Employer who trains and develops staff appropriately.

The Trust was commended for good practice in a number of areas. Following this feedback, an action plan has been developed which includes further work to embed the organisation's vision and values across all aspects of the Trust's activities; developing more explicit leadership and management capabilities which are consistent with these values and widening staff engagement.

Service Improvement and Innovation

To succeed in our commitment to continual quality improvement and eradicating inefficiencies whilst reducing costs, an innovative approach is required.

We are committed to providing a range of opportunities for staff at all levels to develop the skills and knowledge in applying improvement techniques, tools and methodologies in their everyday work, as well as developing their capability to initiate, lead and sustain improvements in patient care.

For the last three years, the Trust has been working with other NHS organisations in the North East, and a hospital in Seattle, USA, to introduce improvement methods called 'lean'. These methods are used widely in different industries and settings across the world, and increasingly in health services. At the heart of this work is looking from a patient point of view about what really matters, and working with staff and patients to ensure our services match this. We use a number of improvement techniques, and have particularly focused on week long workshops where staff have the opportunity to spend time out from their department to work with trained facilitators, testing their own ideas as to how to improve their service. These workshops have helped staff to make real changes for the benefit of patients and also to learn how to use the improvement methods on an ongoing basis, and therefore drive continuous improvement across the Trust.

Twelve wards have participated in the 'Releasing Time to Care' programme. It is an NHS wide programme to help front line clinical teams apply a full of existing knowledge to deliver improvements that make a real difference at ward level.

Increasing the proportion of time staff spend on direct patient care, improves safety, increases staff well being and eliminates staff activities that do not add value. The ward teams have embraced this approach to analyse their working arrangements and have made significant improvements.

Safe and Reliable Care

Safety is a fundamental aspect of high quality, responsive and accessible patient care. We take a proactive approach to patient safety within the context of an integrated governance framework, with safety considerations an important feature in management decision making, service planning and delivery.

Key to tracking our performance is the identification, monitoring and reporting of specific quality measures linked to our delivery of service and programmes of improvement work.

NHSLA Assessment

We achieved full marks in our recent assessment by the NHS Litigation Authority, the national body charged with ensuring that NHS organisations take as many steps as possible to reduce the chances of patients coming to harm. The Trust is one of only 10 Trusts in the country to achieve this.

The assessment looked at the Trust's arrangements for the safety of patients, staff, contractors, volunteers and visitors. This included examining the safety of clinical care, the environment, staff competencies and capabilities, governance arrangements and how the Trust manages the risks it faces on a daily basis in carrying out its everyday work.

The Trust achieved full compliance in all of the 50 areas examined at level three which is the highest level of assessment possible.

The Trust was also awarded level 2 in our assessment of maternity standards with a 6 month development period with a view to achieving level 3.

Our **SafeCare priorities for 2009/10** focused on:

- Reducing Hospital Mortality
- Infection Prevention and Control
- Improving Discharge Communication
- Managing the Deteriorating Patient
- Reducing Medication Errors

Information on some of these areas has been discussed earlier in this report.

Utilisation of the Global Trigger Tool (GTT) is part of our programme for reducing avoidable harm and mortality. The information we are gaining through this case notes review is enabling us to identify areas of risk, suboptimal care and provide an opportunity to address system failures.

Recognising and Rescuing the Deteriorating Patient

This work has been ongoing since the end of 2007. It is aimed at better managing the acutely ill patient through focusing on earlier recognition and

treatment of deterioration. The project utilises the 'Model for Improvement' and much progress has been made.

Positive outcomes include the improvement in the quality and frequency of ward based physiological observations and improvement in the recognition and response when patients show signs of deterioration. The project has been implemented across all acute inpatient areas of the organisation. Both of these process measures are being maintained at above 90%. We have also seen an increase in calls to the Critical Care Outreach Team and subsequent reduction in calls to the Cardiac Arrest Team.

Effective communication and teamwork is essential for the delivery of high quality, safe patient care. Communication failures are an extremely common cause of inadvertent patient harm. The Trust has adopted the Situation, Background, Assessment and Recommendation (SBAR) communication model for handovers, transfers of care and acute situations across the organisation.

Reducing avoidable mortality and morbidity from Venous Thromboembolism (VTE) has been a key focus in 2009/10. Our Thrombosis Committee was established with appropriate representation from departments within the Trust. It reports to the Trust Board via the SafeCare Council. Some of the key achievements have been:

- Successful introduction of post-discharge anticoagulant VTE prophylaxis for elective hip and knee surgery in accordance with NICE guidance.
- Successful introduction of Dabigatran (new oral anticoagulant), licensed for the use of VTE prophylaxis following elective hip and knee surgery.
- Successful introduction of Patient Group Directives (PGDs) to allow Dabigatran to be issued to patients by nursing staff on discharge following elective hip and knee operations facilitating the patient journey.
- Review of Trust VTE risk assessment tool and introduction of drug charts pre-printed with Tinzaparin (an injection that treats or prevents blood clots from forming in the legs, lungs, and other parts of the body) to promote the use of VTE prophylaxis in appropriate hospital patients.

Future work will focus on:-

- Further development of process and outcome data.
- Audit programme to include compliance with Risk Assessment, Risk Re-assessment and appropriate thromboprophylaxis.
- Development of an e-learning module for competency in medicines management related to anticoagulants and thromboprophylaxis for nurses, pharmacists and doctors.
- Review of patient information.

The Trust issues SafeCare Alerts and Good Practice Bulletins in response to information gained through national, regional and local sources such as serious untoward incidents and audits where the potential for local learning and the need for action have been identified. During 2009/10 9 were issued comprising:

- Risks Associated With Transport of Medicines via the Pneumatic Shute System
- Clostridium Difficile
- Information Security Guidance for Staff
- Changing a Urinary Catheter: Antimicrobial Prophylaxis
- Electrical Safety
- Bedrails Safety
- Important Information for Prescribers of NovoSeven®
- Medical Device Alert
- Oxygen Safety with Non Re-Breath Masks

In June 2009 the Trust was one of 26 organisations presented with a certificate of progress as recognition for its work in promoting the nationwide Patient Safety First campaign. The Trust was awarded the certificate after consistently supplying data to demonstrate its progress against the core commitments it signed up to.

Right Care, Right Place, Right Time

Getting the best patient outcomes means providing the right care, in the right place, at the right time. The Trust's 'Improving Clinical Performance Programme' is a piece of work we have put in place as one of a range of measures designed to ensure the Trust meets 'best in class' standards of safe care across our services. In line with the NHS Operating Framework, some of this involves working with other partners to improve patient care and access to services by modernising patient pathways and, in some cases, treating patients more appropriately at home and in community settings. This work has started by looking closely at stroke services and day of surgical admission. The Trust is working to increase the amount of day surgery undertaken and increase the number of patients admitted on the day of their surgery to ensure we can safely see more patients in a quicker amount of time. If we achieve this, it will lead to a reduction in the number of beds the Trust needs. This piece of work will build upon the modernisation initiatives already undertaken to safely reduce the lengths of stay and improve the patient experience.

Positive Patient Experience

Listening to our patients and responding to what they tell us is fundamental to high quality care and the patient experience programme of work which has linked closely to our user involvement strategy and provided feedback through the Patient and Carer Public Involvement group.

We have actively involved patients in lean work and service redesign. An example of this is the work being carried out planning our new Emergency Care Centre.

The Patient Experience Tracker system enables real time capture of feedback. Over 1,100 patients provided feedback within the first month of its use, March 2010. An organisational score of 92% was achieved in relation to the following five questions:

- Did you receive the information you needed from the staff about your care?
- Were you given enough privacy when discussing your condition or treatment?

- Do you think the ward/department was nice and clean during your stay/visit to hospital?
- Have staff been courteous to you and your family/carer?
- Would you recommend this hospital to family and friends?

During 2009 a new scheme to help patients with learning disabilities to communicate some of their problems and concerns more effectively was introduced in Gateshead. "My Health Record", a joint initiative between the Trust and the Primary Care Team at NHS South of Tyne and Wear, provides NHS staff with all the information they need that patients may not remember in an emergency or if they are poorly. The booklet contains information about an individual's health and medical condition, medicines and allergies, the best way to communicate, and their mobility. It also outlines the degree and type of support the person with the learning disability needs.

The SafeCare Patients Panel

The panel was developed to enable service users' and carers' experiences and perspectives to be included in conducting clinical audit, evaluating the quality of services and identifying opportunities for service improvement. They have continued to make a valuable contribution to the SafeCare Programme and the details of their work can be found in their Annual Report which is available from SafeCare Department, Queen Elizabeth Hospital, Sheriff Hill, Gateshead NE9 6SX. Telephone number 0191 445 2934

Safe Environment and Appropriate Equipment and Supplies

The Trust aims to provide a safe environment for patients that enhances the quality of care and helps reduce preventable harm, such as healthcare associated infections and falls. Ensuring a safe working environment for staff is also paramount. These priorities are delivered through a variety of mechanisms including effective risk management and health and safety systems.

The matron's walkabouts that are conducted monthly involve members of the infection prevention and control team, housekeepers and domestic services. They involve assessing general cleanliness, organisation of the area and talking to staff and patients about their perceptions and experiences. The outcomes are reported to the ward and departmental managers and action plans developed where necessary.

The Patient Environment Action Team (PEAT) is a further means by which the quality of the Trust's environment and food is assessed. PEAT is a national inspection, carried out on behalf of the National Patient Safety Agency (NPSA). For the 2008/09 PEAT inspection the Trust was awarded excellent for both environment and food. We are awaiting the outcome of the 2009/10 inspection. The results reflect the investment of monitoring, training and recruitment undertaken over recent years.

"5S" and visual control training sessions have been delivered across the Trust, touching over 800 clinical and non-clinical staff which resulted in significant and visible improvements in the environment in wards and departments.

The Trust range of services can be summarised as:

- A full range of acute services for elective (planned) and emergency care including in-patient, out-patient, day case and day care
- Palliative and continuing care for older people with physical or mental health problems and day care for younger people with dementia
- Provision of services for children with mental health problems
- Community and intermediate care services i.e. physiotherapy, dietetics and community support for older people
- In addition, we provide sub-regional breast screening services – covering Gateshead, South Tyneside, Sunderland and parts of Durham – and we are the North East hub for the National Bowel Cancer Screening Programme. This covers an area east of the Pennines stretching from the Scottish Borders to the Humber.

Review of Services

Patient Safety

Blood transfusion involves a complex sequence of activities and, to ensure the right patient receives the right blood, there must be strict checking procedures in place at each stage. Administering the wrong blood type (ABO incompatibility) is the most serious outcome of error during transfusions. Most of these incidents are due to the failure of the final identity checks carried out between the patient (at the patient's side) and the blood to be transfused.

The Trust took part in the National Comparative Audit of Blood Transfusion focusing on bedside transfusion. The key aim was to determine whether national guidelines for the administration of blood at the bedside were being followed.

The outcomes for Gateshead Health NHS Foundation Trust were very favourable and are outlined in the table below.

Standard	Gateshead Health	National Average
Patients wearing printed wristbands	100%	97.4%
The patient's identification contains the first name, last name, date of birth and NHS or local identification number	100%	97.6%
Patient's details on identification match with patient statement	100%	99.1%
Patients with pre-transfusion observations carried out	96%	90%
Start time recorded	92%	98%
End time recorded	85%	67%
An IT system was used to check the blood	58%	12%
Staff trained	81%	86%
Within 1 year	62%	52%
Within 2 years	38%	34%

The Trust recognises the importance of the education, training and competence of appropriate staff as being a key component to safe blood transfusion. In 2009 an additional Blood Transfusion Nurse was employed to further develop the provision of education and training programmes.

We have implemented the World Health Organisation Surgical Site Checklist in all of our theatres. This initiative has strengthened the commitment of clinical staff to address safety issues within the surgical setting. In addition it will support safe anaesthetic practices, correct site surgery and minimise surgical site infections as well as improving communication within the team.

Clinical Effectiveness

Fractured neck of femur

The evidence-base for hip fracture care is improving rapidly and, in general terms, shows that prompt, effective, multidisciplinary management can improve quality and at the same time reduce costs. One key element of good care is related to minimal delay to surgery. There is some evidence that delay in surgery beyond 48 hours may adversely affect patient outcomes; length of stay is higher, with a trend towards higher mortality. The Care of Patients with Fragility Fracture (also known as the Blue Book) sponsored by the British Orthopaedic Association and the British Geriatric Society, summarises current best practice in the care and secondary prevention of fragility fractures. Standard 2 is 'all patients with hip fracture who are medically fit should have surgery within 48 hours of admission, and during normal working hours'.

The Trust submits data to the National Hip Fracture Database. For the financial year 2009/10, there were 299 patients recorded on the database, 296 of whom had a procedure, 153 had their procedure within 24 hours (51.7%) a further 104 between 24 and 48 hours therefore 257 were operated on in less than 48 hours (86.8%). Of those patients not operated on within 48 hours, 17 were medically unfit. A quarterly report is produced within the Trust to enable us to continually monitor and assist in service improvements.

Diabetes Services – National Inpatient Audit

In September 2009 the Trust took part in this national audit of inpatients with Diabetes. The audit was set up as a result of concerns over the standards of care and clinical outcomes for people with Diabetes whilst an inpatient. At Gateshead Health NHS Foundation Trust a total of 76 inpatients were included in this audit and completed patient experience questionnaires were also received from 31 patients.

The table below illustrates the outcomes for the Trust compared to the national average.

Standard	Gateshead Health	National Average
Appropriate capillary blood glucose monitoring	94%	86%
Mean number of good diabetes days (a day in which the frequency of blood glucose testing is appropriate and results are within a defined range)	4.3	4.2
Visited by a member of the Diabetes specialist team	20%	26%
Physical examination of their feet at least once during the admission	25%	31%
Prescription errors	14%	19%
Management errors	19%	14%
Patient involvement in management decisions related to diabetes	10%	22%
Patients experiencing more hypoglycaemic (low blood sugar) than usual (i.e. when at home)	30%	36%
Appropriateness of timing and choice of meals	68%	64%
Patients feeling confident about the nurses and doctors providing their diabetes care on the ward (score 0-6, with 6 being very confident and 0 being no confidence)	4.7 for nurses 5.3 for doctors	5.0 for both nurses and doctors
Overall satisfaction described by patients (scoring scale as above)	5.0	5.0
Number of patients identifying a positive word for their inpatient experience in relation to their diabetes (like safe, happy or excellent)	59%	73%

The results of the audit have enabled the Diabetes Team to develop an action plan focused on areas for improvement.

Caesarean Section rates

Throughout 2009/10 our caesarean section rate has ranged between 16-28% with an average of 21.7%, this is against a national average of 24%. Detailed audits have been carried out and an action plan implemented with the aim of further reducing this rate in the coming year.

Central Line Infections - Matching Michigan

The Trust has been involved in the pilot phase of the Matching Michigan project. Overseen by the NPSA, the aim of this work is to emulate the state of Michigan by reducing central line infection rates to under 0.5 per 1,000 catheter days. The study is based within the Critical Care Department and involves 2 strands of work.

Firstly there is the technical work stream. This work centres around the practical aspects of central line insertion and use aiming to achieve best practice in all

aspects of care. This is supported by use of a checklist. All potential cases are reviewed with the ultimate aim of performing RCA on each case. The second strand is about building our unit's safety culture which fits perfectly with SafeCare's objectives. We have a link Senior Executive and have undergone a safety culture assessment.

Work on the project is ongoing within the Trust and region as the NPSA rolls out the project across the country.

Patient Experience

Surgical acute abdominal pain pathway

We carried out a Rapid Process Improvement Week that focused on the pathway for the emergency patient with acute abdominal pain. In particular, the team aimed to reduce the time it took to assess, diagnose and review patients.

A care standard was developed for every patient 'nil by mouth' that improved their quality of care.

The surgical medical teams re-organised the way they worked so that they were able to review patients more quickly on arrival in hospital and following a scan. This reduced some of the waiting for patients so that investigations could be carried out and acted on more quickly. Considerable work was undertaken on one of the surgical wards to improve the environment and increase the amount of time spent by staff with patients.

Within Accident and Emergency services a Rapid Process Improvement Workshop has been undertaken focusing on patients with minor injury/illness. This work looked at the flow of patients through the department. Staff were spending a lot of time away from patients because of the way the cubicles were set up. We also wanted to try some different ways to see, assess and treat patients, which could be used in the new Emergency Care Centre that is planned. We re-designed the cubicles used for treating minor injuries/illnesses and managed to set up trolleys and fixed equipment which would enable staff to stay in the room with the patient rather than have to search for these things. This significantly reduced the time staff spent walking and increased time with patients.

Time was taken to stand back and look at different ways to reduce patients' time in the department. The best result showed a big reduction in waiting time, and gave us some ideas for how we can use this in the future.

Stroke Services – Rapid Process Improvement Workshop

The team worked on the patient journey through the stroke pathway and concentrated the work for the improvement week on the rehabilitation phase. They wanted to focus on how the multi-disciplinary team worked, including communication issues, look at reducing time on clerical tasks and adding value to the patient journey.

Previously ward rounds were taking 2-3 hours, this meant ward staff were tied up and not able to provide direct care to their patients. Ward rounds were

streamlined with a dedicated MDT slot where all disciplines were available for planning the discharge process. On completion of the ward rounds the ward nurses were then freed up to look after their patients, allowing 2 hours more direct patient care time.

Consultants changed clinics so that they could be more available on the ward. The ward board was updated to allow good visual awareness of the discharge status of the patient. Work was done on referral for Occupational Therapy, how to get transport and with Pharmacy for take home medicines so that patients spent less time waiting once they were cleared to go home

Paediatric Out-patients - Rapid Process Improvement Workshop

The paediatric team wanted to look at how referrals were processed into the department with a view to reducing the time taken to arrange an appointment for a child.

They also wanted to review how the clinics themselves were managed, so that they were more smooth and consistent and that any of the team supporting would be able to get the right information for the medical team and reduce the waiting times for the children and parents.

The process of making an appointment was changed considerably, reducing the time and number of staff needing to be involved. This meant that children can be given an appointment date sooner.

Checklists were developed so that better information is available for parents before the appointment, so they know which tests the medical team will want to do in advance

The clinic environment and rooms were improved and new standard templates developed, so that it is now much easier to work consistently and cross cover is easier.

Quality Overview- Performance of Trust against selected metrics

A number of metrics, set out in the tables below have been chosen to summarise our performance against key quality indicators that are aligned to our SafeCare Strategy and priority areas of work within the Trust. The 6 key sections further develops the 3 domains of quality (Patient Safety, Clinical Effectiveness and Positive Patient Experience).

Measure	Criteria	Definition	2009/10	2008/09	2007/08	Target	National / Peer	
1	Visible Leadership for Safety & Culture	Outcomes of Trust Wide MaPSaF Assessment	Currently Re measuring		Pro-Active / Bureaucratic	Pro-Active / Generative		
		Number Of Quality & Safety Walkabouts Undertaken	Monthly count of quality and safety walkabouts undertaken	4	..	TBC		
		Cumulative Quality & Safety Walkabouts Undertaken	Financial year to date, total number of quality and safety walkabouts undertaken	10		TBC		
		Cumulative Number of Actions Identified from Walkabouts	Financial year to date, total number of actions identified from quality and safety walkabouts	22		TBC		
		Cumulative Number of Actions Implemented from Walkabouts	Financial year to date, total number of actions implemented from quality and safety walkabouts	4		TBC		
2	Team Effectiveness/Efficient/Innovative	Mandatory Training Compliance	Percentage take up of allocated places	55%	59%	66%	90%	
		PDP Compliance	Staff with PDP completed timely (%) - Latest figure	51.9%	42.4%		90%	
		Bank usage (Qualified)	Shifts of usage for ward, (Number)	12,379	13,857	11,009		
		Bank usage (Non Qualified)	Shifts of usage for ward, (Number)	17,873	20,276	17,185		
		Sickness / Absence	Absence rate as reported from personnel (%)	4.96%	5.29%	5.26%	4.00%	
		Staff Turnover	Labour Turnover based on FTE (%)	10.54%	12.08%	13.47%		
3	Safe Reliable Care / No Harm	Reducing Harm from Deterioration	Hospital Standardised Mortality Ratio (1 year)	Latest Dr. Foster rating from Dr. Foster Website	96.78	92.43	90%	100
			Hospital Standardised Mortality Ratio (3 year)	Latest Dr. Foster rating from Dr. Foster Website	94.10	92.47	TBC	100
			Unadjusted Raw Mortality Rate (%)	Deaths against discharges	2.74%	2.79%	3.03%	1.37%
			No. Of Calls To CRASH Team	Total arrest calls	165	194	213	
			Of the calls to the arrest team how many were actual cardiac arrests (%)		46.7%	52.1%	38.5%	
			Cardiac Arrest Rate	Number of cardiac arrests per 1000 bed days	0.815	0.924	1.066	
			No. Of Visits From CCOT	Total no. of calls re. deteriorating patient to CCOT, (Number)	1018****	863		
		Reducing Avoidable Harm	Rate of Adverse Events / 1,000 patient days using Global Trigger Tool	Rate of Adverse Events / 1,000 patient days using Global Trigger Tool (avg rate achieved across all audits in time period)	30.99	23.95	N/A	N/A
			Medication Errors	Number of medication errors	398	375	324	
			Decubitus Ulcers > Grade 2		208	226	64	
			Number Of Patient Slips, Trips And Falls	Number of patient slips, trips and falls recorded	1608	1603	1580	
			Percentage Of Falls Against Admissions	Percentage of falls on Ward, coded falls against admissions, (%)	4.45%	4.65%	4.14%	
			Never Events		0	0	0	0
			Total Incidents per 100,000 bed days	All incidents*****	2802	2373	2088	
		Infection/Prevention & Control	MRSA Bacteraemias	Numbers of MRSA bacteraemias apportioned to Acute Trust (post 48hrs)	7	16	32	14
			Clostridium Difficile Infections > 48 hrs	Numbers of clostridium difficile infections > 48hrs	105	107	197	128
			Uniform Policy		99.1%	98.0%	n/a	100%
			Hand Hygiene	From sampling undertaken on the wards which is then aggregated up for Trust statistic, what is the level of compliance expressed as a percentage for these indicators. The figure reported is the average for all the weekly readings taken during the year.	97.0%	96.5%	n/a	100%
			Intravenous Cannular		91.9%	85.3%	n/a	100%
Indwelling Catheter			96.4%	91.9%	n/a	100%		
Equipment Clean and Records Up To Date?		97.7%	97.6%	n/a	100%			

Measure	Criteria	Definition	2009/10	2008/09	2007/08	Target	National / Peer	
4	Right Care, Right Place, Right Time	Cancelled Operations	Percentage of cancelled operations from FFCE's	0.76%	0.68%	1.10%	0.80%	0.8%****
		Returns To Theatre	The number of patients returned to the theatre within 30 days (Unplanned/Planned/Unrelated)	482	523	N/A	TBC	
		Percentage of Stroke Patients who spend >90% time within dedicated stroke unit		78%	63.6%	N/A	76%***	
		Fragility Fracture Neck of Femur operated on within 48hrs of admission/diagnosis		86.8%	N/A	N/A	100%	
		Uptake of Cardiac Rehabilitation		79.8%	67%	75%		
5	Positive Patient Experience	Did the patient receive the information they needed from the staff about their care?		89%	-		80%	
		Was the patient given enough privacy when discussing their condition or treatment?		91%		80%		
		Did the patient think the ward/department was nice and clean during their stay/visit to hospital?		94%		80%		
		Were the staff courteous to them and their family/carer?		96%		80%		
		Would the patient recommend the hospital to family and friends?		90%		80%		
		Overall Trust Score	Aggregated Patient Experience Tracker Score for the Trust across all 5 questions	92%		80%		
		Focus on the person score		N/A	76	N/A	88	
		Focus on dignity and respect score		N/A	90	N/A	95	
		Focus on improving as an organisation score		N/A	47	N/A	59	
		Overall score		N/A	71	N/A	80.7	
		Complaints	Number of formal complaints received	206	223	201	223	
6	Safe, Effective Environment, Appropriate Equipment & Supplies	PEAT assessment - FOOD		Results	Excellent			
		PEAT assessment - ENVIRONMENT		Pending	Excellent			
		No Harm To Staff - Needle Stick Injury	Staff with needle stick injury	68	67	76	0	
		No Harm To Staff - RIDDOR Reportable Injury	Staff with RIDDOR reportable injury	43	44	34	0	
		Maximiser results	Aggregated maximiser results for all wards and departments	98.56%	N/A	N/A	98%	

* Data collection utilising the Patient Experience Trackers within all wards and departments commenced on 1st March 2010

** Walkabouts implemented in February 2010

*** In the absence of CQC published tolerance levels the quality thresholds have been applied

**** Accessing data and data extraction issues were resolved in October 09 and thus the figure reported is a pro rata data based on the final 6 months activity

***** This target is coupled with the target of less than or equal to 5% breaches of the 28 day guarantee. The Trust achieved 0% breaches

***** Total incidents is now all incidents rather than just finally approved incidents, also the bed day rate is now calculated correctly as previously it was incorrect and based on admissions as opposed to bed days.

No.	National targets and regulatory requirements	2009/10	2008/09	Target
1	The Trust has fully met the HCC core standards, and national targets	24/24	24/24	24/24
2	Clostridium difficile infections	105	107	128
3	MRSA bacteraemias apportioned to Acute Trust (post 48 hours)	7	16	14
4	Cancer diagnosis to treatment waiting times	98.80%	99.598%	96%
5	Cancer urgent referral to treatment waiting times	87.80%	95.480%	85%
6	Cancer urgent referral to first outpatient appointment waiting times	94.10%	99.375%	93%
7	18 week referral to treatment waiting times (admitted patients)	98.60%	96.00%	90%
8	18 week referral to treatment waiting times (non-admitted patients)	97.40%	98.00%	95%
9	A&E waiting times	98.50%	98.50%	98%
10	Outpatients waiting longer than the 13 week standard	0.003%	0%	0.03%
11	Inpatients waiting longer than the 26 week standard	0%	0%	0.03%
12	Rapid access chest pain clinic waiting times	100%	100%	98%
13	Cancelled Operations	0.76% cancellations & 0% breaches	0.68% cancellations & 0% breaches	0.8% cancellations & 5% breaches of 28 day guarantee
14	Delayed transfers of care	1.44%	1.466%	NYP
15	Ethnic coding data quality	89.21%	86.25%	85%

The number of core standards the NHS foundation trust has declared to the Healthcare Commission/Care Quality Commission that it is compliant with is 24 out of 24 core standards

Annex statements

NHS South of Tyne and Wear Statement

NHS South of Tyne and Wear (serving Gateshead, South Tyneside and Sunderland PCTs) aims to commission safe and effective services that provide a positive experience for patients and carers. Commissioners of health services have a duty to ensure that the services commissioned are of good quality. NHS South of Tyne and Wear takes this responsibility very seriously and considers this to be an essential component of the commissioning function. There are well established mechanisms in place with local foundation trusts to monitor the quality of the services provided and to encourage continuous quality improvement. These mechanisms are regularly reviewed and developed in the light of local and national recommendations; for instance the monitoring of mortality rates and patient experience have been strengthened in the past year following recommendations from the Care Quality Commission.

NHS South of Tyne and Wear has monthly quality and contract review meetings with Gateshead Health Foundation Trust to :

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

In addition to the above the PCT was involved in a peer review of the arrangements to deliver single sex accommodation and there were many positive aspects to the visit and the Trust outlined further plans for improvement.

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

It is positive to note that the priorities for improvement in 2010/11 identified within the report closely align with NHS South of Tyne and Wear priorities that have been included in the 2010/11 CQUIN scheme with Gateshead Health Foundation Trust; this links 1.5% of the contract value to achievement of the CQUIN improvement goals.

Gateshead Healthier Communities Overview and Scrutiny Committee (OSC) Statement

Based on Gateshead Healthier Communities OSC's knowledge of the work of the Trust during 2009-10 we feel able to comment as follows:-

Quality Priority 3- Patient Experience

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

The Trust, along with the Primary Care Trust, has consulted the OSC on proposals for improving and re-providing a range of services at Dunston Hill Hospital. At that time, there was overall support from the OSC for the proposals as it was recognised that the current services were being delivered in buildings which were inappropriate and did not meet the requirements for delivering modern, high quality care. The OSC generally accepted that the proposals should enable the provision of services to Gateshead residents which would meet national and local requirements for a modern, effective, high quality, patient centred service and meet current and future needs because the buildings and services are fit for the future.

The OSC had received evidence that all individuals would be fully assessed on a case by case basis before they were moved and decisions on care and levels of support would be made based on what was right for individual patients and their families. Members of the OSC, at the invitation of the Trust, visited the hospital site and spoke with representatives of the Trust further regarding the proposals.