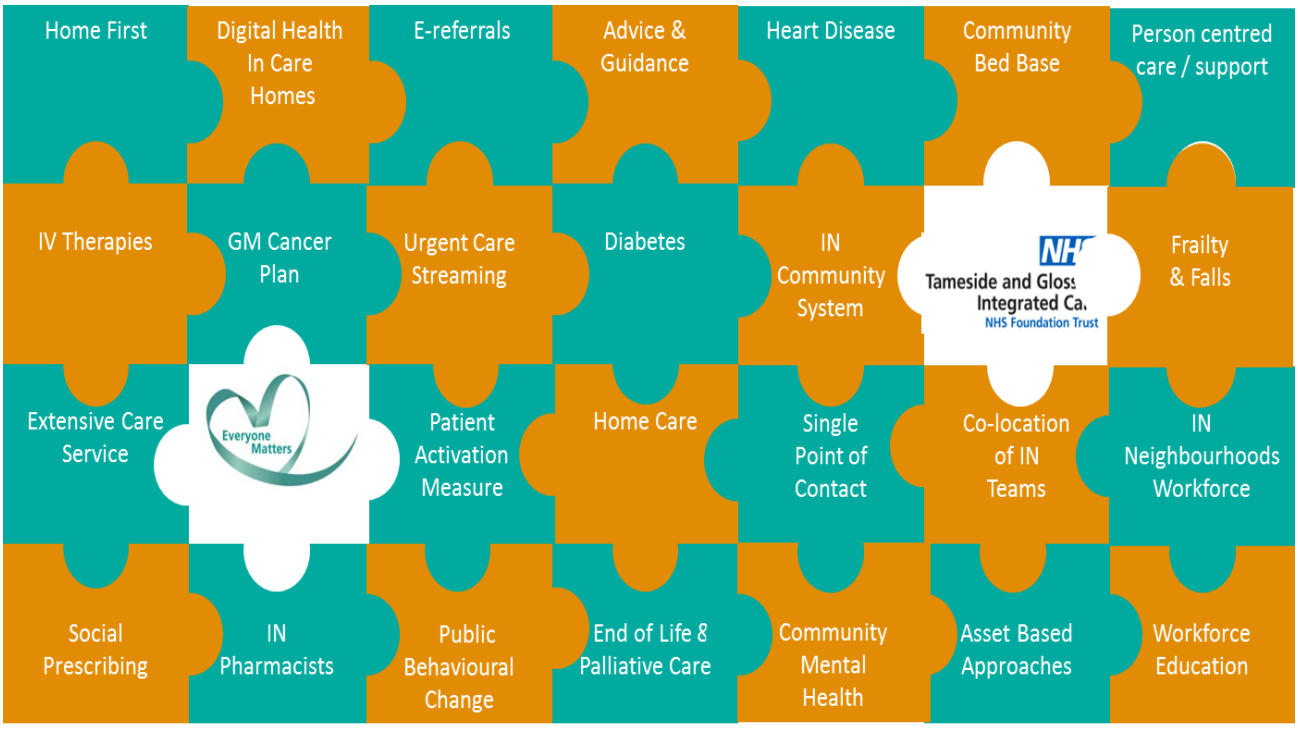
Tameside and Glossop Integrated Care NHS Foundation Trust

Annual Quality Account covering 1st April 2017 – 31st March 2018



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Statement on the Quality of Services from the Chief Executive

Chief Executive's Overview

I am pleased to present our Annual Quality Account for 2017/18. This year has seen significant and important changes as we develop as an Integrated Care Organisation to develop closer working relationships and integration across health and social care sectors. This reflects the joint role we plan with our Local Authority colleagues to align our mutual ambitions to improve the health outcomes and wellbeing of our communities.

The formation and development of the five community neighbourhood locality service areas are already enabling and facilitating better and more responsive services defined by the needs of the local populations. The transformation programme to provide integrated care in partnership with our Commissioners and Social care partners enables us to continue our improvement strategy we began over three years ago.

We use every opportunity to ensure our regulators are aware of the service transformation being undertaken and the impact which this is having on the model of services we provide. Our transformation programmes are enabling us to deliver services differently across the whole health and social care economy (which is central to improving the health and wellbeing outcomes of our communities) to enable the Trust to meet its national and locally agreed quality standards. We continue to maintain those services which are rated Good by our regulators, but aspire to be rated Outstanding.

This year we welcomed our new Chair Jane McCall and a new Non–executive directors to the Trust Board. We continue to further strengthen our leadership teams ensuring we have the skills and capabilities to oversee and deliver our focus on service quality and safety.

I wish to record my gratitude to our staff for their hard work dedication and resilience during periods of transition and high demand. This also includes the ongoing support from our local health and social care partners as we strengthen our partnership to provide integrated and seamless services.

In this report I hope you will see evidence of the outcomes of our improvements which have been recognised by our regulators, service users and others. I remain confident that the continued enthusiasm and determination of our staff will drive forward our improvement and transformation programme. This will enable us to provide services that we can all be proud of.

I trust that you find our latest Annual Quality Account informative. I believe it is an accurate reflection of our performance against our quality indicators. We remain committed to continuous improvement and the use of innovative practice and welcome your feedback. To provide us your comments, or to request the Account in different languages or formats, please use any of the contact details on the rear cover of the report.

I confirm to the best of my knowledge the information in this document is accurate.

Karen James

Chief Executive **Date** **23rd May 2018**

Part Two

Priorities for Improvement and Statement of Assurance from the Board

Tameside and Glossop Integrated Care NHS Foundation Trust

Statement of Assurance from the Board

Tameside and Glossop Integrated Care NHS Foundation Trust operates from Tameside General Hospital in Ashton-under-Lyne, providing a range of acute hospital and community services for a population of approximately 250,000 people living in the surrounding area.

The Trust became a Foundation Trust in February 2008 and in 2017/18 employed around 3500 WTE staff, across a range of professions.

Review of Services

During 2017/18 the Tameside and Glossop Integrated Care NHS Foundation Trust provided and/or sub-contracted 7 relevant health services (defined using the Care Quality Commission's regulated activities).

The services provided were:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Family planning services
- Maternity and Midwifery services
- Surgical procedures
- Termination of pregnancies
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

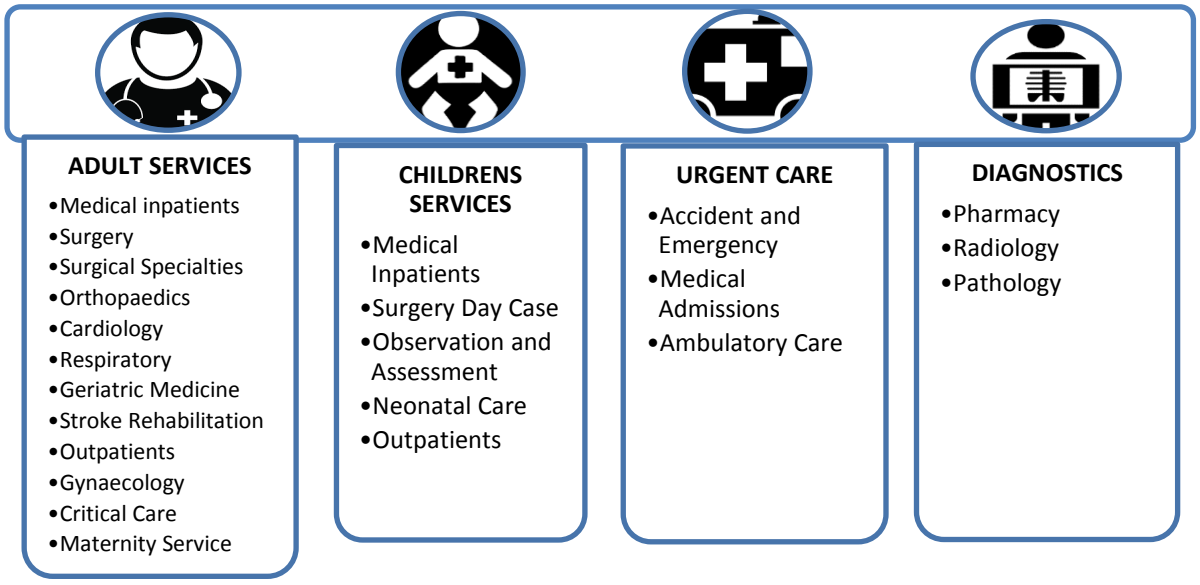
The Tameside and Glossop Integrated Care NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 7 of these relevant health services. The data the Trust has reviewed covers the three dimensions of quality patient safety, clinical effectiveness and patient experience where necessary. Where appropriate the Trust has indicated where the amount of data for review has impeded this objective. The Trust systematically and continuously reviews data related to the Quality of its services. The Trust uses its Quality, Safety and Performance metrics to demonstrate this. Reports to the Trust Board, the Trust's Quality and Governance Committee, Trust Executive Team and other key committees and the Performance Management Framework all include data and information relating to our quality of services. The Tameside and Glossop Integrated Care NHS Foundation Trust have reviewed all the data available on the quality of care in all of these NHS Services.

The income generated by the relevant health services reviewed in 2017/18 represents 93% of the total income generated from the provision of relevant health services by the Tameside and Glossop Integrated Care NHS Foundation Trust for 2017/18.

Tameside and Glossop Integrated Care NHS Foundation Trust provides a wide array of services which are set out below across the hospital and community settings in Tameside and Glossop.

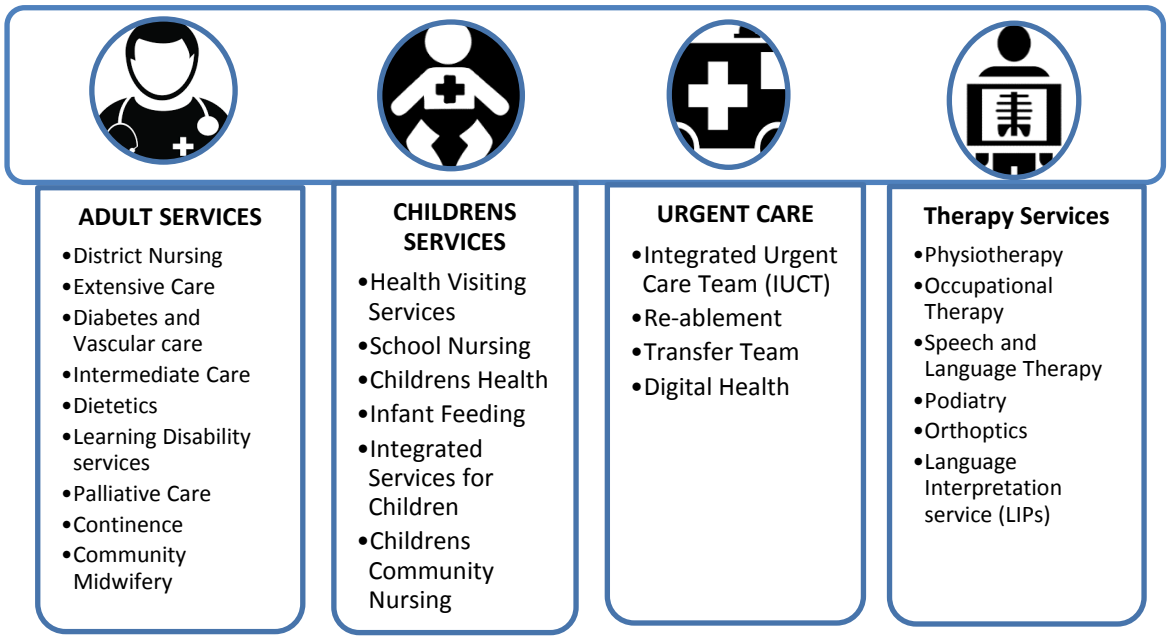
Hospital Services

The ICFT provides local hospital services for the Tameside and Glossop population on the Tameside Hospital site.



Community Services

The Trust provides community services from a range of premises within the Tameside and Glossop locality and in some cases in people's homes.



Whilst this describes the services provided the transformation work being undertaken by the Trust and the formation of integrated neighbourhood teams described later in the quality account will mean that the traditional boundaries of hospital and community service provision is increasing less distinct especially as further integrated working takes place with adult social care across the health and social care settings within the Tameside and Glossop localities.

How Quality Initiatives are prioritised at the Trust

In prioritising our Quality initiatives we have considered the key requirements identified within National and Local Priorities informed by the Commissioning and regulatory requirements.

These have informed our improvement programme which has been agreed with key stakeholders to ensure delivery of the fundamental standards of Quality and Safety whilst also undertaking service improvement and service transformation. The programmes are evident in the agreed Trust Board objectives, and embrace the vision identified in the Quality Improvement strategy and Trust values and behaviours agreed and set out in the vision that “Everyone Matters “.

The service improvement and transformation programme are key drivers and the content of this Quality Account will provide an overview of progress against these. The Trust Board continues to oversee the delivery of these.

Tameside and Glossop Integrated Care NHS Foundation Trust has demonstrated that we are able to deliver our improvement plan and we have made significant progress with this which we believe are recognised by stakeholders and we have been actively looking to demonstrate to the CQC during our engagement with them.

The Trust has set out in its 5 year strategic plan “Beyond Patient Care to Population Health” its vision and aims which is aligned with the delivery of the triple aims of the national five year forward view and the Greater Manchester plan, Taking Charge, and sets out the vision, aims and how we will deliver the strategy.

Our Vision

The Tameside and Glossop Integrated Care NHS Foundation Trust vision is to improve health outcomes for our population and influence the wider determinants of health, through collaboration with the people of Tameside and Glossop and our health and care partners.

Our Aims

To deliver this vision our aims are to:

- Support local people to remain well by tackling the causes of ill health, supporting behaviour and lifestyle change, and maximising the role played by local communities to enable people to take greater control over their own care needs and the services they receive.
- When illness or crisis occur, provide high quality integrated services that are designed around the needs of the individual and are provided in the most appropriate setting, including in people’s own homes.
- Develop and retain a workforce that is fit for the future needs of the organisation; reward talent; and instil pride in the workforce which demonstrates our values and behaviours and has the skill and ambition for continuous improvement
- Work with partners to innovate, transform and integrate care provision in Tameside and Glossop and in doing so contribute to the delivery of financial sustainability

Delivering the Strategy

The Trust acknowledges that delivering these ambitions will require a clear vision, strong leadership and a transparent implementation plan delivered through the Integrated Care Foundation Trust (ICFT) as the vehicle to deliver this fundamental change to the way health and social care is provided in Tameside and Glossop. The

ICFT has with partners started to develop and deliver integrated models of care.

However, we recognise that some key enablers which the Trust and its partners will need to develop to provide the capability and capacity to innovate and deliver integrated services, including our workforce, the estate and our informatics systems.

This is reinforced through the aims and drivers of the Quality Improvement Strategy, which sets out how we aim to Listen, Learn and Act to Improve. Our quality initiatives are identified and supported through our Patient Safety Programme, Patient and Service User Experience Strategy reinforced by our values and behaviours which should be evident in all that we do. These are set out in the pages below in schematic form

Everyone Matters

Our values and behaviours

SAFETY

- We provide a clean safe environment for everyone.
- We take responsibility for everything we do.
- We challenge and respond to improve quality for everyone.

RESPECT

- We recognise, value and respect everyone around us.
- We treat everyone with dignity and kindness.
- We are polite and professional.

COMMUNICATION

- We actively listen to our patients, their relatives, carers and our colleagues.
- We are honest and open.
- We encourage and welcome feedback.

CARE

- We are caring and compassionate.
- We offer comfort and show support and understanding.
- We involve patients and their relatives in their care.
- We care about our staff and their welfare.
- We respect privacy and confidentiality at all times.

LEARNING

- We promote and encourage learning.
- We motivate, train and develop ourselves and others.
- We recognise and celebrate achievements.
- We learn and develop from incidents, complaints and compliments received.

Quality Improvement Strategy

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Our Quality focus

Enablers and drivers

Our Quality Aims

- Improve consistency and reliability of care and treatment
- Implement integrated and innovative care closer to home
- Deliver what matters most to meet the individual needs
- Continuously reduce avoidable harm
- Reduce preventable deaths

'Everyone Matters' - Our Aim is deliver with our partners, safe, effective and personal care, which you can Trust by always Listening, Learning and Acting to Improve

The continuous improvement of clinical quality continues to be further incentivised through the contracting mechanism which includes quality schedules, penalties and CQUIN payments.

NHS England and regulation frameworks highlight the focus on quality, and are linked to the NHS Mandate and Constitution. We have worked with key partners Tameside and Glossop Clinical Commissioning Group and Tameside Metropolitan Borough Council to align our quality aims and to maximise the potential delivery through these mechanisms.

Priorities for Quality Improvement

The priorities for 2017/18 were set out in the Trust Objectives and in the previous Quality Account. These are identified below and what we are reporting on in this quality account

- We will maintain compliance with the CQC Fundamental Standards of Care
- We will maintain our overall CQC ratings at good and aspire to gain outstanding ratings in future service inspections
- We will maintain and or increase our incident reporting rate per 1000 bed days and aim to be in the top 25% of Trusts
- We will minimize levels of severe and catastrophic harm and be below the national average of 1%
- We will ensure our patient safety programme work streams uses metrics for anticipating and predicting potential future harm in at least five of the work streams for 2017/18
- We will achieve the identified CQUIN metric related to patient safety
- We will maintain or improve the completed eligible VTE risk assessment at an 98% or above
- We will continue to seek improvement of the Trust's mortality indices (HSMR and SHMI) and maintain them in the 'as expected' or "better than expected" bandings
- We will continue to ensure Learning from Deaths is part of the organisational learning and reported in line with the national requirements.

To improve our patient and service user experience through the delivery of a personalised, responsive, integrated, caring and compassionate approach to the delivery of care.

- We will further reduce the number of KO41 complaints per 1000 patient contacts to below 1 complaint per 1,000 patient contacts
- We seek to increase the number of recorded compliments and improve the Compliments to KO41 Complaints ratio by a further 20% to 40% from the Q4 2014/15 baseline.
- (PROMS) Patient reported outcomes continue to be reported on for a range of conditions. We will improve our participation rates for Hip and Knee procedures for questionnaires issued by the Trust from the March 2017 baseline and aspire to be better than the national average.
- We will improve our organisational PLACE Scores reported in 2017 to be at or above the 2016 national average reported scores: Cleanliness 97.57, Food and Hydration 88.49, Privacy, Dignity and Wellbeing 86.03, Condition, Appearance and Maintenance 90.11 and dementia 74.51

- The 2017/18 annual improvement measures for Patient and Service User Experience described in the Strategy are:
- Friends and Family Test - All in-patient areas to achieve a 30% response rate. Maternity to achieve a 30% response rate. ED to sustain the 25% response rate. Out-patients to achieve a 20% response rate. All areas to achieve 95% positive response rate. Adult community services to achieve a 95% positive response rate. Children's community services to achieve a 95% positive response rate.
- NHS Survey - Reduction in disturbance from noise in the in-patient environment. Improved levels of support at mealtime. Improved involvement in decision making.
- Active Patient Pathways - A minimum of 70 patients / service users on active pathways have been spoken to and their feedback is being presented to the Patient and Service Users Experience Group.

Corporate Objectives 2018/19

Tameside and Glossop Integrated Care NHS Foundation Trust's priorities for improvement in 2018/19 are embedded in the Trust Board agreed objectives provided in full at the end of the Quality Account. Our priorities for improvement are developed in the context of our Quality Improvement Strategy and Patient Safety Programme which have been implemented and are currently being redeveloped to reflect the changes in organisational structure and further integration and service transformation.

To ensure our patients and users receive harm free care by improving the quality and safety of our services through the delivery of our Quality, improvement and Safety programmes.

- Maintain compliance with the CQC Fundamental Standards of Care and our overall CQC rating of "Good", but aspire to gain "Outstanding" ratings in future service inspections.
- Further increase our NRLS incident reporting rate per 1000 bed days and aim to be in the top 20% of Trusts and will improve the staff survey feedback response related to incident reporting.
- Minimize levels of severe and catastrophic harm and be below the national average of 1% in NRLS reports
- Ensure our patient safety programme work streams delivers reduced harm by learning from experience, feedback and implementing agreed best practice care pathways for Pressure ulcers, Falls, Infection prevention, Venous Thrombo embolism, Sepsis, Acute Kidney injury and Hyperkalaemia
- Continue to seek improvement of the Trust's mortality indices (HSMR and SHMI) and maintain them in the 'as expected' or "better than expected" bandings.
- Continue to ensure Learning from Deaths is part of the organisational learning and reported in line with the national requirements and aim to have zero avoidable deaths.

To improve our patient and service user experience through the delivery of a personalised, responsive, caring and compassionate approach to the delivery of care.

- Introduce Dining Companions to 50% of adult in-patient wards.

- Manage the FFT within the Emergency department to achieve a 20% response rate and a >90% positive response.
- Further reduce the number of KO41 complaints per 1000 patient contacts from 1 to 0.7 per 1,000 patient contacts.
- Increase the ratio of recorded compliments to complaints received from the Q4 2017/18 baseline (Jan, Feb, March average) 21.84 by 5%.
- Increase the percentage of complaints responded to within an agreed time scale from 90% by 5%.
- Decrease the average time to close concerns (KO41 and PALS) from 12 days to 10 days.
- Improve our participation rates for Patient Reported Outcomes (PROMS) for Hip and Knee procedures for questionnaires issued by the Trust from March 2017 baseline and be better than the national average.
- Continue to work with our partners to reduce the number of delayed discharges to no more than 3.3% across the financial year.

These objectives build on those undertaken in the last year to continue our improvement programme and delivery of Safe, Effective and Personalised care in the services we provide. Progress against these objectives will be reported and monitored through the Trust Board and its subcommittees against agreed standards.

These priorities have been chosen based upon national/local priorities and taking analysed patient and stakeholder feedback. Where benchmarking information has been used in data provided in this report, unless otherwise stated, it has been taken from data available from the Health and Social Care Information Centre.

Monitoring Priorities at Tameside and Glossop Integrated Care NHS FT

The strengthening of divisional and speciality governance systems across the Trust continues to be a priority to ensure that the organisation is assured of the services being provided through the divisional and directorate structures.

We have developed the capacity and capability in our divisional infrastructure with an emphasis on Clinical Leadership with overview and scrutiny from Non- Executive Directors, Governors and third party organisations. This enables the Corporate and executive teams to appropriately monitor, challenge and seek assurance on the improvement, innovation and transformation of services base on the agreed priorities. Furthermore they provide for systematically ensuring that concerns and risks are appropriately managed and escalated with assurance provided through the board subcommittees to Trust Board.

Participation in Clinical Audits

Clinical Audit involves improving the quality of patient and service users care by looking at current practice and modifying it where necessary. We take part in national and regional clinical audits, and we carry out local clinical audits. The Trust also participates in clinical outcome review programmes which investigate an area of healthcare and recommend ways of improving it.

National Clinical Audits

The National Quality Account requirement for 2017/18 contained 54 National Clinical audits and 4 Clinical Outcome reviews.

During 2017/18, 36 National Clinical Audits and 3 Clinical Outcome Review programmes (formally known as National Confidential Enquiries) covered relevant

health services that Tameside and Glossop Integrated Care NHS Foundation Trust provides.

During 2017/18, Tameside and Glossop Integrated Care NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the clinical outcome review programmes which it was eligible to participate in. The high level of participation in Clinical Audits across the Trust demonstrates the commitment to improving care quality, and allows us to benchmark our performance with other Trusts nationally.

The national clinical audits and clinical outcome review programmes that Tameside and Glossop Integrated Care NHS Foundation Trust was eligible to participate in during 2017/18 are as follows and whether we participated during 2017/18 are listed below:

National Clinical Audits	Participation
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes
Bowel Cancer (NBOCAP)	Yes
Cardiac Rhythm Management (CRM)	Yes
Case Mix Programme (CMP) ICNARC	Yes
Diabetes (Paediatric) (NPDA)	Yes
Elective Surgery (National PROMs Programme)	Yes
Endocrine and Thyroid National Audit	Yes
Falls and Fragility Fractures Audit programme (FFFAP)	Yes
Fractured Neck of Femur (care in emergency departments)	Yes
Head and Neck Cancer Audit (HANA)	Yes
Inflammatory Bowel Disease (IBD) programme	Yes
Learning Disability Mortality Review Programme (LeDeR)	Yes
Major Trauma Audit	Yes
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes
National Audit of Dementia	Yes
National Audit of Intermediate Care (NAIC)	Yes
National Audit of Rheumatoid and Early Inflammatory Arthritis	Yes
National Audit of Seizures and Epilepsies in Children and Young People	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Yes
National Comparative of Blood Transfusion Programme	Yes
National Diabetes Audit – Adults	Yes
National Emergency Laparotomy Audit (NELA)	Yes
National End of Life Care Audit	Yes
National Heart Failure Audit	Yes
National Joint Registry (NJR)	Yes
National Lung Cancer Audit (NLCA)	Yes
National Maternity and Perinatal Audit	Yes
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes
Oesophago-gastric Cancer (NAOGC)	Yes

National Clinical Audits	Participation
Pain in Children (care in emergency departments)	Yes
Procedural Sedation in Adults (care in emergency departments)	Yes
Prostate Cancer	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes
UK Parkinson's Audit	Yes

Clinical Outcome Review Programmes	
Child Health Clinical Outcome Review Programme a) Young People's Mental Health b) Chronic Neurodisability c) Cancer in Children, Teens and Young adults	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme a) Confidential enquiry into serious maternal morbidity b) Maternal mortality surveillance c) Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) d) Perinatal mortality surveillance	Yes
Medical & Surgical Clinical Outcome Review Programme a) Perioperative Diabetes b) Heart Failure	Yes

The national clinical audits and clinical outcome review programmes that Tameside and Glossop Integrated Care NHS Foundation Trust participated in, and for which data collection was completed during 2017/18 are listed below alongside the number of cases submitted for each audit or review as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits	Number submitted	Percentage submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Continuous Data Collection	
Bowel Cancer (NBOCAP)	Continuous Data Collection	
Cardiac Rhythm Management (CRM)	Continuous Data Collection	
Case Mix Programme (CMP) ICNARC	Continuous Data Collection	
Diabetes (Paediatric) (NPDA)	Continuous Data Collection	
Elective Surgery (National PROMs Programme)	Continuous Data Collection	
Endocrine and Thyroid National Audit	Continuous Data Collection	
Falls and Fragility Fractures Audit programme (FFFAP) a) Inpatient falls b) Hip Fracture database	a) 30/30 b) Continuous Data collection	a) 100% b) Continuous Data collection
Fractured Neck of Femur (care in emergency departments)	100/100	100%
Head and Neck Cancer Audit (HANA)	No data collection required in 2017/18	
Inflammatory Bowel Disease (IBD) programme	Continuous Data Collection	
Learning Disability Mortality Review Programme (LeDeR)	Continuous Data Collection	
Major Trauma Audit	Continuous Data Collection	
National Audit of Breast Cancer in Older Patients (NABCOP)	Continuous Data collection	
National Audit of Dementia	20/20	100%
National Audit of Intermediate Care (NAIC)	2/2	100%
National Audit of Rheumatoid and Early Inflammatory Arthritis	No data collection required in 2017/18	
National Audit of Seizures and Epilepsies in Children and Young People	No data collection required in 2017/18	
National Cardiac Arrest Audit (NCAA)	Continuous Data Collection	
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Continuous Data Collection	
National Comparative Blood Transfusion Programme a) Transfusion Associated Circulatory Overload (TACO) b) Red cell and platelet transfusion in adult haematology patients	a) 37/37 b) 14/14	a) 100% b) 100%
National Diabetes Audit - Adults	71/71	100%
National Emergency Laparotomy Audit (NELA)	Continuous Data Collection	
National End of Life Care Audit	No data collection required in	

National Clinical Audits	Number submitted	Percentage submitted
	2017/18	
National Heart Failure Audit	Continuous Data Collection	
National Joint Registry (NJR)	Continuous Data Collection	
National Lung Cancer Audit (NLCA)	Continuous Data Collection	
National Maternity and Perinatal Audit	Continuous Data collection	
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Continuous Data collection	
Oesophago-gastric Cancer (NAOGC)	Continuous Data Collection	
Pain in Children (care in emergency departments)	50/50	100%
Procedural Sedation in Adults (care in emergency departments)	50/50	100%
Prostate Cancer	Continuous Data Collection	
Sentinel Stroke National Audit Programme (SSNAP)	Continuous Data Collection	
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Continuous Data Collection	
UK Parkinson's Audit	71/71	100%

Clinical Outcome Review Programmes	Number submitted	Percentage submitted
Child Health Clinical Outcome Review Programme a) Young People's Mental Health b) Chronic Neurodisability c) Cancer in Children, Teens and Young adults	a) 6/6 b) 4/4 c) N/A	a) 100% b) 100% c) N/A
Maternal, Newborn and Infant Clinical Outcome Review Programme a) Maternal Mortality Surveillance b) Perinatal Mortality and Morbidity (Term Intrapartum Related Neonatal Deaths) c) Perinatal Mortality Surveillance	Continuous Data Collection	
Medical & Surgical Clinical Outcome Review Programme a) Peri-operative Diabetes b) Heart Failure	a) 6/6 b) 4/4	a) 100% b) 100%

The reports of 36 national clinical audits were reviewed by the provider in 2017/18 and Tameside and Glossop Integrated Care NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Reports are scheduled for presentation and discussion at speciality or multi-speciality audit/clinical governance meetings. At these meetings recommendations and action plans are agreed to improve practice to ensure care is improved. Examples are provided below of national audit reports received and the associated quality improvement actions taken or being implemented. Updates on all 36 reports reviewed are reported in the annual audit report.

Audit Title	Quality Improvement Actions

Audit Title	Quality Improvement Actions
Sentinel Stroke National Audit Programme (SSNAP)	Findings of the national reports discussed at stroke business meetings, improvements identified include: • Junior Doctor Induction training on Transient Ischaemic Attack and Stroke pathways • Stroke team attend daily admission unit board rounds to identify overnight stoke admissions • Liaison with community teams including daily handover with community neuro-rehabilitation team and the stoke association long term support service (commissioned third sector organization) who offer patient and family support • Occupational Therapy – Speech and Language Therapy (SALT) are looking at increasing group work to maximize input and social interaction for the patients • Exploring the approach to repatriate patients from the hyper-acute stoke centres following the first 72hrs of care. • Working towards improving data completion rates by developing a process to monitor data submission timescales, establish thresholds and escalation alerts for patients 7 day discharge / transfer information.
National Diabetes Core Audit	Findings of the national report shared with the division. • Diabetes improvement project being undertaken in conjunction with the commissioners. • Practice level dashboards produced showing compliance with annual checks and non-elective attendances/admissions. • Trust diabetic specialist nurses to provide education and training to GP practices.
National neonatal audit programme	Findings of the national report sent to the division and discussed at the Paediatric audit meeting: • A revised thermoregulation policy introduced that includes the use of gel pads for all babies less than 13 weeks. • Nurse/midwives measuring and documenting temperature prior to transfer and immediately on admission to Neonatal intensive Care unit (NICU), before removal from transport incubator. • Incident forms submitted for any baby with an admission temperature outside the recommended range. • Focus on minimising draughts in the delivery suite. • Guideline regarding the use of magnesium sulphate re-circulated. • Obstetricians ensuring clear documentation of administration of magnesium sulphate and midwives ensuring this is entered on the maternity information system (specific prompt now in place). • Retrospective review of cases where magnesium sulphate was not administered. • Data regarding consultation with parents shared with consultants quarterly.
National heart failure audit report	Findings of the national report sent to the division and discussed in the cardiology business group. • Business case being developed to expand heart failure specialist nurse service. • Review of cardiac unit set-up and resources to improve the rates of patients with heart failure being managed on a cardiac ward. • Pathway awareness raising; medicine audit meeting, junior doctor teaching session and meeting with an emergency department consultant.
National Cardiac Arrest Audit (NCAA)	Findings of the report sent to Trust Resuscitation Lead to be progressed via the Managing Deteriorating Patient Group. Long term programme of quality improvement and local audit identified: • Revised DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) Policy introduced

Audit Title	Quality Improvement Actions
	• New DNACPR form implemented across the organisation • Local cardiac arrest test call and response audit being undertaken.

The results of 64 local clinical audits were reviewed by the provider in 2017/18 and Tameside and Glossop Integrated Care NHS Foundation Trust intends to take the following actions to improve the Quality of healthcare provided. Reports are scheduled for presentation and discussion at speciality or multi-speciality audit/clinical governance meetings. At these meetings recommendations and action plans are agreed to improve practice to ensure care is improved. Examples are provided below of local audit reports received and the associated quality improvement actions taken or being implemented. Updates on all 64 reports reviewed are reported in the annual audit report.

Audit Title	Quality Improvement Actions
Management of Acute Hyperkalemia	The results have been presented at various forums to highlight the main findings. The following actions have been taken: • A local guideline for the acute management of hyperkalemia in adult inpatients has been introduced (incorporating The Renal Association Guidance) • Teaching for Foundation doctors has been delivered
Standardising Ear Nose & Throat (ENT) Operative Notes	Four cycles of data collection have been undertaken, with various actions taken. The main focus was the introduction of an electronic ENT operative notes proforma, with compliance with the Royal College of Surgeons Guidance reaching 100%.
Fluid Balance on Surgical Unit & Acute Kidney Injury (AKI) on the Acute Medical Unit	These two projects have followed previous work to improve AKI management throughout the Trust. Following the collection of baseline data, a need for further education around AKI and the importance of effective fluid management was identified. The following actions have been undertaken: • New Trust Fluid Balance Chart developed and launched in conjunction with World Kidney Day • Revised AKI Care Bundle introduced • Training provided on all wards with ongoing point of care support provided • Stage 2/3 AKI identified and attended by Clinical Effectiveness nurse • Awareness raising through presentations at Divisional meetings/Trust events • AKI training included in Trust Induction and available on request • 'Improving AKI Care' Intranet page developed Further data collection will be undertaken to monitor progress but feedback from observations suggests improved knowledge and patient management.
Sepsis CQUIN	Below are some of the actions implemented: • Revised Adult Sepsis Care Bundle and a Sepsis Screening Sticker introduced in Emergency Department (ED) • Clinical Effectiveness Nurse Lead for Sepsis designated • Awareness raising through presentations at Divisional meetings/Trust events • Sepsis training added to Trust/Junior Doctor/Nurse induction training programmes & point of care training delivered • Sepsis recognition and treatment guidance cards provided for all clinical staff • 'Improving Sepsis Care' intranet page developed As a result, compliance with the administration of IV antibiotics to patients presenting with red flag sepsis or septic shock, within 1 hour of presentation is consistently achieving 100%.
Audit of British Dermatology Association (BAD) minimum standards for a phototherapy service	A compliance rate of > 80% was achieved in 17/22 of the audit standards. The following actions have been taken to improve in other areas: • A consultant lead has been appointed for phototherapy • A phototherapy nurse has been recruited • The phototherapy request form has been redesigned to include skin phototypes • When patient leaflets are given, this is now documented in the patient notes
Decontamination of Flexible Nasendoscopes	The results were presented and discussed, with the following actions taken: • Decontamination instructions appropriately displayed • Gloves provided close to the scope • Sterile bags ordered for storing and transporting the scope

Audit Title	Quality Improvement Actions
	• Training in decontamination provided Further data collection has showed significant improvements, with compliance of 100% in most areas. Further education has been provided regarding completion of the log book and a third cycle of data collection showed compliance of 80%.
Dermatology Record Keeping	The report highlighted significant improvements in the recording of a printed name, professional registration number and designation, with an increased use of professional stamps. Further education has been provided to the clinical team.
Recognition and Management of Fragility Fractures	The following actions have been taken to improve: • An Osteoporosis & Fragility Fractures Patient Information Leaflet has been designed and is now given to appropriate patients attending fracture clinic • Fragility Fractures are now explicitly referred to in GP letters, with advice provided • The potential for a Fracture Liaison Service is being discussed with the Rheumatology Department
Paediatric early warning score (PEWS)	Following audits in both the Children's Unit and Emergency Department (ED), the teams have worked together to introduce a new consolidated PEWS proforma , which is suitably sensitive to set appropriate early warning triggers in both areas. An audit measuring compliance with the new proforma has shown significant improvements in doctor review times and correct completion of the PEWS score. Training on the new tool is on-going and further data to measure the impact has recently been undertaken.
National Early Warning Score (NEWS)	As an action from data collected in 2016, a project manager was designated to design, co-ordinate and monitor a Trust wide NEWS improvement programme. This included extensive training and education, the introduction of a revised escalation protocol and a review of the Trust's Adult Observation Chart for NEWS, leading to the development and launch of a comprehensive Clinical Observation Booklet. Appropriate training has been incorporated into the Trust induction process. Further data collection has found significant improvements in the scoring and calculating of NEW scores.
GAMMA Nail	Following the findings of the initial audit to assess degree of mismatching the lateral view of distal femur of all gamma nails, it was agreed to change length R200 to R150 Gamma Nail. A re-audit noted an improvement from 80% of eccentric placement to 25%. These findings were discussed in the orthopedics audit meeting with the surgeons agreeing that the remaining eccentric placements are due to variation of angle in the population and are therefore acceptable.
Audit of the Discharge Policy for Children	To ensure accurate and timely transfer of information from the hospital to primary care, a discharge checklist has been introduced. A second cycle of data collection shows improved compliance at 100% in many areas.
Maternity early warning score (MEWS)	Following a number of quick data collection cycles, it was agreed that the MEWS chart should be aligned to the Trust's national early warning score (NEWS) chart. Staff commitment to improving patient care has resulted in the below key achievements: • A revised MEWS chart, aligned to the Trust NEWS chart has been integrated into the antenatal, labour and postnatal clinical care guidelines and launched via training sessions with appropriate staff throughout the trust • The ward manager audits compliance with MEWS and escalates areas of concern via the O&G Clinical Governance Group • Opportunity for compliance has been increased by placing the MEWS chart near the patient in specially procured folders

Audit Title	Quality Improvement Actions
	These measures have resulted in significant improvements between Nov 2016 and Nov 2017.
Unnecessary Admissions for Hyperemesis	In order to reduce unnecessary hospital admissions for women suffering from mild/moderate nausea and vomiting in pregnancy (NVP) and to ensure compliance with Royal College of Obstetricians and Gynaecologists (RCOG) Guidelines, the following improvements have been implemented: • A new pathway has been introduced, with low/moderate risk patients presenting to ED/GP/Antenatal Clinic/Midwives provided with an out-patient IV therapy service to avoid hospital admission • All appropriate services/stakeholders have been informed and appropriately trained in order to implement the pathway
Carbon Monoxide Screening	The audit resulted in the following improvements: • All maternity staff have been trained on using CO2 monitors • Stop smoking champions have been recruited in all maternity areas, undergoing training on behavioral support/use of Nicotine Replacement Therapy to enable them to support women to stop smoking • CO_2 reading recording has been added to Euroking, with prompts at booking and 36 weeks • Staff have been briefed on the problems caused by faulty boilers and passive smoking and how to discuss smoking with mums A further audit cycle is currently being undertaken to measure the impact of the changes made.
Audit of Neonatal Sepsis Guidelines	This audit was based on NICE guidance for early onset sepsis to prevent this significant cause of mortality and morbidity in newborn babies. The audit resulted in the following quality improvements: • A cannulation trolley has been purchased • The observation proforma has been redesigned • Consensus of IV antibiotics to neonates has been disseminated • IV antibiotics administration in neonates training for midwife is continuing
Adherence to Ventilator Associated Pneumonia (VAP) Bundle	The audit found encouragingly high levels of compliance with the care bundle throughout, with the following actions for improvement currently being implemented: • VAP teaching sessions to be delivered and integrated into the induction programme • A section on 'sedation hold' is to be added to the daily clerking sheet
Perioperative Hypothermia	Following previous cycles of data collection, the results were discussed at various forums and the following actions implemented: • Core temperature probes introduced for major surgery • Importance of temperature monitoring in relation to inadvertent hypothermia communicated • Guidance/pathways for temperature monitoring displayed in theatres The results show some encouraging results but progress will be monitored through further data collection cycles.
Nutrition and Hydration	Three cycles of data collection have been undertaken with significant improvement in dietician referral for high scoring patients demonstrated. The following are some of the actions taken: • Body Mass Index (BMI) calculation charts made available on patient note trolleys and ward based teaching on their use delivered • Tape measures made available/new standometers purchased • The weighing hoist has been located centrally in Adult Medical Unit (AMU) • Hoist scales training included in Trust mandatory manual handling training for all clinical staff • A revised Malnutrition Universal Screening Tool (MUST) proforma has been launched and is included in the AMU Quality & Safety Round checklist • MUST e-learning completion is encouraged • Regular MDT Nutrition Study days offered • Dieticians/nutrition nurse led nutrition sessions delivered to FY1 Doctors

Learning from Deaths

The National Quality Board (NQB) Learning from Deaths framework requires hospital trusts to adopt a standardised and transparent approach to learning from the care provided to patients who die.

The Tameside & Glossop Integrated Care NHS Foundation Trust has undertaken mortality reviews (case review) on all deaths since November 2014 as part of its Quality Improvement Programme which we believe is best practice and avoids us having to identify which cases need to be reviewed. We focus on learning from the care provided, and being accountable for our actions and ensuring improvement if sub-standard care is identified.

The mortality review process under the leadership of the Medical Director is in place to support the Trust in developing a culture of learning, openness and transparency and sharing information with the bereaved family or carer by providing them with the opportunity to inform the review of investigation process in addition to the Duty of Candour requirements. We have commenced reporting to Trust board on a quarterly basis and have an identified non-executive director lead in this regard.

The reviews are completed by trained multi-disciplinary team members, using standardised documentation which is aligned to the National Learning from Deaths Guidance and the requirements of the Child Death Overview Panel (CDOP) and Learning Disability Mortality Review (LeDeR) Programme.

All case reviews and investigations are completed with an aim of identifying any learning by way of missed opportunities or to identify practice related issues. The reports are shared through divisional and trust governance and safety forums, and the executive led Mortality Steering Group to share the learning trust wide and across the health economy.

Through the Mortality Steering Group the clinical teams are required to develop comprehensive action plans to address missed opportunities, the group also recognise and highlight areas of good practice which are shared with staff involved in the care.

The Trust is committed to learning from the mortality review process and continues to develop and strengthen the process, for 2018/19 the Trust recognises the importance of gaining the views of bereaved relatives and carers and is developing a process to ensure that they are involved and may direct any investigation.

The Trust Learning from Deaths Policy applies to all patients that die in hospital and where the Trust has been involved in the care of the patient (including deaths that have occurred outside of the organisation whereby shared care has been provided).

The scope of the policy therefore may include deaths where other triggers for investigation are evident. Wherever possible an integrated approach to investigations is adopted to ensure investigations provide for the requirements of any incident, complaint, safeguarding concerns or coronial inquests requirement to avoid unnecessary duplication.

During 2017/18, 1101 Tameside & Glossop Integrated Care NHS Foundation Trust patients died.

By 31st March 2018, 983 case record reviews and 10 Investigations have been carried out in relation to 10 of the patient deaths detailed. In 10 cases a death was subjected to both a case record review and an investigation.
The number of deaths in each quarter for which a case record review or an investigation was carried out was:

10 representing 1.0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 4 representing 1.9% for the first quarter;
- 0 representing 0.0% for the second quarter;
- 2 representing 0.7% for the third quarter;
- 1 representing 0.2% for the fourth quarter;

The table below shows the quarterly breakdown of required activity in each quarter of that reporting period:

	Patients that died	Completed case record reviews	Case review and investigation (Number)	Case review and investigation (%age)
Q1 Apr – Jun 17	210	210	7	1.9%
Q2 Jul – Sep 17	202	202	0	0.0%
Q3 Oct - Dec 17	273	273	2	0.7%
Q4 Jan – Mar 18	416	298	1	0.2%

0.3% (2) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter this consisted of:

- 0% of deaths for the first quarter
- 0.9 % (2) for the second quarter
- 0% of deaths for the third quarter
- Completed fourth Quarter data not available at time of report

These numbers have been estimated using the following methods

Mortality reviews completed using the standardised mortality review process in accordance with the Trusts Learning from Deaths Policy. Investigations completed in accordance with the Trusts Incident Reporting, and Incident and Complaint Investigation Policy.

The focus of the case reviews and investigations is to identify any learning by way of missed opportunities or practice related issues. The outcomes are shared through divisional and trust wide governance and safety forums, including the executive led Trust Mortality Steering Group to share the learning Trust wide, and the information triangulated with other sources of information to ensure thematic learning is understood and actioned.

The Table below highlights the learning and action taken

Learning	Action taken
Inconsistent communication and documentation documented in plans of care, handover or escalation plan when patients deteriorate by clinical teams	Reminders to all Clinical teams and staff of the importance and requirement for consistent and comprehensive documentation to enable high quality patient care and treatment. The Trust has also implemented an E CAS card system to standardise processes and approach providing greater clarity and consistency.
Necessity for ensuring senior clinician oversight, review and awareness of patients prior to discharge from the emergency department	Implemented process for consistent senior clinical oversight prior to discharge.
Inconsistency in NEWS scoring and calculation and therefore appropriate escalation of the deteriorating patient	Review and implementation of a revised National Early Warning Score (NEWS) Chart incorporating NEWS 2 in line with National Guidance overseen by the Managing the Deteriorating Patient Safety Workstream. The Trust has also implemented an E CAS card system which standardises this process. The development will be considered for Trust wide implementation to provide clarity and consistency.

Learning	Action taken
Delay's in the recognition, timely management and treatment of Acute Kidney Injury (AKI), hyperkalaemia & Red Flag Sepsis with inconsistency in completion of fluid balance charts	AKI – Generation of a daily laboratory report to identify patients with AKI stage 2 & 3, a clinical review of the patient is completed to ensure timely interventions and management in line with the implemented revised AKI pathway and guidance AKI Awareness training delivered to all clinical staff on trust induction and various MDT forums – including toolbox talks in clinical areas AKI Risk Assessment Flow Chart Guidance incorporated into a new Fluid Balance Chart that also incorporates a Recommended Protocol for Commencing Fluid Balance Monitoring to support clinical staff, implemented Trust wide. Awareness training delivered to all clinical staff on trust induction and various MDT forums – including toolbox talks in clinical areas Sepsis Care Pathway and Screening Tool updated to reflect revised NICE guidance in association with the clinical teams - Awareness training to all clinical staff on trust induction and various MDT forums – including toolbox talks in clinical areas Management of acute Hyperkalaemia Guidance developed and implemented - Awareness training to all clinical staff on trust induction and various MDT forums – including toolbox talks in clinical areas

As a Trust we continue to learn and improve our approach to learning from deaths following the implementation of the actions described above the impact of these is that we do not anticipate these issues arising again and or have reviewed the effect of implementation of revised care pathways and guidance and can demonstrate:

- Sepsis: compliance with the administration of IV antibiotics to patients presenting with red flag sepsis or septic shock, within 1 hour of presentation is consistently reported at 100% in monthly audits as part of the CQUIN.
- NEWS: following an extensive training programme further audit data collection has showed significant improvements, with compliance in the scoring and calculating of NEW scores.
- Clinical review of patients identified with AKI has found encouragingly high levels of compliance by the clinical teams with use of the AKI care bundle and reduction in time taken to reduce the stages of AKI to 0, progress will be monitored through further audit cycles to validate these observations.

Compliance and assurance has been assessed during the reporting period and taken from monitoring of action plans in place within Divisions, clinical audits of compliance and reviews at point of care for these patient groups.

Whilst the Quarterly learning from deaths reporting process started formally to Trust

board in September 2017, 2 deaths that were subject to both a case record review and an investigation have been completed during the reporting period April 17 to March 18) which related to deaths which took place before the start of the reporting period.

0% of the 2 patient deaths before the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. This number has not been estimated as we review all deaths using the methods as described above.

The total number of deaths identified in the 2017/18 reporting period and the previous reporting period for Tameside & Glossop Integrated Care NHS Foundation Trust is 0.3% (2) that were judged to be more likely than not to have been due to problems in the care provided to the patient. However a number of deaths are still to be reviewed through the Coronial process and this may change the reported figure.

Implementing the priority clinical standards for seven day hospital services.

The Trust has considered the priority clinical standards for seven day services and the potential impact of these. We have undertaken a gap analysis and developed a business case to set out the consequence of the implementation. This is being discussed with commissioners.

The service improvement and transformation programmes being implemented are also being used where possible to ensure that where service review and redesign is being undertaken that we make progress towards achievement of these standards where possible. The Trust undertakes the national audits of the four priority standards to assess it compliance and progress towards the requirements by 2020. The results of these are captured in the annual audit report published separately.

Research and Development

Research is vital to improve the knowledge needed to develop the current and future quality of care for patients. Carrying out high quality research gives the NHS the opportunity to minimise inadequacies in healthcare and improve the treatments patients receive. The Trust is only involved with research studies that have received a favourable opinion from the Research Ethics Committee within the National Research Ethics Service (NRES), and the Health Research Authority, signifying the research projects are of high scientific quality and have been risk assessed.

The Research Department is committed to providing patients with the opportunity to participate in research, if they wish. We aim to ask all eligible patients if they would like to participate in a clinical trial.

The number of patients receiving relevant health services provided or sub-contracted by the Tameside and Glossop Integrated Care NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 588 (at 23/01/2018). This has surpassed our target of 544 participants, set by the Clinical Research Network.

Currently, there are 108 research studies, a growth from 2016/17, either in the planned stage, are active or in follow up. We have 34 actively recruiting studies which are adopted on to the National Institute for Health Research (NIHR) Clinical Research Network portfolio. These studies are high quality trials that benefit from the infrastructure and support of the Clinical Research Network (CRN) in England. We are currently hosting 4 actively recruiting clinical trials involving medicinal products, with two further CTIMP studies in the planning stage, which demonstrate the Trusts enthusiasm to improve and offer the latest medical treatments.

The Trust has strong team of 6 (3 full time and 3 part time) dedicated research nurses working generically on a variety of research studies and 2 clinical trials administrators. The Trust has strong research activity in Cancer, Orthodontics and Paediatrics and we continue to get more and more departments involved. This year, we have seen a large increase in recruitment to reproductive health & childbirth and Stroke studies. The recruitment to musculoskeletal disorders has also increased in recent months. The ophthalmology department has recently opened to their first research study. A number of other departments have shown interest in becoming research active, in areas covering dementia, cardiology and ENT and we are waiting for suitable studies to become available to get involved with. There are currently over 20 clinical staff acting as the Trust lead investigator on approved research studies.

The Trust research nurses work closely with the investigators to identify suitable research studies that fit with the patient population and also to identify eligible patients to participate. It is envisaged that the continued dedication and flexibility of the research nurses, together with the enthusiasm and support of the clinicians will further raise the profile of Research and Development in 2018/19.

2017/18 has seen a number of achievements for the research department;

- The research department held its first Research Conference at Tameside hospital in February 2018. This will hopefully become an annual occurrence.
- The research team and EPAU staff enrolled 150 patients to the VESPA study within 6 weeks. This is the result of the dedication to work out of hours and weekends.

- Tameside Hospital is the highest recruiter to the Stroke Rehabilitation and Dementia study with 45 patients recruited, exceeding our target of 40 patients.
- Tameside Hospital is the highest recruiter in Greater Manchester to the international study PRED 4.
- The research department has surpassed its annual recruitment target for 2017/18, well ahead of the end of the financial year.
- The research department holds an annual stand for International Clinical Trials Day, to promote research within the Trust
- Tameside Hospital is regularly praised for recruitment achievements at the Clinical Research Network: Greater Manchester Board meetings
- The research team continue to achieve high performance rates and regularly surpass the study recruitment targets and the Clinical Research Network targets

The Trust continues to participate in research studies that are feasible in terms of the services we offer and our patient population and aspire to raise the profile of research further in 2018/19.

Goals agreed with the Commissioners

The Clinical Commissioning Group for Tameside and Glossop holds the NHS budget locally and they decide how it is spent within the hospital and other community health services. This is known as commissioning. Tameside and Glossop CCG is the lead commissioner of services at Tameside and Glossop Integrated Care NHS Foundation Trust and incentives based on Quality and Innovation. These payments support Quality as a driving principle.

A proportion of Tameside and Glossop Integrated Care NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Tameside and Glossop Integrated Care 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. The monetary total for the amount of income in 2017/18 conditional upon achieving quality and improvement goals was £3.60m and the monetary value to CQUIN in 2017/18 which was achieved was £3.58m compared to £3.36m in 2016/17.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at http://www.england.nhs.uk/nhs-standard-contract/

The summary detail of Tameside and Glossop Integrated Care NHS Foundation Trusts CQUIN goals are identified in the table below

2017/18 CQUIN Goals

Indicator Number		Indicator Name	year ends status
National	1a	Improvement of health and wellbeing of NHS staff	Achieved
	1b	Healthy food for NHS staff, visitors and patients	Achieved
	1c	Improving the uptake of flu vaccinations for frontline clinical staff	Partial achievement
	2a	Timely identification of patients with sepsis in emergency departments and acute inpatient settings	Achieved
	2b	Timely treatment for sepsis in emergency departments and acute inpatient settings	Achieved
	2c	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	Achieved
	2d	Reduction in antibiotic consumption per 1,000 admissions	Achieved
	4	Improving services for people with mental health needs who present to A&E	Achieved
	6	Advice & Guidance	Achieved
	7	E-referrals	Achieved
	8a	Supporting proactive and safe discharge - discharge pathways	Achieved
	8b	Supporting proactive and safe discharge - Emergency Care data set	Achieved
	8c	Supporting proactive and safe discharge - increased discharges within 7 days of non-elective patients	Achieved
	10	Improving the assessment of wounds	Achieved

	11	Personalised care and support planning	Achieved

What others say about Tameside and Glossop Integrated Care NHS Foundation Trust

The Care Quality Commission (CQC) regulates and inspects Health and Social Care organisations. If it is satisfied that the organisation provides care which meets the Fundamental Standards of Quality and Safety it registers the organisation to provide services "without conditions".

Tameside and Glossop Integrated Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "GOOD".

Tameside and Glossop Integrated Care NHS Foundation Hospital Trust has no conditions on its registration.

The Care Quality Commission has not taken enforcement action against Tameside and Glossop Integrated Care NHS Foundation Trust during 2017/18.

Tameside and Glossop Integrated Care NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2017/18.

In August 2016 the CQC undertook a Chief inspector of Hospitals comprehensive inspection, and inspected specific core services of the Hospital Trust identified in the matrix below, covering all acute services. The report was issued in February 2017 and the matrix of current outcomes reported is identified in the table below by service area.

CQC Ratings for Tameside and Glossop Integrated Care NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care (including older people's care)	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Urgent and emergency services (A&E)	Good	Good	Good	Requires improvement	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

The Tameside and Glossop Community Services have not yet been inspected and rated as part of the Trust.

The Chief Inspector of Hospital's review made 1 non-urgent recommendation relating to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities), drawn from the "MUST DO's "within the CQC report to enhance the Safety, Effectiveness and Responsiveness of care provided by the Trust.

The key themes of these recommendations were related to:

- Improving patient flow throughout the hospital minimise transfers and ensure timely access to services to meet the patient's needs.
- Maintaining staffing levels to meet the needs of patients.
- Achievement of consistent levels of mandatory training and appraisal in all areas.
- Consistent management of medicines in line with best practice in all areas.

We have implemented actions or reviewed ongoing work programmes to ensure the issues identified are addressed. Oversight and improvement arrangements have been put in place to support the changes required. The required improvements have been integrated into the Trust Patient Safety Programme work streams or Improvement work streams which are systematically monitored and provide updates and assurance on progress through our Divisional and Corporate Governance structures.

The Quality and Governance committee continues to oversee the organisational assurance of these actions and progress through direct reports to the committee or by use of Assurance walk rounds which committee members participate in to obtain real-time assurance on actions previously reported to the committee.

Tameside and Glossop Clinical Commissioning Group Quality walk round visits

Tameside and Glossop Clinical Commissioning group have not undertaken Quality walk round visits in 2017/18, however the CCG Director of Nursing and Quality continues to be a routine invitee to the Trust Quality and Governance committee meetings and walk rounds during the year and Chairs the Contact Quality and performance meeting to seek and receive assurance on service provision.

Other Reports

UNICEF Baby friendly award

Our Health Visitors and Children's Centres have been awarded the UNICEF Baby Friendly Award in 2017

JAG (Joint Advisory Group on Gastrointestinal Endoscopy) Accreditation

The Trust successfully retained its JAG (Joint Advisory Group on gastrointestinal endoscopy) accreditation. This accreditation is a quality improvement and service accreditation programme which assesses endoscopy units for quality of service provision to provide assurance to patients and commissioners of the quality of service being provided.

GIRFT (Get It Right First Time) reports

The Getting It Right First Time (GIRFT) Programme is helping to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes. The Trust is engaging with these work streams and the

analysis provided to identify learning and service changes that could impact on the Quality and Safety of Care and impact on the effective use of resources.

Data Quality

Tameside and Glossop Integrated Care NHS Foundation Trust recognise that good data quality and information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. Improved Data quality will improve patient care and improve value for money.

NHS Number and General Medical Practice Code Validity

Tameside and Glossop Integrated Care NHS Foundation Trust submitted records during April 2017 to March 2018 to the Secondary Users Service (SUS) for inclusion in the Hospital Episode Statistics. These are included in the latest published data (Jan 2018). The percentage of records in the published data which included the patient's valid NHS number was:

- 99.9% for admitted patient care;
- 100% for outpatient care; and
- 99.6% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

Tameside and Glossop Integrated Care NHS Foundation Trust continue to take the actions to improve data quality. The Trust recognises that the metrics listed above constitute an extremely narrow view of data quality and has, therefore, created a forum to monitor and manage data quality, using a wider definition, across the organisation. The Data Quality Steering Group is designed to provide assurance on the implementation and maintenance of information quality assurance standards, ensuring that system users are engaged in the enterprise of continuous data-quality improvement through informed discussion and shared knowledge on the accuracy, completeness and timeliness of data entry and the resolution of any issues with data quality. The Data Quality Steering Group will manage and oversee the Trust's Data Quality Improvement Plan and continuously reviews the Trust's Data Quality Scorecard, identifying areas for improvement and supporting the development of strategies and processes to facilitate this.

Information Governance Toolkit attainment levels

Information Governance is about how NHS and social care organisations and individuals handle information. This can be personal, patient, sensitive and/or corporate information. Tameside and Glossop Integrated Care NHS Foundation Trust Information Governance Assessment Report for 2017/18 was 68% and was graded Green (satisfactory for all requirements).

Clinical Coding Error Rate

Tameside and Glossop Integrated Care NHS Foundation Trust was not subject to the Payment by Results (PbR) Clinical Coding Audit during 2017/18 by the Audit Commission.

The Trust's 2016/17 Clinical Coding Audit Report conducted in November 2016 by our Accredited Clinical Coding Auditor, related to coded activity from the period July to September 2016 identified that:

The overall standard of clinical coding was good and the Trust had attained the recommended information governance level 2 target. (See table below for details).

The general standard of clinical coding at the Trust is good and has shown improvement since last year's audit. 93% of primary diagnoses audited and 94% of the primary procedures were correctly recorded. Therefore the Trust has attained the recommended information governance level 2 targets.

Table of main findings

	Total from episodes audited	**Total correct**	**% correct**
Primary diagnosis	200	186	93
Secondary diagnosis	592	520	88
Primary procedure	178	168	94
Secondary procedure	449	391	87

In order to deliver the further improvement the Tameside and Glossop Integrated Care NHS Foundation Trust will be taking the following action to improve data quality through its Clinical Coding Department by continuing to internally audit and action the results and provide a training programme.

The purpose of the programme is to ensure continuous improvement and increased effectiveness of the clinical coded data being produced. The impact of the training and validation during the last 12 months has resulted in further improvement in data quality evidenced in the results provided.

Reporting against Quality Account Core indicators

The prescribed requirement for reporting against core indicators listed below has been undertaken and is provided in the next section of the Quality account - How we performed on Quality in 2017/18 alongside the reporting of the current performance for the indicator.

Core indicator requirement number and description	Reported on
12. (a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	Page 80
18. The trust's patient reported outcome measures scores for: (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.	Page 75
19. The percentage of patients aged - (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	Page 76
20. The trust's responsiveness to the personal needs of its patients during the reporting period.	Page 66
21. The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	Page 69
23. The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	Page 52
24. The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	Page 55
25. The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death	Page 58
Friends and Family Test results	Page 61
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Page 67
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	Page 67
All cancers: 62-day wait for first treatment from:	Page 68

Part Three

How we performed on Quality in 2017/18

This section of the Quality Account provides an overview of the quality of care based on performance in 2017/18 against indicators selected by the Board in consultation with stakeholders following the regulatory reviews and agreed as part of the Trust Improvement programme. Where appropriate and available historic information has been provided, and where mandated for Core indicators with national benchmarking data and commentary as required.

The benchmarking data provided reflects the information currently available via the NHS digital indicator portal at the time of finalising the report.

Organisational Transformation and Quality and Safety Initiatives progressed throughout 2017/18

The Trust strategic plan sets out the organisational goals for continuous improvement by developing and transforming the services we provide. To progress these we have continued to implement a range of quality initiatives, service development and a programme of transformation. In doing this we continue to ensure service provision meets the requirements of the Fundamental Standards of Quality and Safety. Implementation has been monitored internally and assurance provided through the Trust Governance structures. In order to ensure openness and candour with our key stakeholders we continue to invited attendance at the Trust Quality & Governance Committee of the CCG Director of Nursing and Quality and the Healthwatch Tameside manager, and Trust Governors have also attended the Quality and Governance meetings.

Service improvement and transformation

Throughout 2017/18 we have focussed on a number of system-wide transformational schemes and improvement programmes to improve the way we provide our services and improve the Quality, Safety and effectiveness of the care provided. Each of these schemes have agreed performance indicators and criteria which are monitored through the Governance structures in place.

Our system-wide Care Together Programme across Tameside and Glossop aims to:

- support local people to remain well by tackling the causes of ill health, supporting behaviour and lifestyle change, and maximising the role played by local communities.
- ensure that those receiving support are equipped with appropriate knowledge; skills and confidence to enable them take greater control over their own care needs and the services they receive.
- provide high quality integrated services that are designed around the needs of the individual and, where appropriate, are provided as close to home as possible.

The following highlights are intended to provide an update on the work being progressed in delivery of the trust agreed strategy and transformational work programmes.

Integrated Neighbourhoods

The purpose of five neighbourhood teams is to support residents in choosing healthy lifestyles, encouraging them to take more control and responsibility for their own health. The neighbourhood teams will enable care closer to the person's home through a co-ordinated approach with primary care, health and social care services in addition to voluntary, community and faith sector services.

The integrated neighbourhood teams will facilitate the provision of, and access to, place based care with local services responding to local need. By working together these teams will aim to work in a multi-disciplinary way to provide joined up services. Where possible people will be treated and cared for closer to home and will only access hospital based care when necessary.

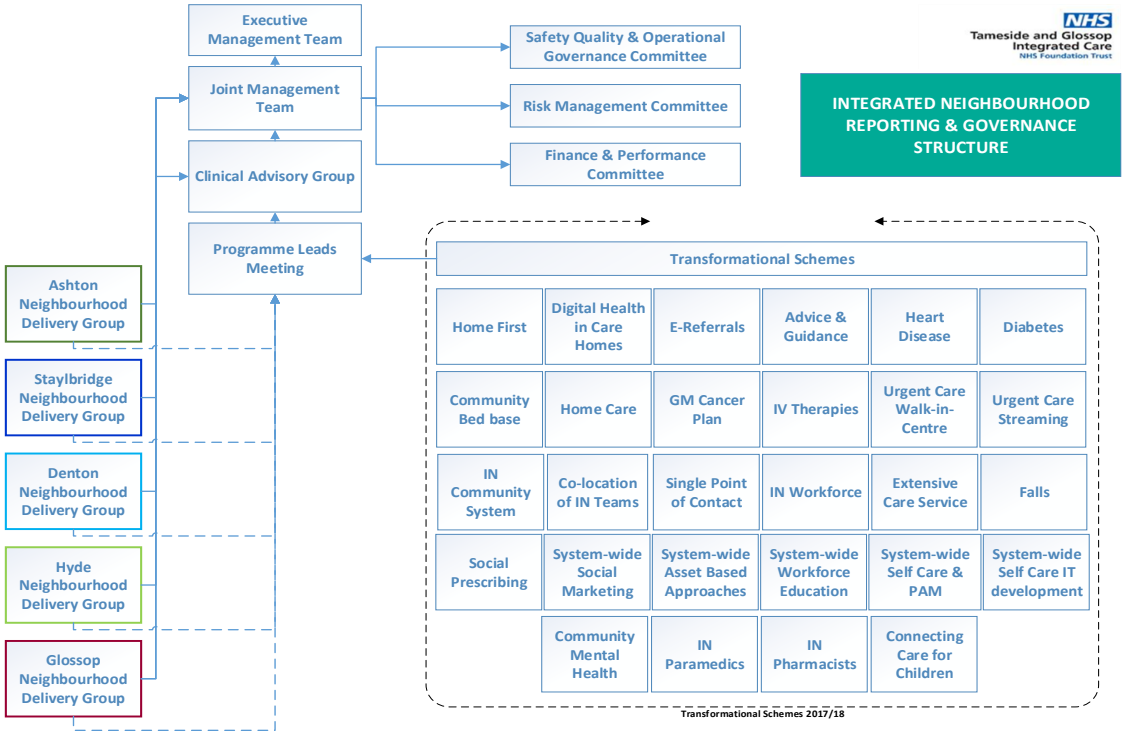
Leadership – we have appointed a Neighbourhood Clinical Director in each neighbourhood, who are supported by three Integrated Neighbourhood Managers working across the five neighbourhoods. The neighbourhood leads are:

Neighbourhood	Clinical Director	Neighbourhood Manager
Stalybridge	Dr S Ahmed	Julie Moore
Ashton	Dr N Riyaz	
Denton	Dr S A Ali	Jeanette Leach
Hyde	Dr L Gutteridge & Dr J Harvey	Julia Worthington
Glossop	Dr G Wilkinson & Dr R Jha	

Each neighbourhood has established a monthly Neighbourhood Delivery Group (NDG) which is an operational group, working with key stakeholders in each area.

A formal governance and reporting structure is in place:

Diagram 1: Integrated Neighbourhood Transformation Schemes Reporting & Governance Structure



Phase one of the organisational development sessions for senior Health and Social care leaders and neighbourhood teams have been completed, and the planning for phase 2 of this programme is now underway.

Co-location of neighbourhood teams

In order to achieve more integrated working we are progressing with our plans to co-locate district nursing and adult social care teams across the five integrated neighbourhoods, and to co-locate those teams identified as being part of the Intermediate Tier across Tameside and Glossop. There is a strong clinical case for change in favour of bringing these teams together, in addition to providing benefits to our local population and our staff. The issue of co-location has been long understood amongst staff groups to be one of the benefits of the Care Together Programme, in strengthening the integrated services for the benefits of our people of Tameside & Glossop.

A base has been confirmed in four of the five neighbourhoods, with options in the Hyde neighbourhood still being explored. These are:

- Stalybridge – Stalybridge Civic Hall
- Ashton – Ashton Primary Care Centre
- Denton – Denton Festival Hall
- Glossop – Glossop Primary Care Centre
- Hyde – options being explored

The Intermediate Tier Teams work programme was completed in April 2018 and is based in Crickets Lane in Ashton, operating across all five neighbourhoods.

Now staff are co-located the emphasis is to develop systems and processes to effectively work together; learning from each other; reducing duplication of effort to provide a quality service for our location population. This will include:

- A focus on early action and prevention
- Community based multi-professional teams promoting close working and communication between colleagues and across organisations
- A single point of contact, with single assessment and shared clinical records
- Targeting individuals who are a high risk of future emergency admission to hospital before they deteriorate
- Proactive personalised care planning bringing together an individual's personal circumstances with their health and social care needs
- Continuity of care, including effective communication processes where information is streamed through appropriate teams

Single Point of Contact

The establishment of a joint Single Point of Contact (SPOC) for health and social care is a key element within our service model to develop integrated neighbourhood teams. It is envisaged that the SPOC will be based in Crickets Lane co-locating health and social care staff, and will operate 7 days a week. This service will provide entry into the Neighbourhood teams and urgent care for all new referrals and those in crisis. The fundamental principle of the SPOC is to ensure that an individual is assessed for the level of care they require. The model takes a proactive approach to the management of individuals across the whole risk spectrum and not just those at the higher end of need. This will ensure the first assessment is responsive, holistic and multi-professional.

Digital Health in Care Homes

Digital Health has been developed to support a reduction in the attendances and subsequent admissions to hospitals from care homes (both residential and nursing). This programme compliments the existing tele-health model already in operation and connects healthcare staff in care homes with an advanced practitioner in the Acute Trust through Skype for Business. This programme aims to ensure that an individual's needs are accurately assessed and met as swiftly as possible while individuals remain in their own home when possible.

Whilst our focus initially is on the introduction of new digital technologies to help need the healthcare needs of people living in care homes, the opportunities for this technology is endless by providing a platform for people to have a 'virtual consultation' with the digital health nurse where clinically appropriate. In doing this, we aim to improve care, prevent health conditions escalating, and to reduce unnecessary admissions which can be uncomfortable and disruptive for individuals as well as costly for the healthcare system.

The Digital Health Centre (DHC) opened on 6th March 2017 and now includes almost all care homes in Tameside and Glossop and also encompasses the Tameside Council Community Response Service which provides a service that enables people, especially older and more vulnerable individuals, to live independently in their own home with the provision of technology known as lifestyle monitoring which can provide early warning of deterioration, prompting a response from family or professionals. To the end of November 2017 the team DHC has completed over 1300 calls and avoided 907 attendances at ED and potential non-elective hospital admissions.

The DHC is receiving great interest both locally and from across Greater Manchester.

Home First – Discharge to Assess

In order to be responsive to patients needs and deliver against this principle the Trust has implemented the "Home First" service model, which responds to meet an urgent/crisis health and/or social care need for patients. Home First is fundamental to the intermediate care offer and is a key interface between the integrated neighbourhoods, community services and the acute setting ensuring that people are supported in the environment that is suited to their own care needs and most likely to achieve positive outcomes, and supports the intermediate care aims of;

- Help people avoid going into hospital unnecessarily;
- Help people to be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until absolutely necessary.

The Home First service ensures that individuals are supported through the most appropriate pathway with "home" always being the default position. However, it is recognised that not all individual's intermediate care can be managed safely in their own home and there is a need for an alternative community based bed, for a short period of time, to enable the appropriate interventions to be undertaken with the individual to enable them to return home, whether this be following an admission to the hospital or to avoid the need for an admission in the first place.

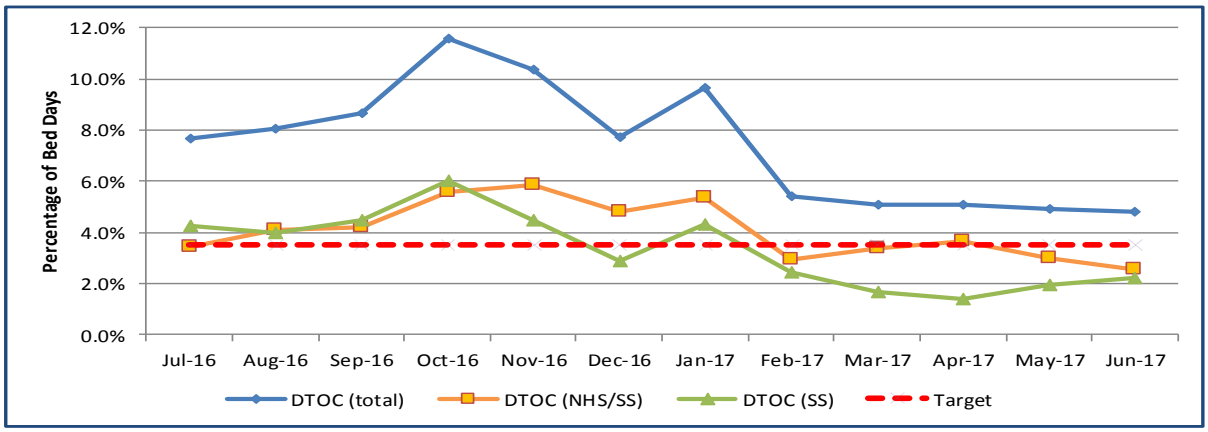
This service began in July 2016 and has been rolled out to all acute wards within the

hospital including the Stamford Unit, and is a key element of our patient flow campaign 'On the Move, On the Mend'.

Diagram 2: On the Move…. on the Mend Campaign

There has been a general increase in the uptake of this service and we are seeing a positive impact in a number of areas, including a reduction in the number of delayed transfers of care (DTOC)

Chart: Delayed Transfers of Care



Extensive Care Service

Extensive Care is a fundamentally different way of organising care around the needs of a specific cohort of people, which includes all aspects of need: medical, social, psychological, functional, pharmaceutical and self-care.

The aim of an extensive care service model is to work closely with people with long term conditions, complex needs and those who are intensive users of the health and social care system. Within an agreed timeframe it aims to move to predicting exacerbations of underlying conditions, whilst helping people improve the management of their condition and their overall general health and well-being, therefore reducing the need for hospital admissions. The service has also reduced the number of appointments that patients attend at different locations within our local health and social care system. The service includes health and well-being support that pulls together health and social support, including a range of community assets to ensure early intervention and proactive prevention.

We have appointed four part-time neighbourhood-based doctors known as an Extensivist, who will be supported by a multi-disciplinary team of health and social

care professionals.

Using the risk stratification data available across the system, this new service recruited its first patients in the middle of July 2017, focussing on the Ashton neighbourhood. The team have now successfully recruited over 60 patients and the roll out programme continues, moving to incorporate the other neighbourhoods from February 2018. Early indications are that this service is highlighting areas for improvement across the health and social care system and this invaluable learning is being shared with the members of the Clinical Advisory Group.

The team have faced some early challenges in relation to data sharing with some primary care colleagues but with the support from the Executive Team the team are resolving these.

Community Intravenous Therapy Services

Community IV therapy services can be of significant benefit to both patients and the NHS. They can prevent hospital admissions and facilitate early discharge, improve patient safety by reducing the risk of infection and improve choice by enabling patients to stay in their homes.

Aligned to our commitment to provide optimum quality of care across Tameside & Glossop we have expanded the service offer from our Community Intravenous (IV) Therapy Team to ensure we can provide care closer to home for our patients. This service was launched on 18 August 2017 and will provide IV therapy treatment in patient's own homes and/or at community out-patient clinics.

Integrated Neighbourhood Pharmacists

The role of the Neighbourhood Pharmacists is to extend and expand upon the work undertaken by the GP practice pharmacists to optimise patient outcomes through effective use of medicines and contribute to a reduction in A&E attendances, unplanned admissions, length of hospital stay and outpatient attendances. They will contribute to reducing medication-related hospital admissions and readmissions, supporting patients to get the best outcomes from their medication and identifying and addressing medication-related issues.

At practice level, pharmacists are reviewing high cost - high volume prescribing areas, establishing Long-Term Condition (LTC) medication optimisation clinics, reduce prescription wastage and support the integrated neighbourhoods, patients and carers with medicine related queries, ultimately aiding medicines optimisation. The neighbourhood pharmacy team work with GP practices and in an integrated way across the new models of care with all our neighbourhood and community teams, including colleagues from the Intermediate Tier.

Neighbourhood Mental Health

A fundamental component of our integrated neighbourhood offer for Tameside and Glossop is to improve and integrate mental health services to better support the needs of individuals in line with the Mental Health Five Year Forward View. As a priority, our plans seek to increase mental health capacity within the integrated neighbourhoods through:

a) Commissioning an integrated Improving Access to Psychological Therapy Plus (IAPT+) service. This will increase access to emotional and mental health well-being workers by offering easy accessible drop-ins in GP surgeries and other community locations and a broadened mental health offer with a wider range of interventions;

b) developing a new model, integrated with the Neighbourhood Teams, to meet the needs of people with complex needs who are currently falling between secondary care and IAPT;

c) increasing dementia support in the Neighbourhoods by integrating Dementia Practitioners and Admiral nurses in the Neighbourhood Teams and commissioning a Dementia Support Worker Pilot from the Alzheimer's Society; and

d) Establishing a self-management education college to support people to develop the knowledge and skills to manage their own health.

In addition to this, we are working to improve mental health crisis support through reviewing the needs of the population, existing crisis support including crisis resolution and home treatment within the locality, and appraising new models of care, with a view to improve and integrate mental health crisis care across all tiers. This will include identifying a local model that meets the national standard of establishing a Core 24 service offering mental health support throughout the hospital. We are also working to improve services for people with serious mental health needs including those with early psychosis as well as those stepping down from secondary care mental health services.

System-wide Self-care

Our approach to health and care in Tameside and Glossop is one where we work harmoniously with local communities and people for the benefit of all our residents. It acknowledges that the population of Tameside and Glossop is changing and with this change comes a need for a greater focus on the ageing population and the increased prevalence of chronic diseases, as well as a need to shift resources from merely treating ill health to proactively preventing and managing health and wellbeing. This means fostering a 'social model of health' that combines a deep understanding of what matters to people, with excellent clinical care, timely data, and strong, sustained social support.

We have therefore worked with a range of partners, including the voluntary/community sector, to develop a comprehensive supported self-care programme of work, and will be investing additional funds in the voluntary care sector over the next three years, which will develop capacity in the following key areas:

Diagram: System-wide Self-care & Social Prescribing Programme

A fundamental part of the self-care programme is the implementation of asset based

approaches, delivering targeted investment in the voluntary, community and faith sector to ensure that at a neighbourhood level we can support universal access to a range of opportunities that support people's health and wellbeing by capitalising on community assets. The providers for Tameside (Action Together) and Glossop (The Bureau) are currently designing the system and application process for the grants fund specifically ring fenced to pump prime community assets and resources that promote the health and wellbeing of people with long term conditions.

Social Prescribing

The social prescribing service will deliver a comprehensive, flexible, and proactive service, which includes: non-medical case management, information, advice, signposting, and support to people within Tameside and Glossop to optimise their potential health and wellbeing, with the aim of participants gaining greater control and remaining healthy and independent within the community. The programme will offer a person-centred approach to identifying individual assets, needs and aspirations and support people to access a menu of services and self-help groups. The programme is not a replacement for statutory health and care services, but rather acts in a complimentary manner alongside and integrated within these services. Our social prescribing service will:

- signpost and support individuals to opportunities for a range of activities including arts, physical activity, advocacy, peer support, befriending as well as signposting to support for welfare advice, debt, housing etc.;
- become a fully integrated part of the health and social care system, providing a bridge between traditional health and care services and more than medicine approaches usually accessed in the voluntary, community and faith sectors;
- align with the five neighbourhood footprints of Tameside and Glossop with staff linked to each integrated neighbourhood team and also linked to the hospital site with a focus on links with A&E, admission avoidance and discharge teams;
- work with individuals, their families, carers and supporters viewing peoples' needs holistically and supporting them to tackle non-medical influences on health and wellbeing;
- build capacity in the local voluntary, community and faith sector, working with a range of groups to support their development and growth. The funding for social prescribing will include capacity for investment in the sector, including spot purchasing and the award of small contracts/grants.

Our social prescribing service is already working in Glossop – led by Glossop Volunteer Centre working in partnership with High Peak Community and Voluntary Services and other agencies. To date the Glossop service has received 297 referrals.

The new provider for Tameside is currently at the early stages of implementation of the new service.

In addition to the transformation schemes described above we are managing a portfolio of change programmes to support a reduction in health inequalities across Tameside and Glossop, working with our clinical and management colleagues in achieving operational improvements and outcome benefits for both patients and staff. Tackling premature mortality and health inequalities is vital to rebalancing our

local health economy and achieving sustained reductions in health inequalities and improvement in local life expectancy. The projects within this portfolio include:

- Heart Disease
- Diabetes
- Respiratory
- End of Life / Palliative Care
- Musculoskeletal

E-referral system implementation

The NHS e-Referral service combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their first hospital or clinic appointment; book it in the GP surgery, online or on the phone. This process harnesses the use of new technologies to deliver modern and efficient healthcare. The benefits include:

- Fewer missed appointments
- Fewer inappropriate referrals
- Shorter referral to treatment times
- Cost and time savings
- Choice of hospital or specialist
- Choice of appointment date and time

A phased implementation programme across all specialties has been developed and began in March 2017. Our plans are to see the completion of this scheme ahead of the national deadline in 2018. This successful implementation of this improvement work will also bring about the introduction of an electronic solution for hospital referrals, thus reducing the need for paper.

Advice & Guidance Service

We first began a pilot of this new way of working in August 2016 with our Cardiology Service, offering 'advice and guidance' to our local general practitioners. This advice and guidance service enables general practitioners to contact the Cardiology Team at the hospital, obtaining access to timely specialist opinion on patient diagnosis and treatment, thereby reducing unnecessary referrals to secondary care.

This model aims to build on clinical best practice, provide flexibility for innovation, and allow for shared care of patients. Our pilot with Cardiology resulted in a number of significant benefits for patients and clinicians, including:

- A reduction in unnecessary hospital admissions
- A reduction in unnecessary hospital out-patient attendances
- Increase in skills and knowledge for local clinicians

We have recently started to offer this same service for paediatrics and are working with other specialties to agree an implementation plan.

Improving Endoscopy Productivity to deliver a more cost effective endoscopy service which is capable of meeting current demands, whilst at the same time deliver on its internal and external access standards. This improvement project was aligned to our Corporate Objectives to

- ensure our patients and users receive harm free care by improving the quality and safety of our services through the delivery of our Quality and Safety Programme.

- improve our patient and service user experience through the delivery of a personalised, responsive, caring and compassionate approach to the delivery of care.
- develop our staff and future workforce to support the integration and transformation of our services whilst ensuring we recruit and retain talented individuals.
- deliver against the required local/national regulatory frameworks and standards in addition to securing the most effective and efficient use of resources to deliver services that we provide directly or indirectly through our partner organisations.

The project has delivered on a number of key work streams and the operational team are now taking the improvements forward as business as usual, with a key future aim for the Unit to be in a favourable position to take additional work derived from the national bowel screening programme.

People powered health improvements

The 100 day challenge is a rapid improvement methodology that generates innovation and progress on key challenges by empowering leadership from the frontline. The challenge is supported and facilitated by the Nesta People Powered Results Team. Nesta are a national health innovation charity.

In Tameside & Glossop we have just reached the end of our 100 day challenge and seen some fantastic results. Three teams (in Denton, Glossop and Hyde) were established and identified a problem and solutions to test all in the window of 100 days. The teams comprised of frontline staff from health, social care, the voluntary and community sector, and patient groups, all working together on an equal footing, to demonstrate leadership in driving change forward on some of our most testing issues.

The **Denton and Hyde teams** both delivered pieces of work that aimed to identify and work differently with people at risk of diabetes. Overall, they contacted over 700 people to participate in action to reduce their blood sugar levels through community events, brief intervention on the phone and lifestyle support. Some of those people hadn't engaged with health services for over 2 years, and others said they weren't even aware that they were pre-diabetic. Those that did engage have had some great results; the vast majority of people re-tested at the end of the intervention had reduced their diabetes risk as measured by HBA1c. 49% of all people retested are no longer categorised as pre-diabetic. In another cohort the average increase per week in physical activity of 155 minutes and an average decrease in waist circumference of 6cm. There was a cumulative 79kg weight lost amongst participants who were measured at the end. A register of people at risk of diabetes has been created by those practices involved, and a protocol for managing pre-diabetes in primary care produced.

The Glossop team focused on improving end of life care for their residents. Using a family who had a particularly negative experience (not being identified until the final 48hrs of life) as the inspiration for change they built local partnerships to transform the way in which people are identified and then subsequently supported through end of life. The % of people identified as being in the final 12 months of life at each of the three practices involved has increased dramatically (in one case by 438%). They have introduced, tested and improved a new IT tool, and developed bereavement support, connecting with social prescribing and volunteering

approaches in the voluntary sector. The Patient Neighbourhood Group has been at the centre of the work.

In addition we have progressed the following initiatives during 2017/18:-

To improve patient safety

- Continued to implement our Patient Safety Programme workstreams. This formed our "Signed up to Safety" campaign and formed a key part of our Improvement programme to enhance the quality and safety of care provided. (The programme is shown on page 11) the workstreams are focus on
    - Pressure Ulcer Prevention
    - Early recognition of the deteriorating patient and managing the acutely unwell
    - Reducing the number of falls and falls with injury
    - Improved nutritional care and hydration
    - Reduction of harm from Venous Thrombosis
    - High Risk Medicines and Safe Medicine Management
    - Infection prevention
    - Local Safety Standards for invasive procedures
    - Maternity services governance
    - Results governance
- We have implemented a system of patient bed mattresses which are able to be adapted to provide additional pressure relieve if required without the need to transfer the patient or wait the delivery of specialist equipment.
- We have developed a further 30 AQuA Patient Safety Champions across the organisation in the process of undertaking our Quality improvement initiatives.
- Continued to implement best practice with regard to Infection prevention and commenced a health-economy wide programme to enable awareness of good hand hygiene with patient relatives and carers to improve the rate of acquired infections.
- Continued to implement our policies and ensure best practice relating to harm free care including Implemented revised Care bundles with increased surveillance to improve compliance with clinically effective care pathways for Sepsis, Acute Kidney Injury, and hypercalcemia.
- Continued to increase our incident reporting rate and embed the incident reporting culture across the organisation, whilst ensuring that lessons are learnt.
- Continued to work across the Health Economy to promote best practice in relation to Pressure ulcer prevention and management and infection prevention.
- Continued to undertake Mortality reviews on every death in hospital.
- Sharing our learning through a range of media including our "Closing the Loop" newsletter and our newsletter for Learning from Deaths.
- Implemented our electronic CAS card in the emergency department which has been developed with the clinicians to ensure effective capture of data and recording of key measures is accurate and timely and help us improve the escalation, management, discharge and handover of patients

To improve our effectiveness

- Implemented initiatives to enable admission avoidance through Digital health.
- Implemented our “on the move on the mend” process to encourage patients to be more active in preparation for discharge including our pledge to “end PJ paralysis”.
- Established our Neighbourhood management teams and recruited lead GP’s to each of the 5 teams, and commenced co-location and integration of the teams to facilitate closer more integrated working and working
- Commenced GP streaming to reduce the pressure on the emergency department
- Continued to deliver our Health Care assistant - Care Certificate training programme for new recruits and existing staff.
- Recruited additional New Trainee Nurse Associates to the Trust programme
- Continue to Implementation of our Medicines Optimisation action plan through our integrated Medicines optimisation group which spans the health economy
- Continued implementation of a Clinical handover policy and professional standards to improve consistency of the clinical handover process and improve continuity of care.
- Retained our Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation
- Revised the Clinical audit team to ensure emphasis and focus on Quality improvement and learning.

To improve our responsiveness

- Implemented monthly review/reset weeks to ensure that issues relating to patient flow are optimised
- Continued to implement our range of initiatives aimed at admission avoidance including Digital health services to provide remote consultation with nursing homes and other agencies to provide advice and clinical review and develop links with social care provider tele-healthcare provision.
- Continued implementation of our Home first initiative.
- Commenced implemented our extensive care service
- Continued work to Improve the percentage of discharge summaries issued in 2 days for urgent and 5 days for routine
- Continued to implement and further strengthen our clinical coding service team and continue to deliver our data quality assurance programme

To improve our caring

- Continued to implement values based recruitment for all staff.
- Continued to implement and strengthen the use of Volunteer dining companions in selected wards to support meal times
- Continued to reinforce the “Hello my name is campaign” and appointed our first Kate Granger professionals as champions of these values
- Continued implementation in year 3 of the dementia strategy with increased dementia awareness

- Revised and updated our patient and service user experience strategy
- Officially opened the Tameside Macmillan unit and through Macmillan introduced the Cancer Recovery Package
- Opened our new refurbished antenatal clinic facilities
- Launched our 3rd Thursday café and our "chatter and natter initiative" to support patients and carers.

To ensure we are well led

- Undertaken service Integration and commenced the transformation of services with Community colleagues
- Further strengthened our capacity and capability to manage Service transformation by ensuring Neighbourhood, Divisional and Directorate Medical, Nursing and Management structures are in place
- Continued to run streamlined Nurse Recruitment process as a "one stop shop". Shortening the time to undertake Nurse Recruitment.
- Continued to implement our "If in doubt speak out - Speak out" campaign to remind staff that they are able to raise concerns or issues of concern.
- Continue to ensure the presence of our "Freedom to Speak up Guardian" and the associated reporting from them is captured and informs the organisation.
- Implemented a Mandatory training improvement programme.
- Continue to strengthened the Finance function to ensure managers and directors receive high quality information to ensure all resources are used effectively and efficiently in order to deliver safe high quality care
- Delivered our £10m savings programme
- Introduced a ban on sugary snacks in the restaurant and provision of healthy choices

How we performed on Quality in 2017/18

This section indicates how some of the Quality Initiatives were progressed during 2017/18 and outlines the performance against the priorities and goals we set ourselves in 2016/17 Quality Account.

The following symbols have been used to identify our performance and whether we achieved our goals.

Achieving our aim/goals

Improving Performance

No change in Performance

Deteriorating Performance

Significant Concerns about Performance

Patient Safety

Patient Safety Programme

NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	

The Trust has continued to use the Patient Safety Programme as a focus for ensuring quality improvement. Each work stream has agreed performance monitoring metrics in place to identify improvement and how well we are protecting patients from avoidable harm.

- Pressure Ulcer prevention, improved Tissue Viability
- Earlier recognition of the deteriorating patient and management of the acutely unwell (including improved communication/ handover).
- Reducing the number of falls and falls with injury.
- Improved nutritional care and hydration.
- Reducing harm from Venous Thrombosis.
- Reducing harm from high risk medicines and providing safe and effective medicines management.
- Improving peri-operative outcomes through safer surgery.
- Infection prevention.
- Maternity
- Results Governance

Performance against the 10 work streams are captured in this part of the Quality account with further metrics being developed for each work stream for 18/19.

We continue to produce monthly know your safety data packs which provide speciality level range of safety metrics with the ambition of providing a source of information to help drive local quality improvement and consistent measurement.

We will continue to embed and develop these work streams and work to further improve our performance during 2018/19.

NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	

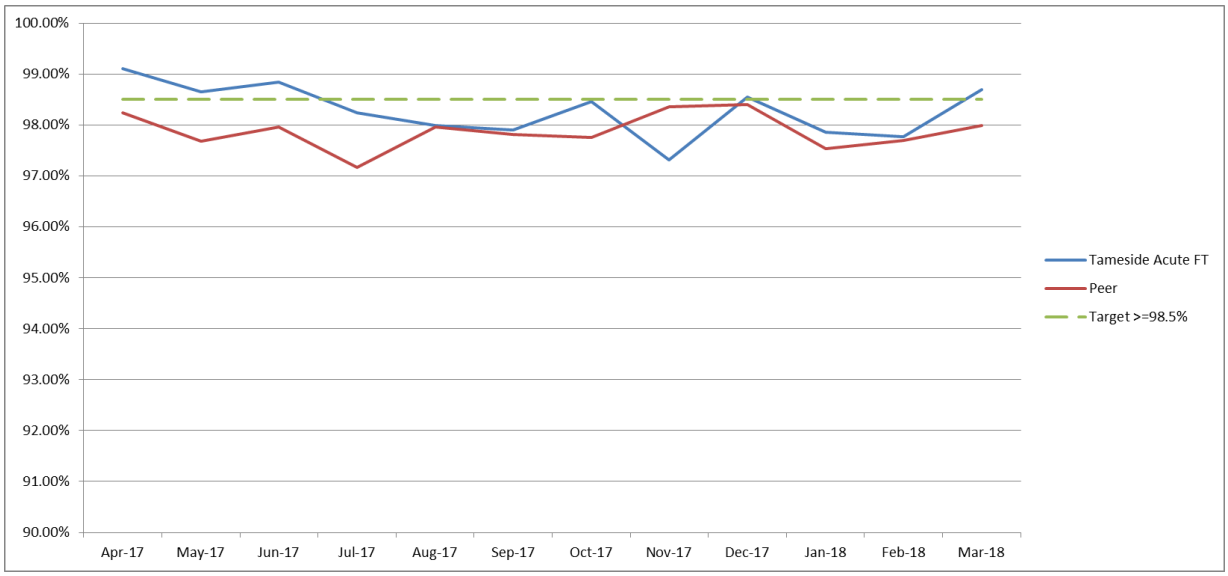
The Safety Thermometer is a monitoring tool for inpatients areas including Community Wards to identify the provision of harm free, safe care in relation to 4 Patient safety areas of Pressure ulcers, Falls, Catheter acquired urinary tract infections and Venous Thrombo Embolism (VTE).

It is well documented that health care has high levels of system harm; the Safety Thermometer tool is unique in identifying the impact of collective harms within the ward areas and attempts to measure this as a composite score across 4 key areas to understand the impact and support improvements to deliver harm free care to our patients.

The thermometer captures a snap shot sample of data from 100% of patients on sample day in order to attempt to suggest the prevalence of harm across those patient groups sampled. We publish monthly data in line with the CQUIN requirement and this is demonstrated below.

We pledged to improve patient safety by increasing the percentage of harm free care from our revised baseline of 98.5% with the aim of harm free care for every patient. We did not consistently achieve this but achieved an average of 98.4% in 2016/17.

New Harm free care graph for all 4 harms



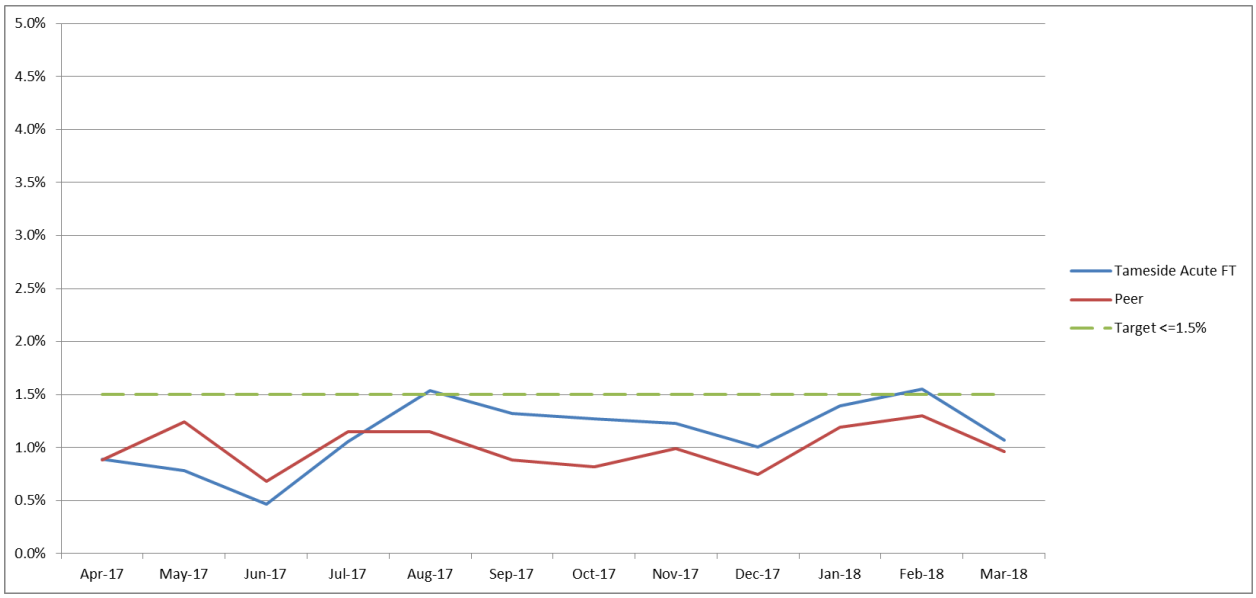
The performance data is reported monthly and included in our board reports available on the Trust website. We continue to aim for our stretch target for Harm free care to be consistently at or better than 98.5% all new harms in 2018/19.

T&G Integrated Care - Safety Thermometer New Harm Free Care Performance

Pressure Ulcer prevention

We pledged to improve patient safety by reducing the number of avoidable Inpatient (including community wards) acquired pressure ulcers and we will reduce the incidence of pressure sores Grade 2 and above.

In 2017/18 we aimed to ensure less than a 1.5% incidence rate, we achieved an average of 1.25%.

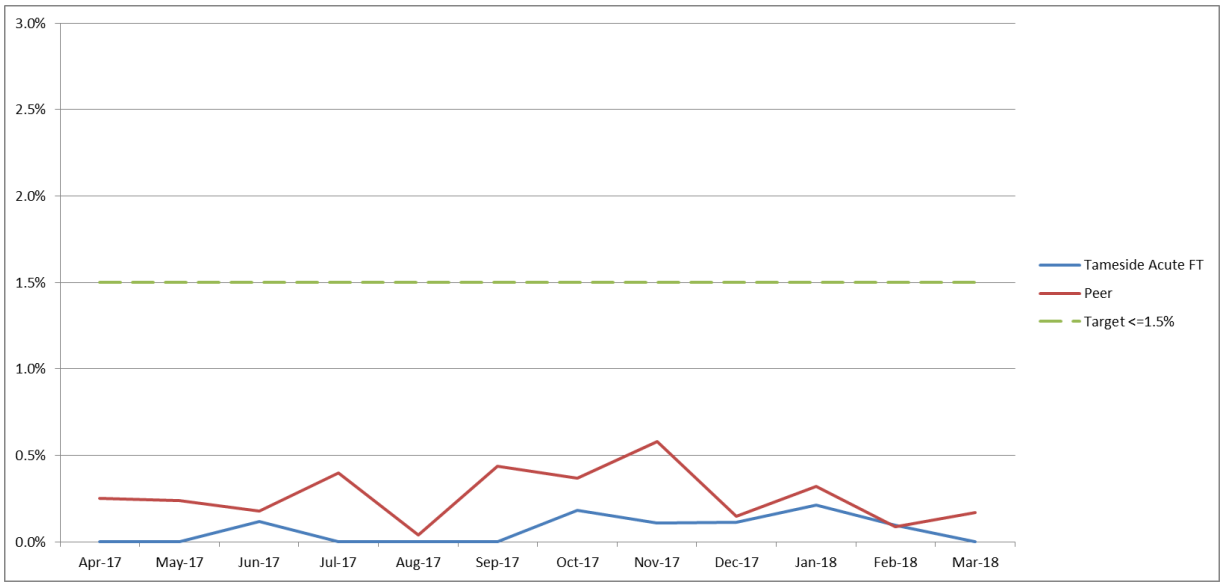


Within our local quality initiatives for 2017/18 we committed to a work programme to improve pressure care further across both Acute and Community service settings. Whilst the Safety thermometer trajectory was achieved we identified that a lot more work needs to be done to assertively progress further improvement in patient safety across the health economy. We have been part of the NHS improvement collaborative quality initiative on pressure ulcers and won the Most improved Trust & Most Innovative Idea award for the focused work undertaken to and is address upskill team members with the roll out of a training package and the launch of the Sskin bundle.

Catheters & New Urinary Tract infection (UTI) Performance

We pledged to improve patient safety by reduction in catheter associated urinary tract infection ensuring 99% of patients receive no avoidable UTI.

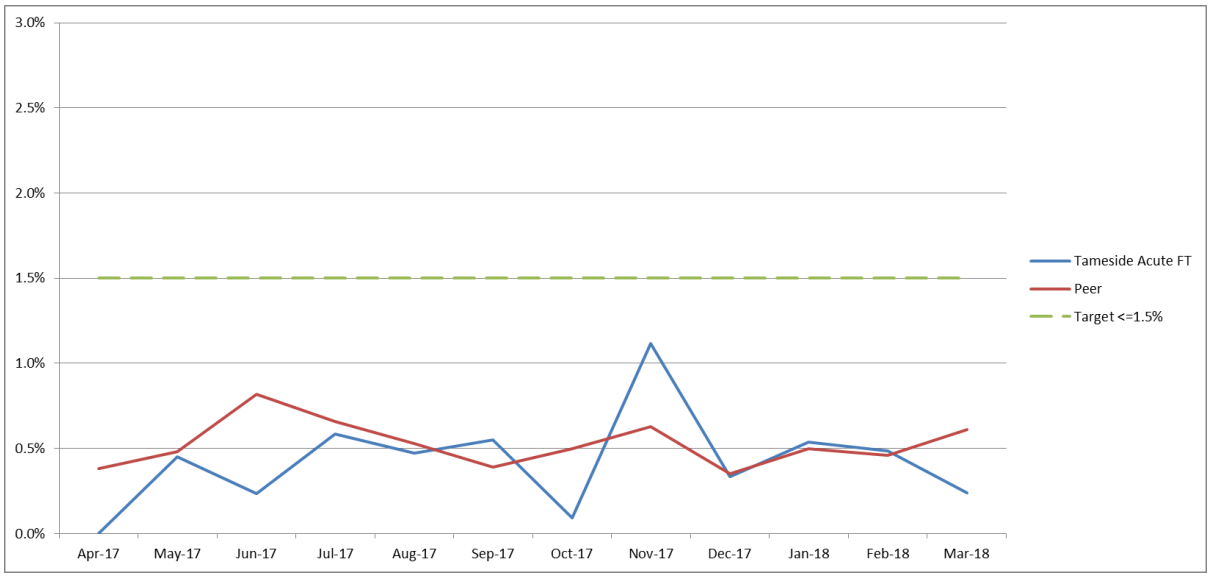
In 2017/18 we achieved this with an average 0.02% incidence of Inpatient (including community wards) acquired Catheter Acquired Urinary Tract infections. We aim to maintain or improve on this performance in 2018/19



Reducing the number of falls and falls with injury.

We pledged to improve patient safety by reduction inpatient (including community wards) falls resulting in harm ensuring less than 1% incidence resulting in 99% of patients receiving harm free care.

In 2017/18 we achieved this with an average 0.59% incidence of falls resulting in harm

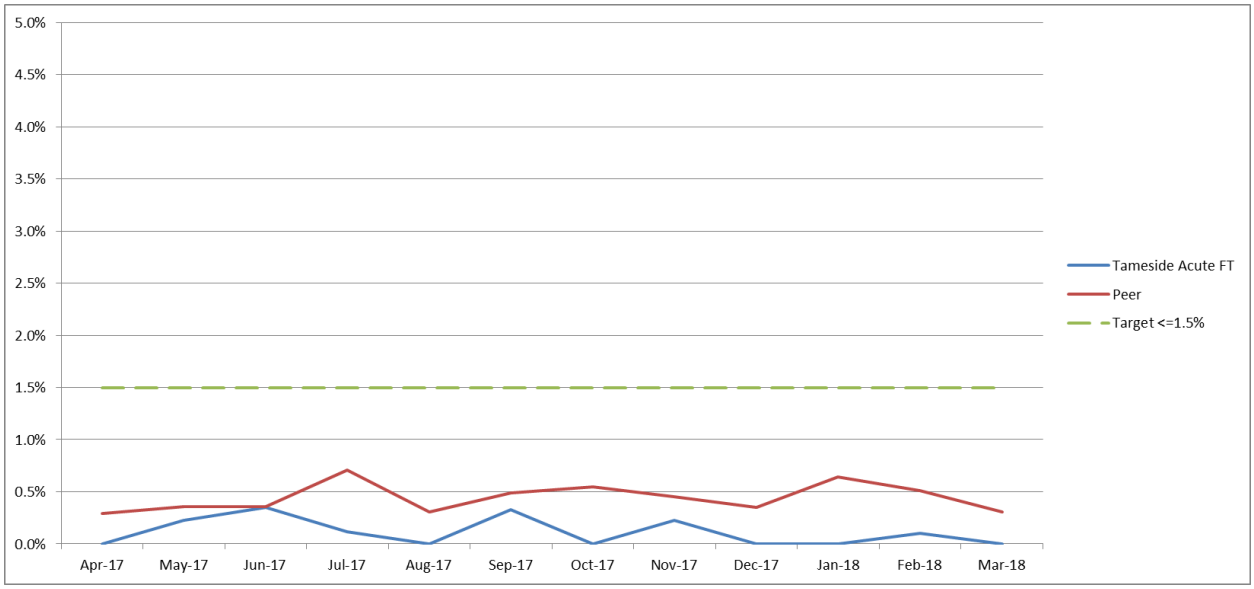


NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	

Venous Thrombo Embolism (VTE) Risk Assessment

We pledged to improve patient safety by reduction in harm from VTE through appropriate risk assessment and thromboprophylaxis for all inpatients (including Community wards).

In 2017/18 we achieved this with an average 0.12% incidence of number of new VTE risk assessments not being completed using the Safety Thermometer data.



The Trust also records assessment of all inpatients (including Community wards) requiring a VTE risk assessment on Lorenzo, and this data is produced by ward to ensure that compliance is monitored daily. The tables below demonstrate the continued year on year improvement where we are now consistently recording over 98% compliance with these risk assessments

2016/17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Average
Recorded Risk assessment	96.2%	96.0%	96.0%	97.7%	97.6%	97.7%	97.7%	97.1%	97.6%	97.7%	97.9%	97.5%	97.23%
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

2017/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Average
Recorded Risk assessment	97.3%	97.8%	97.8%	98.8%	98.5%	98.4%	98.6%	98.2%	98.0%	98.4%	98.8%	95.5%	98.0%
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

Tameside and Glossop Integrated Care NHS Foundation Trust consider that this data is as described for the following reasons. We have taken the assertive action to ensure compliance with the required standard.

- Having a VTE workstream in place as part of our Patient Safety Programme to monitor and drive improved provision of the correct care to prevent VTE for all patients and the avoidance of hospital acquired VTE.
- Reviewed the process for recording to ensure correct data collection guidance is followed for patient
- Ward based system in place to ensure completion of VTE assessment and electronic recording.
- Continued reinforcement and training of medical, nursing and administration staff in assessment and data collection.
- Daily compliance data provided at ward level with follow up visits by VTE nurse to drive compliance.

VTE risk assessments	Q1 2016/ 17	Q2 2016/ 17	Q3 2016/ 17	Q4 2016/ 17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Rank in most recent reporting period
THFT Risk assessment rate	96.1%	97.7%	97.2%	97.8%	97.7%	98.6%	98.4%	23
Lowest Nationally	80.6%	72.1%	76.5%	63.0%	51.4%	71.9%	76.1%	n/a
Highest Nationally	100%	100%	100%	100%	100%	100%	100%	n/a
National average	95.7%	95.5%	95.6%	95.5%	95.1%	95.2%	95.4%	n/a

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the action described above to improve this indicator and so the quality of its services by the implementation of a Trust wide improvement program agreed with key stakeholders and progress monitored by the Trust board.

Performance is expected to continue to improve with continued year on year improvement demonstrable in 2018/19.

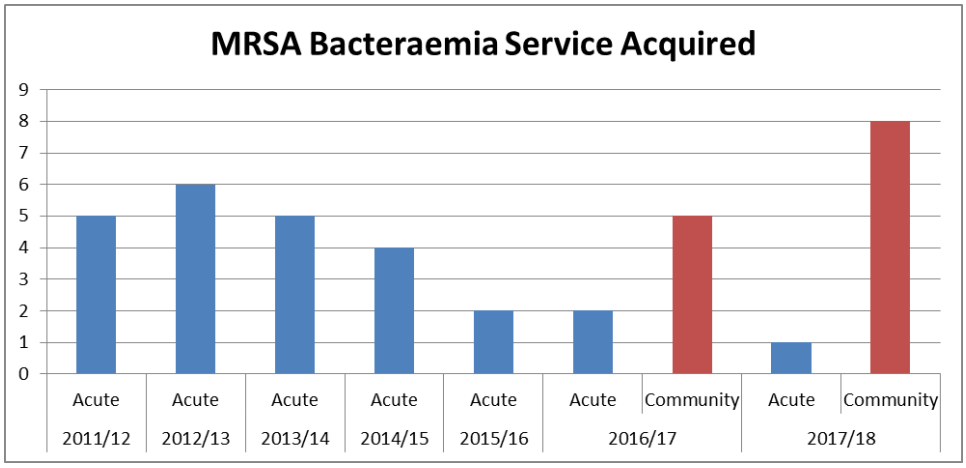
Infection Prevention and Control – MRSA bacteraemia

NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	

Tameside and Glossop Integrated Care NHS Foundation Trust aimed to comply with the NHSE 'zero tolerance' trajectory for MRSA bacteraemia.

The Trust continues to systematically implement its agreed policies and procedures to minimise the occurrence of Service Acquired MRSA cases and has a zero tolerance approach to these. In year the Trust recorded only 1 Hospital cases and 5 community cases none of these have been identified as avoidable cases.

All cases of MRSA infection undergo a detailed investigation to identify how and why it occurred, to ensure learning and further reduce harm. The Trust has robust systems and processes in place to reduce the likelihood of this, however, it is recognised that there is still more to do to ensure full compliance with the zero tolerance approach.



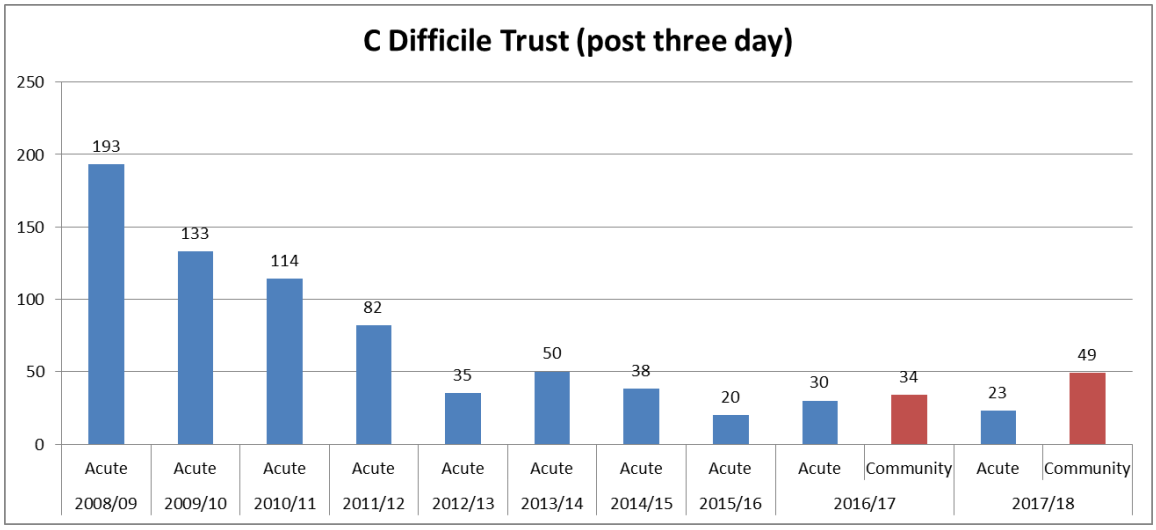
Tameside and Glossop Integrated Care NHS Foundation Trust aims to continue to achieve a reduction in the rate of numbers of MRSA Bacteraemia working to achieving 'zero'. We will improve our performance by a number of actions included in the 2016-18 HCAI Whole Health Economy (WHE) Strategic Objectives Action Plan:

- Continuous surveillance of MRSA bacteraemia throughout the WHE
- Prompt identification, isolation and monitoring of MRSA bacteraemia patients
- Review of all Whole Health Economy MRSA bacteraemia cases via a process which gives assurance on stakeholder participation and learning from 'lapses in care'
- Multidisciplinary education and training focusing on Aseptic Non Touch Technique (ANTT) and care of invasive devices
- Management of antibiotics

Infection Prevention and Control – C difficile

NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	

Tameside and Glossop Integrated Care NHS Foundation Trust aimed to achieve or better the CDI target of 46 hospital attributable (post 3 day) cases for the year which we achieved in 2017/18 with 22 reported hospital cases with 1 being avoidable which is an improvement on 2016/17. In 2018/19 we aim improve on this positon. In community services in 2017/18 we identified 49 cases (5 avoidable) of C difficile against an NHSE trajectory of 52 which whilst within the target was higher than in 2016/17, however the number of avoidable cases was reduced.



The national benchmarking identifies how the Trust compares nationally for inpatients:

Rate of C difficile per 100,000 bed days for patient aged 2 years and over

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	Rank in most recent reporting period
National rate	22.3	17.4	14.7	15.0	14.9	13.2	n/a
Tameside (Trust apportioned)	53.3	21.6	32.5	24.4	12.7	20.4	145/153
Best performing nationally	0.0	0.0	0.0	0.0	0.0	0	n/a
Worst performing nationally	58.2	31.2	37.1	62.6	66.0	82.7	n/a

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the assertive Infection Prevention Improvement Plan which has been in place to minimise the potential for harm from Healthcare Associated Infections (HCAI's). The Improvement Plan was agreed with key stakeholders and progress has been monitored by the Trust Board. The

challenges regarding reducing HCAI's have been recognised and being assertively addressed.

Tameside and Glossop Integrated Care NHS Foundation Trust will continue to assertively progress the reduction in HCAI's and will proactively aim to reduce the rate further.

This will be achieved by a number of actions included in the 2016-18 HCAI Whole Health Economy (WHE) Strategic Objectives Action Plan and includes:

- Continuous surveillance of CDI throughout the WHE
- Prompt identification, isolation and monitoring of CDI patients
- Strict Antimicrobial prescribing
- Review of all Whole Health Economy CDI cases via a process which gives assurance on stakeholder participation and learning from 'lapses in care'
- Multidisciplinary education and training focusing on CDI prevention and management
- Instigation of environmental actions (infrastructure and cleaning) to prevent any indirect / direct transmission

Tameside and Glossop Integrated Care NHS Foundation Trust aims to continue to achieve a reduction in the rate of numbers of C difficile infection cases based on the NHSE trajectories

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Infection Prevention and Control – MSSA and E –Coli bacteraemia

NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	**E Coli**  **MSSA** 

Tameside and Glossop Integrated Care NHS Foundation Trust aimed to comply with the requirement to monitor MSSA and E Coli Bacteraemia. Although no formal NHSE trajectory is set for these parameters local agreements are that the Trust should aim to reduce the amount of cases from the baseline recorded in 2013/14. It should be noted that E-Coli bacteraemia data is only collected and reported to Public Health England (PHE) for epidemiological purposes.

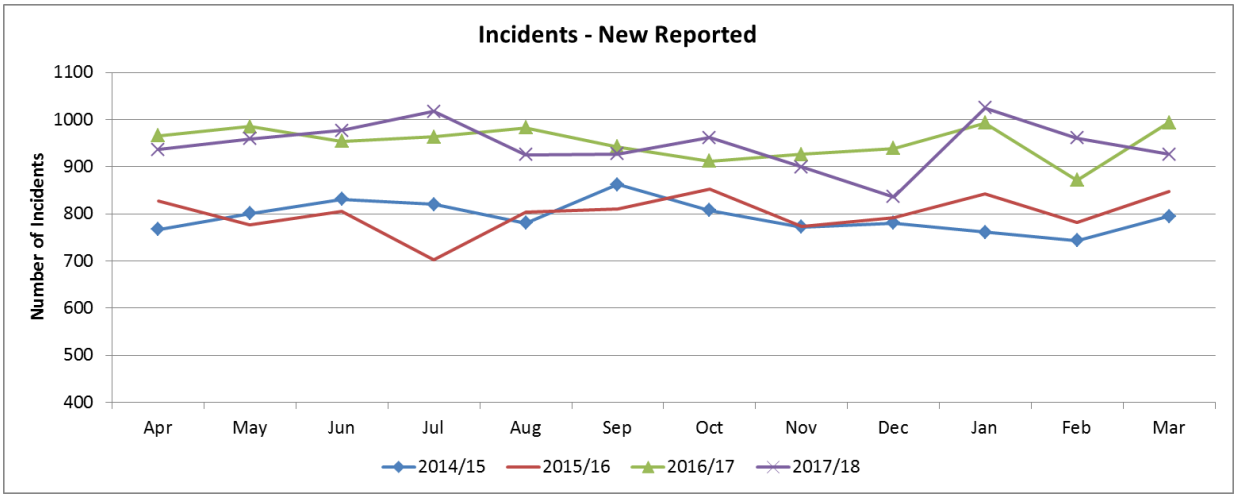
	2014/15	2015/16	2016/17		2017/18	
	Acute	Acute	Acute	Community	Acute	Community
E Coli Bacteraemia:	27	30	25	144	17	118
MSSA Bacteraemia:	6	15	9	30	10	34

In 2017/18 the Trust has reported further reductions in the number of infections for both E Coli in the Acute and community areas from those reported in 2016/17, however there has been a reported increase of 1 for Acute and community MSSA infections compared to 2016/17. The Trust expectation to see a reduction of 10% in MSSA and E-Coli bacteraemia across the whole Trust has only been achieved E coli this year but we will continue to work to reduce further the infection rates by utilising the same actions as those employed to reduce our rates of MRSA bacteraemia (as noted above).

Incident Reporting

NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	

We aim to increase the number of reported incidents whilst reducing harm associated with these.



The NRLS identifies that organisations who report high levels of incidents are likely to be safer organisations, since the certainty that incidents will be reported is higher. We therefore pledged to improve patient safety by ensuring incident our reporting rate will increase and result in the Trust and being identified as having a good incident reporting culture.

The National benchmarking data now groups us in with all acute non specialist Trusts and activity is benchmarked per 1000 bed days. We have increased the reported rate of incident to NRLS further in 2017/18 by 9% in the comparable period last year as part of an assertive programme of ensuring incidents are reported. We are now in the top 10% of Trust for incident reporting. The underlying trajectory for this Trust is increasing year on year. This is also reflected in the information published from the NRLS which demonstrates that the percentage of incidents reported with moderate, severe harm or death is decreasing.

Reporting rate incidents per 1000 bed days published by the NRLS	April - September 2015	October 2015 – March 2015	April - September 2016	October 2016 – March 2017	April 2017 – September 2017	Rank in most recent reporting period
Tameside & Glossop Integrated Care NHS Foundation Trust	50.68	51.04	57.29	38.28	62.47	5
Highest value for Acute Non specialist Trusts	74.67	75.91	71.81	68.97	111.69	n/a
Lowest rate for Acute Non specialist Trusts	18.07	14.77	21.15	23.13	23.47	n/a

% of incidents with Moderate, Severe and death reported	April to September 2015	October 2015 – March 2016	April - September 2016	October 2016 – March 2017	April 2017 – September 2017	Rank in most recent reporting period
Tameside & Glossop Integrated Care NHS Foundation Trust %	1.4	1.3	0.9	2.2	0.1	78
Highest % for Acute Non specialist Trusts	31.1	15	11.6	11.3	11.1	n/a
Lowest % for Acute Non specialist Trusts	0.3	0.5	0.4	0.2	0.2	n/a
National Average %	3.6	3.1	2.8	2.6	2.3	n/a

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the assertive action taken to increase the number of incidents reported and the move towards electronic reporting and the use of incident trigger lists to ensure standardised and consistent reporting of issues across all areas of the organisation.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to improve this indicator and so the quality of its services by the implementation of a Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust Board. The Trust has as part of this continued to reinforce incident reporting, which will ensure feedback to incident reporters on action taken.

Other Important Patient Safety and Effectiveness Indicators

NHS Outcome framework 3: Helping people to recover from episodes of ill health or following injury	**See individual indicators below**

Tameside and Glossop Integrated Care NHS Foundation Trust made goals regarding other key patient safety indicators, progress of which is identified in the table below and monitored through the Dr Foster intelligence tools used by the Trust.

Indicator	Observed Rate per 1000	Expected Rate per 1000	
Accidental puncture or laceration	0.7	1.3	
Deaths after Surgery	74.1	78.3	
Deaths in low-risk diagnosis groups	0.5	0.5	
Decubitus Ulcer	52.6	52.2	
Infections associated with central line	0	0	
Obstetric trauma - caesarean delivery	0	4.2	
Obstetric trauma – vaginal delivery with instrument	66.4	72.3	
Obstetric trauma – vaginal delivery without instrument	24.3	31.3	
Postoperative Haemorrhage or Haematoma	0.7	0.4	
Postoperative hip fracture	0.1	0.1	
Postoperative Physiologic and Metabolic Derangement	0.1	0.1	

Indicator	Observed Rate per 1000	Expected Rate per 1000	
Accidental puncture or laceration	0.7	1.3	
Deaths after Surgery	74.1	78.3	
Deaths in low-risk diagnosis groups	0.5	0.5	
Postoperative pulmonary embolism or deep vein thrombosis	3.2	2.1	
Postoperative respiratory failure	1.0	0.8	
Postoperative sepsis	9.8	13.4	
Postoperative wound dehiscence	0	0.9	

As at March 2018

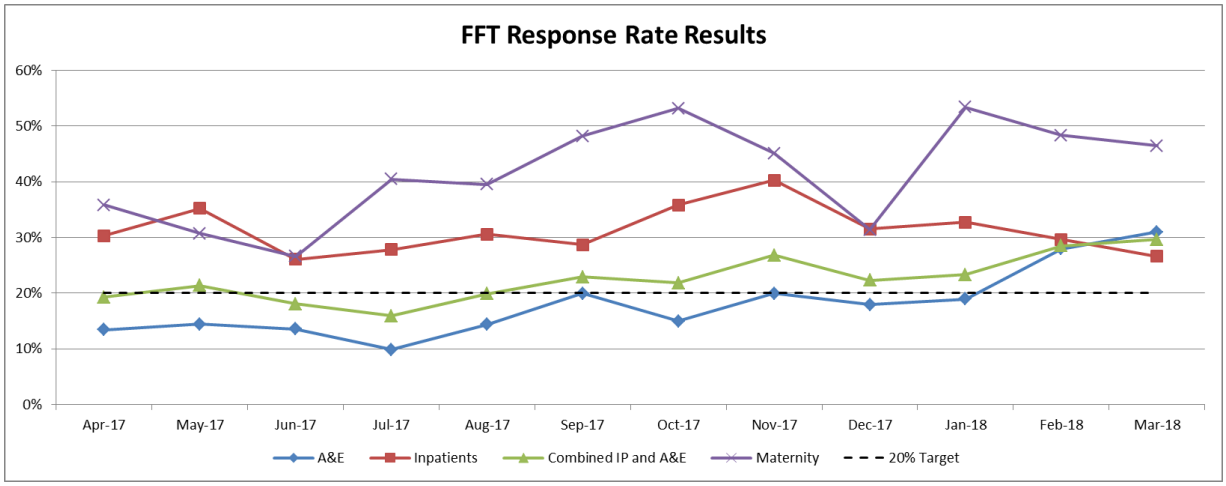
We pledged to Implement and deliver the Trust Safety plan for 2017/18 measuring and monitoring safety objectives across the Trust. The metrics reported in this Quality account are evidence of this achievement.

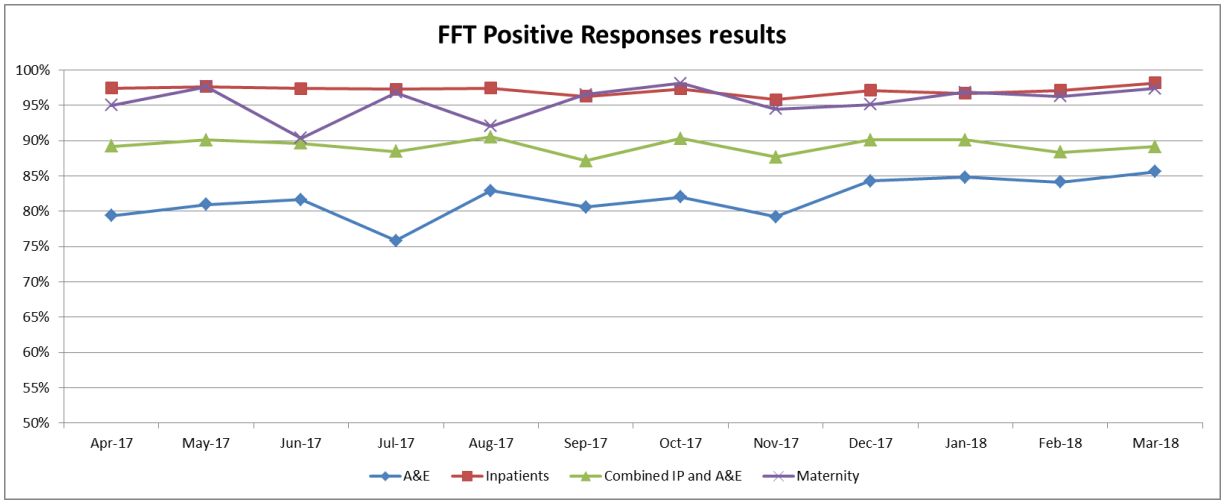
Patient Experience - Friends & Family Test

NHS Outcome framework 4: Ensuring that people have a positive experience of care	

The Friends and Family test has been introduced to collect Patient feedback by asking "How likely are you to recommend our ward, department or service to your friends and family if they needed similar care or treatment?" The Trust performance is reported to the Trust board monthly.

We pledged to ensure that we would improve our Friends & Family Test response rates by a further 5% on the national trajectory.





We pledged in 2017/18 in our revised objectives to achieve the following FFT results

- All in-patient areas to achieve a 30% response rate.
- Maternity to achieve a 30% response rate.
- ED to sustain the 25% response rate.
- Adult community services to achieve a 95% positive response rate.
- Children's community services to achieve a 95% positive response rate.
- Out-patients to achieve a 20% response rate
- All areas to achieve 95% positive response rating.

We have achieved improvement towards these trajectories.

We also pledged to see improvement in patient experience percentage recommended scores improving. We have achieved this for in the Inpatient and Maternity and have seen more recent improvement for A&E which we will aim to maintain. Our objectives for 2018/19 set out our ambition for the coming year.

Our patient experience strategy and revised expectations are identified in the objectives set expectation for all areas to achieve.

National Benchmarking demonstrates

Inpatient Friends and Family test

Friends and Family Inpatient response rate	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
THFT response rate	40.3%	31.5%	33%	30%	26%
Rank	25/166	45/171	44/172	64/172	79/172
Worst performing trust	3%	2.6%	3%	3.6%	0.2%
Best performing Trust	100%	100%	100%	100%	100%
England average	25.5%	22.1%	23.3%	24.5%	23.2%
Friends and Family Inpatient percentage recommended					
THFT percentage recommended	96%	97%	97%	97%	98%
Rank	108/166	72/171	90/172	73/172	36/172
Worst performing trust	73%	64%	75%	82%	81%
Best performing Trust	100%	100%	100%	100%	100%
England average	96%	95.6%	96%	96%	96%

Accident and Emergency Friends and Family test

Friends and Family A&E response rate	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
THFT response rate	19.9%	18%	19%	28%	31%
Rank	29/138	33/136	28/138	7/140	4/140
Worst performing trust	0%	0%	0%	0%	0%
Best performing Trust	58.7%	45.4%	49.1%	69.7%	45.1%
England average	12.9%	11.6%	12.3%	13.4%	12.8%
Friends and Family A&E percentage recommended					
THFT percentage recommended	79%	84%	85%	84%	86%
Rank	130/138	95/136	93/138	90/140	79/140
Worst performing trust	66%	57%	66%	67%	64%
Best performing Trust	100%	100%	100%	100%	100%
England average	87%	85%	88%	85%	84%

* = Joint Ranks

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the assertive improvement programme implemented in place and the Care and Treatment provided by the Trust being provided to the standards expected more consistently and the assertive work of the patient experience team with clinical colleagues to ensure that receipt of feedback is

prioritized.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services through the continued implementation of its Patient and Service User Strategy and agreed objectives which are reported through to Trust Board.

Complaints and Concerns Monitoring

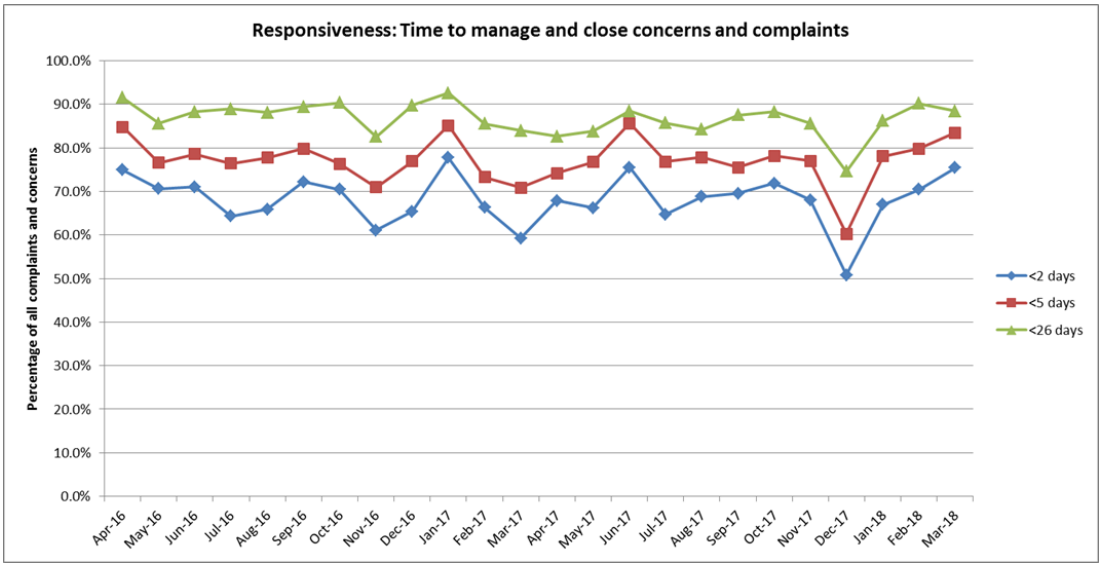
NHS Outcome framework 4: Ensuring that people have a positive experience of care	

The percentage of total cases closed within an agreed time or negotiated extension of time frame is 94% at the end of March 2018.

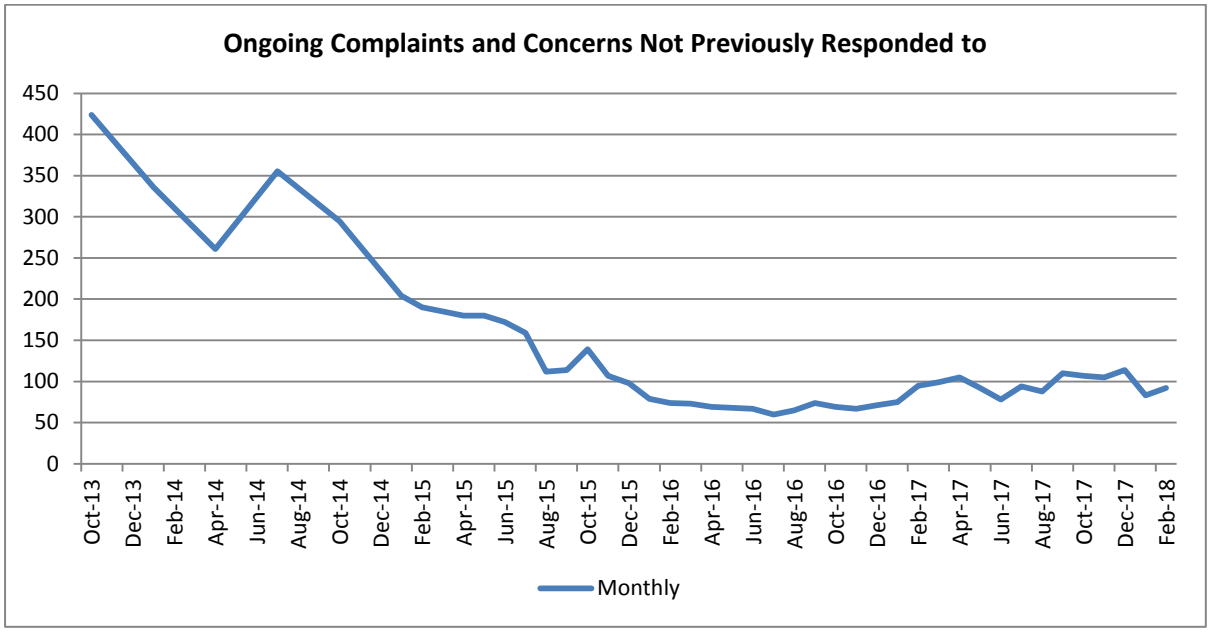
We have continued to refine the way we handle Complaints and PALS cases in order that we become more responsive to patient and carers that raise issues with the complaints and PALS service. The clinical and operational teams have also streamlined their part of the process to ensure that the leadership and infrastructure was strengthened to reinforce divisional engagement rather than a Trust centrally based service.

- We have increased our responsiveness and attempt to ensure real time response management when possible.
- We continue to show openness and Candour in the way we work and our responses which is evident in the responses for cases reviewed by the PHSO
- All complaints are triaged for harm and aligned, if applicable to the Serious Incident and escalated investigation process.
- We continue to recommend and undertake face to face resolution meetings which are recorded and a CD issued as a record of the meeting for complainants to keep.
- We offer apology and appropriate redress for harm in line with the PHSO redress principles.
- We use the learning from complaints to provide our patient stories and inform the organisational development and learning through our Governance Processes across the organisation.

Our responsiveness to concerns and complaints has been maintained but was impacted by some staff absence as demonstrated below



And have managed the backlog of ongoing cases.



The table above shows the average number of ongoing complaints and concerns not yet responded to on a monthly basis. The increase in Quarter 3 2017/18 is due to staff changes and revised skill mix of staff from December 2016. We expect to see less than 80 ongoing cases as our average in 2017-18.

We pledged to reduce the number of KO41 complaints per 1000 patient contacts to below 1.15. We have achieved this in 2016/17. We have seen a small increase in the number of complaints in 2016/17 in line with what was expected as we now provide community services.

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Number of K041 complaints received	403	450	532	445	450	468
Complaints per 1000 patient contacts across the Trust including community services	1.15	0.95	1.11	0.80	0.52	0.58

Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Complaints per 1000 contacts	0.62	0.46	0.56	0.66	0.76	0.53	0.59	0.57	0.39	0.52	0.68	0.61

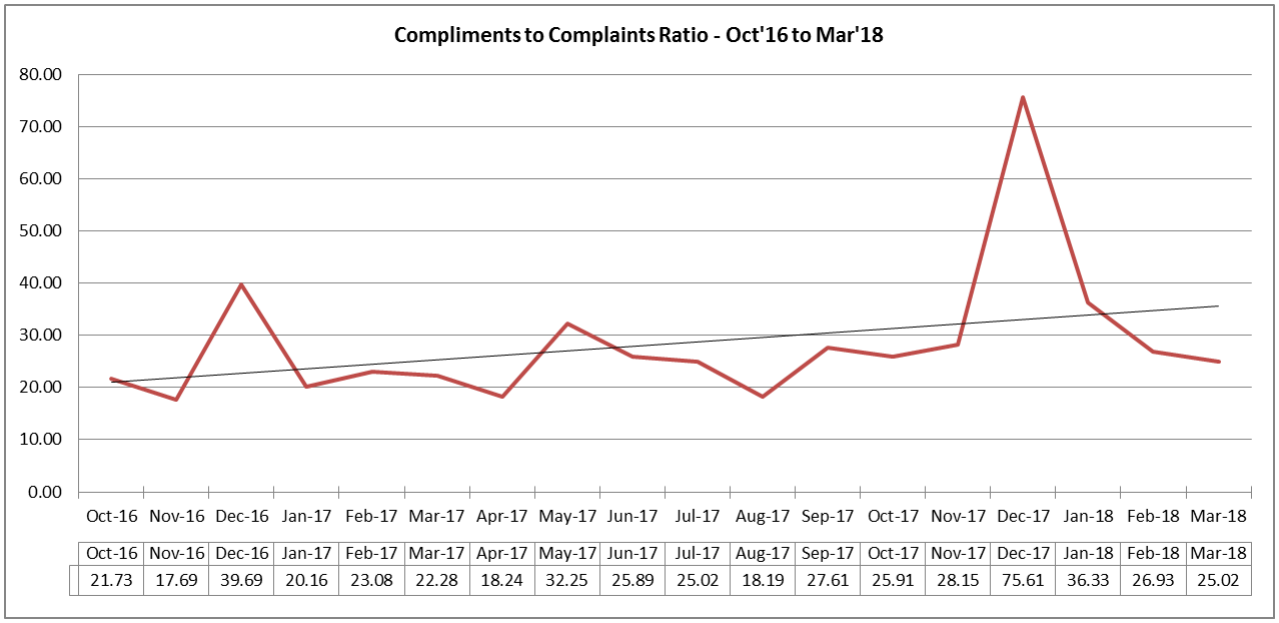
Compliments

We pledged to increase in the number of recorded compliments per 1000 patient contacts by 25% from the baseline of 4092 in April 2016.

We have in developed and implemented a more robust method of capturing this data and the compliments recorded at ward level have continued to increase on a quarterly basis throughout the year. We have achieved this pledge. In 2017/18 we captured a total of 13307 compliments. This equates to 28.43 compliments for every K041 complaint received. This is an increase of 31% since 16/17.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Number of compliments received	693	1032	958	1076	946	994	1114	1154	1739	1417	1158	1026
Compliments per 1000 patient Trust contacts	11.27	14.86	14.52	16.50	13.85	14.72	15.19	16.08	29.21	19.00	18.30	15.39
Compliments to complaints ratio	18.24	32.25	25.89	25.02	18.19	27.61	25.91	28.15	75.61	36.33	26.93	25.02

In 2018/19 the Trust will aim to reduce further the rate of complaints received and improve the percentage of responses provided within an agreed timeframe whilst maintaining the low rate of comeback letters, and improving the Compliments to complaints ratio.



Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
21.73	17.69	39.69	20.16	23.08	22.28	18.24	32.25	25.89	25.02	18.19	27.61	25.91	28.15	75.61	36.33	26.93	25.02

Responsiveness to the patients personal needs

NHS Outcome framework 4: Ensuring that people have a positive experience of care	

The 2017 in patient survey results are not yet available.
The results of the 2016 In-patient Survey are based on responses from patients discharged in August 2016 and January 2017.

Section	2014 Survey	2015 Survey	2016 Survey	2017 survey
The A&E department	About the same	About the same	About the same	Not available nationally at the time of the publication
Waiting list and Planned admissions	About the same	About the same	About the same	
Waiting to get a bed on a ward	Worse	Worse	About the same	
The Hospital and Ward	About the same	About the same	About the same	
Doctors	Worse	Worse	About the same	
Nurses	About the same	About the same	About the same	
Care and Treatment	About the same	About the same	About the same	
Operations and procedures	About the same	About the same	About the same	
Leaving Hospital	About the same	About the same	About the same	
Overall view and experience	Worse	About the same	About the same	

We also pledged in our Patient and Service User Experience Strategy to improve the scores in the inpatient survey for

- Reduction in disturbance from noise at night
- Improved levels of support at mealtimes
- Improved involvement in decision making

We will report on the success of these criteria when the results are available (Not available the time of the publication)

Benchmarking scores

NHS England provides benchmarking scores which are demonstrated below for the Trust.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Tameside	69.3	73.7	75.2	72.2	72.6	74.2
England Average score	75.6	76.5	76.9	76.6	77.3	76.7

NHS England provide the following explanation of the scores
The scores are out of 100. A higher score indicates better performance: if patients reported all aspects of their care as "very good" we would expect a score of about 80, a score around 60 indicates "good" patient experience.

The overall score is the average of the domain scores.

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the feedback received from Patients, and the improvement achieved due to the improvement and patient safety work undertaken.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services by the implementation of a Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust board.

NHS Outcome framework 3: Helping people to recover from episodes of ill health or following injury	

We pledged to achieve all access standards – we have not achieved all of these.

Performance against the access standards is reported monthly in the Trust board papers. The reported position for March 2018 is shown below.

Key Performance Indicators	Target 17/18	Actual YTD	4-mth Trend	Actual Month	Current Period	1-mth F'cast
4-hour wait*						
Type 1 and Type 3 activity	≥95%	89.65%	↘	85.57%	●	●
Type 1 activity	NA	83.20%	↘	75.56%	NA	NA
Waiting times						
18-week incomplete*	≥92%	92.61%	→	92.01%	●	●
RTT waits- incompletes (>52 weeks)	0	1	↗	0	●	●
A&E						
HAS compliance	≥95%	94.8%	↗	94.8%	●	●
Notify to Handover (30-60mins) (Feb-18)	≤30	629	↘	93	●	●
Notify to Handover (>60mins) (Feb-18)	≤10	199	↘	42	●	●
Diagnostic test waiting times						
≤6 weeks from Referral for a diagnostic test	≥99%	99.80%	→	100%	●	●

Referral-to-Treatment

In this year's Quality account we identified our improvement programme to ensure we met the RTT requirements. We implemented this and the Trust met the national Referral-to-Treatment standard in each month from August 2016, and has continued to do this throughout 2017/18.

Six week Diagnostic target

We have met the requirement throughout the year and not had a six week diagnostic breeches for the last 4 months of the year.

The Four-hour Target

The Trust did not meet the emergency access four-hour standard in any quarter of 2017/18. Performance has been constrained by high levels of bed occupancy and patient acuity, despite the improvement and transformation work which has been implemented as describe earlier. Our performance against the 95% standard has been a challenge all year, and were ranked 46th out of 133 Trusts.

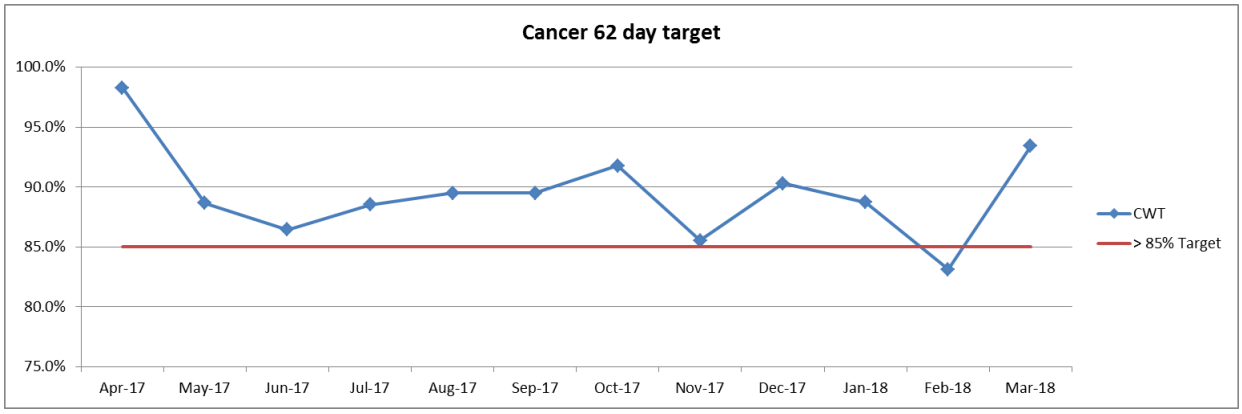
The Trust has engaged with stakeholders and implemented the NHSI best practice guidance to enable admission avoidance and facilitate early discharge, and plans to develop this work further as described in section 2 of the Quality account as part of the service transformation work being undertaken and the health-economy implementation plan.

Cancer indicators - including 62 Day cancer performance

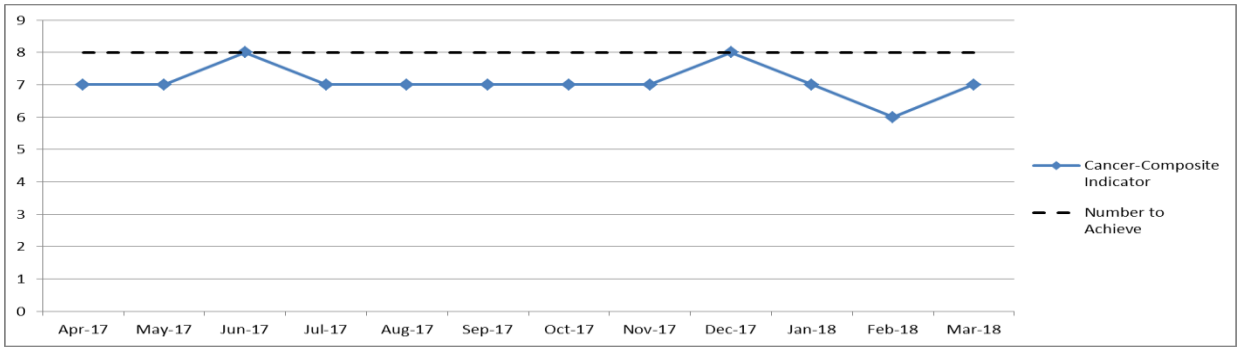
NHS Outcome framework indicators: All domains	

The monitoring of Cancer performance is undertaken by the Trust board through its routine reporting process. The performance indicators are set to identify best practice minimum standards to ensure that patients receive care and treatment in the most effective way. With respect to the Cancer performance criteria we believe that this has been achieved in 2017/18 and we ranked 19th out of 133 Trusts for these.

Measure	Target %	YTD %
Two-week wait	93	97
Breast symptomatic target	93	98.2
31-day target	96	100
Subsequent 31-day target (Drug treatments)	98	100
Subsequent 31-day target (Surgery)	94	100
62-day target (CWT)	85	89
Upgrade 62-day target	85	96.3
NHS Cancer Screening Programmes(62-days)	90	100



Cancer composite indicator number achieved out of 8



The Trust aims to maintain compliance with all national and local performance standards as identified in the Trust Objectives for 2018/19.

Staff Survey Results (including Friends and Family Test)

NHS Outcome framework 4: Ensuring that people have a positive experience of care	

During autumn 2017 the Trust participated in the annual staff survey. The survey was sent out to a random sample of 1250 eligible staff, 503 staff took part in the survey providing a response rate of 40% which was slightly better than last year's response rate of 39%. The average response rate for all Combined Acute and Community NHS Trusts was 43%.

Nationally the Trust was 7th out of 43 Combined Acute and Community Trust remaining in the top 20%.

The results are extremely positive with 21 of the 32 areas classed as better than average when compared to other Combined Acute and Community Trusts, 10 areas are classed as average and only 1 areas are worse than average.

We have maintained 28 of our previous year's scores and have improved on 1 area. We have 3 areas where performance was worse than the previous year; however in each of these three areas the Trusts score is higher than the average score for combined Acute and Community Trusts.

There were also 4 areas where the Trust scored the maximum score of any Combined Acute and Community Trust.

- KF29 – Percentage of staff reporting errors, near misses or incidents witnessed in the last month.
- KF4 – Staff motivation at work
- KF8 – Staff satisfaction with the level of responsibility and involvement
- KF2 – Staff satisfaction with the quality of work and care they are able to deliver

TOP AND BOTTOM RANKING SCORES

This highlights the Key findings where the Trust compares most favourably with other combined acute and community trusts (CA&CT) in England

TOP FIVE RANKING SCORES	Trust Score 2017	National Average for CA&CT	Trust Score 2016
KF2. Staff satisfaction with the quality of work and care they are able to deliver (the higher the score the better, highest is 5)	**4.16**	**3.90**	**4.11**
KF4. Staff motivation at work (the higher the score the better, highest is 5)	**4.01**	**3.91**	**4.03**
KF8. Staff satisfaction with level of responsibility and involvement (the higher the score the better, highest is 5)	**4.05**	**3.89**	**4.06**
KF24. Percentage of staff / colleagues reporting most recent experience of	**81%**	**67%**	**83%**

violence (the higher the score the better)			
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)	**94%**	**91%**	**96%**

This highlights the Key findings where the Trust compares least favourably with other acute and community trusts in England

BOTTOM FOUR RANKING SCORES	Trust Score 2017	National Average for CA&CT	Trust Score 2016
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	**10%**	**10%**	**8%**
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (the lower the score the better)	**14%**	**14%**	**13%**
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (the lower the score the better)	**28%**	**27%**	**25%**
KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse (the higher the score the better)	**47%**	**47%**	**46%**
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (the lower the score the better)	**29%**	**29%**	**24%**

Significant Improvements – this highlights the areas where staff experience has shown a statistical significant improvement since 2016

Significant Improvements	Trust Score 2017	Trust Score 2016
KF11. Percentage of staff appraised in last 12 months	**94%**	**90%**

Significant deteriorations -

Significant deterioration	Trust Score 2017	Trust Score 2016

KF9. Effective team working (the higher the score the better)	**3.80**	**3.91**
KF31. Staff confidence and security in reporting unsafe clinical practice (the higher the score the better)	**3.72**	**3.86**
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (the higher the score the better)	**89%**	**93%**

Overall Staff Engagement - Above better than average

Trust Score 2017	Trust Score 2016	National Average for CA&CT 2017
3.89	**3.95**	**3.78**

Although there was a slight drop against last year this was not statistically significant.

Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

	Your Trust in 2017	Average (median) for combined acute and community trusts
Q21a "Care of patients / service users is my organisation's top priority	82%	75%
Q21b "My organisation acts on concerns raised by patients / service users	80%	73%
Q21d "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	71%	69%
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.86	3.75

The Trust benchmarked performance with others demonstrates

Staff survey Q21a, 21c and 21d The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	2014	2015	2016	2017
Tameside	3.70	3.94	3.92	3.86
Rank	61/138	16/99	7/39	7/43
Worst performing trust	3.00	3.30	3.32	3.06

Best performing Trust	4.20	4.10	4.20	4.54

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because of the assertive improvement programme implemented including staff engagement undertaken in the past year to ensure delivery of Services, Care and Treatment and staff support was enabled and was being consistently provided to the standards required.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services by the continuation of this a Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust board. Specifically:

The results of the 2017 survey were disseminated across the whole organisation and all staff groups and shared with the Divisional Teams to ensure they had a full opportunity to review the results for their areas and to agree the core actions that needed to be taken.

ACTION PLANNING FOR 2018

The NHS Staff Survey provides an opportunity to build up a picture of staff experience and, with care, to compare and monitor change over time and to identify variations between different staff groups. Obtaining feedback from staff is vital for driving real improvements.

On the whole the survey results are positive, we have high levels of staff job satisfaction and motivation and staff would on the whole recommend the Trust as a place to work or receive treatment.

The results of the 2017 survey will be disseminated through the usual communication mechanisms and Divisional teams. Next steps will be to work with divisional teams to develop bespoke action plans to celebrate some of the very positive results but also to address areas identified where improvements are required.

Divisional action plans and progress against those actions will be reported via the Workforce Committee for oversight and assurance.

Actions already commenced:

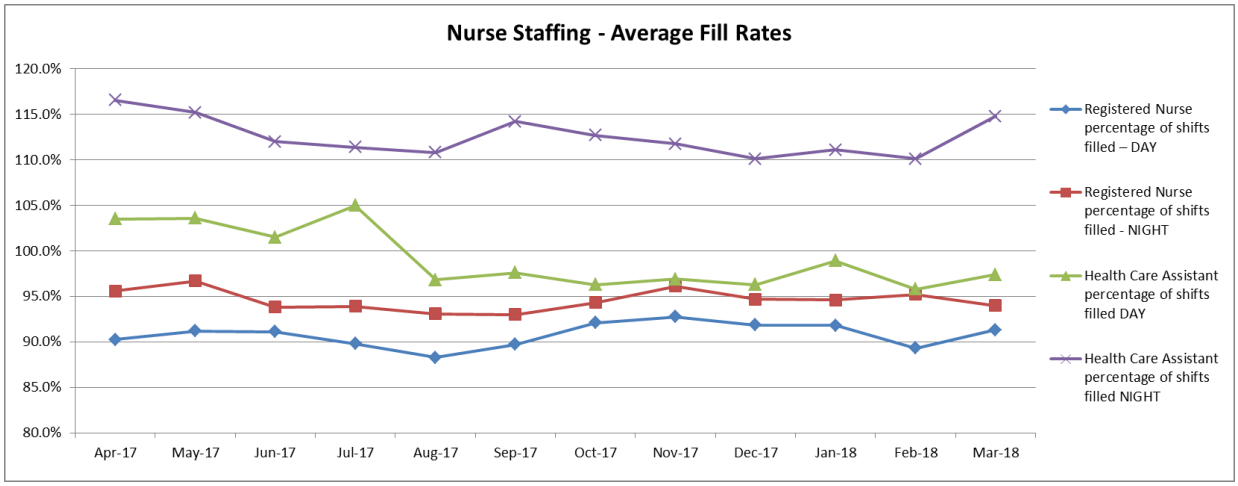
- Medical Staffing team as part of the Medical Staffing retention work stream will be conducting aspiration interviews with Trust Grade Junior and Specialty doctors to understand what support/career development that they would benefit from.
- A programme of resilience training dates have been arranged throughout 2018 so that staff and teams can access some tips and tools to support them to increase their own resilience and develop strategies to reduce levels of stress.
- Mental Health First Aid Training for Managers/Mental Health Champions has been arranged for May 2018, the course will equip the Mental Health champions to support staff experiencing Mental Health issues and create and maintain a healthier workforce.
- In response to feedback from staff in terms of experiencing high levels of violence and aggression during the course of their work last year, Conflict

Resolution De-escalation training has been commissioned. Additional dates are booked in February and March with 20 staff booked on to attend from ward Areas within Medicine and Urgent Care. Further dates, are to be scheduled throughout 2018 for teams identified requiring this support.

- A series of Focus Groups to be held at the end of April with BME staff initially to explore their experiences in the workplace and further understanding of the results.
- Re-design of the Equality and Diversity Training with a greater emphasis on discrimination.
- Focus Groups with staff to further understand the results where we have scored lower than the national average
- Benchmarking with other Trust's that have scored higher on those areas where we require improvement.

Safe Staffing levels

Safe Staffing levels continue to have a high profile within the organisation and are reported on Monthly to Trust board. The graph and table below demonstrate the data which has been presented throughout the year with Registered Nurse staffing and Care staff achieved fill rates for day and night shifts.



Percentage	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Registered Nurse percentage of shifts filled – DAY	90.2	91.2	91.1	89.8	88.3	89.7	92.1	92.7	91.9	91.8	89.3	91.3
Registered Nurse percentage of shifts filled - NIGHT	95.6	96.7	93.8	93.9	93.1	93.0	94.3	96.1	94.7	94.6	95.2	94.0
Care Staff percentage of shifts filled DAY	103.5	103.6	101.5	105.0	96.8	97.6	96.3	96.9	96.3	98.9	95.8	97.4
Care Staff percentage of shifts filled NIGHT	116.6	115.2	112.0	111.4	110.8	114.2	112.7	111.8	110.1	111.1	110.1	114.8

NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	

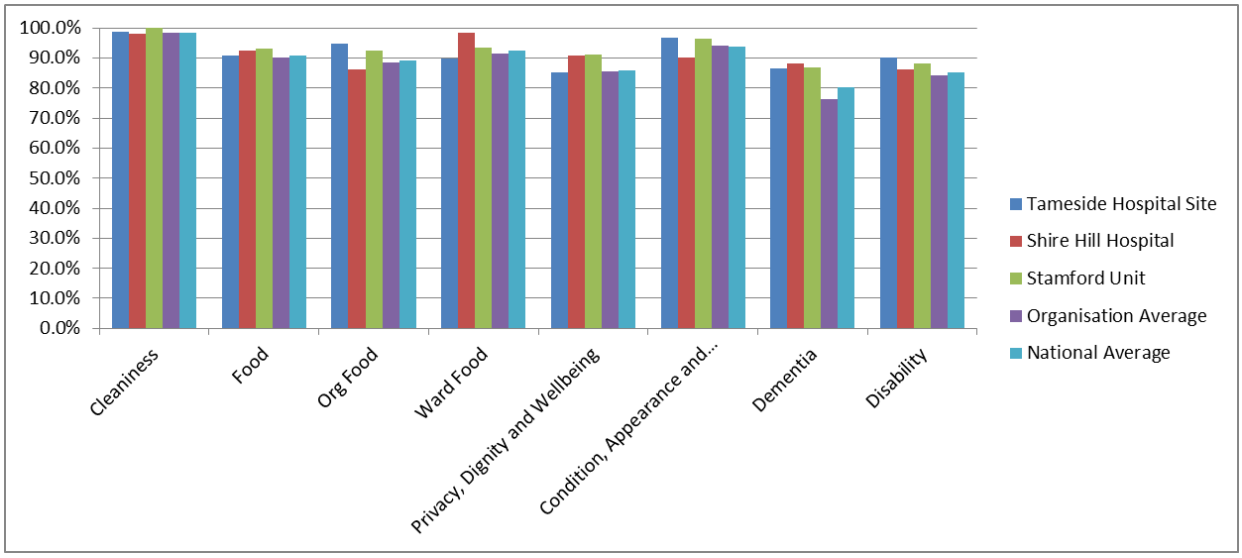
PLACE inspections
(Patient-led assessments of the care environment)

PLACE is the Patient Led Audit of the Care Environment and covers a number of areas: Environment, Cleanliness, Food, Condition, Appearance and Maintenance, Dementia and Privacy, Dignity and Wellbeing and for the first year Disability was also reviewed. Staff and Volunteers are split into groups and choose which areas to audit. This ensures that as many areas as possible are audited and also means that the audits are led by the volunteers.

In 2017 we had a large number of new volunteers joining us for the PLACE assessments as well as a large number of volunteers who had helped on previous PLACE Audits.

The scores in all areas increased from previous years and in all cases were either very close to or exceeded the national average scores from the previous year and the current year.

The graph demonstrates the Tameside and Glossop Hospital site, Shire Hill Hospital and the Trust Average against the national average. We achieved improved scores in the areas of Cleanliness, Food, Condition and appearance and dementia, but seen a small reduction in Privacy dignity and wellbeing. Disability is a new indicator with which we benchmark at about the national level.



Patient Outcomes

PROMS (Patient Reported Outcome Monitoring)

NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	

The Trust continues to participate in the Patient Reported Outcome monitoring measures identified below. The information provided demonstrates the Trust Performance compared to the national benchmarking which demonstrates that in the main patients are reporting benefits from the outcome of the procedures reviewed

The information provided below is the nationally published year on year comparison data of our involvement and benchmarked comparison of pre- and post-operative patient questionnaires (a combination of five key criteria concerning patients' self-reported general health called EQ-5D Index' scores). The EQ5D scores are compared to the England average scores in the table below.

A positive number indicates a net health gain being identified and comparison to the England Average is also provided. This is the case for all data reported below. In some areas the data we provide during part of a year is too small to be evaluated separately, but will be included in the national average.

Hip Replacement	**2013/14**	**2014/15**	**2015/16**	**2016/17**
TGH EQ5D Adjusted Average Health Gain	0.369	0.415	0.398	0.460
England average EQ5D index Adjusted Average Health Gain	0.436	0.436	0.438	0.449

Knee Replacement	**2013/14**	**2014/15**	**2015/16**	**2016/17**
TGH EQ5D index Adjusted Average Health Gain	0.261	0.319	0.284	0.303
England average EQ5D index Adjusted Average Health Gain	0.259	0.315	0.320	0.337

Tameside and Glossop Integrated Care NHS Foundation Trust considers that these data are as described because of the improvement programme put in place and the implementation of care pathways being implemented.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services by the continued implementation of a Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust board.

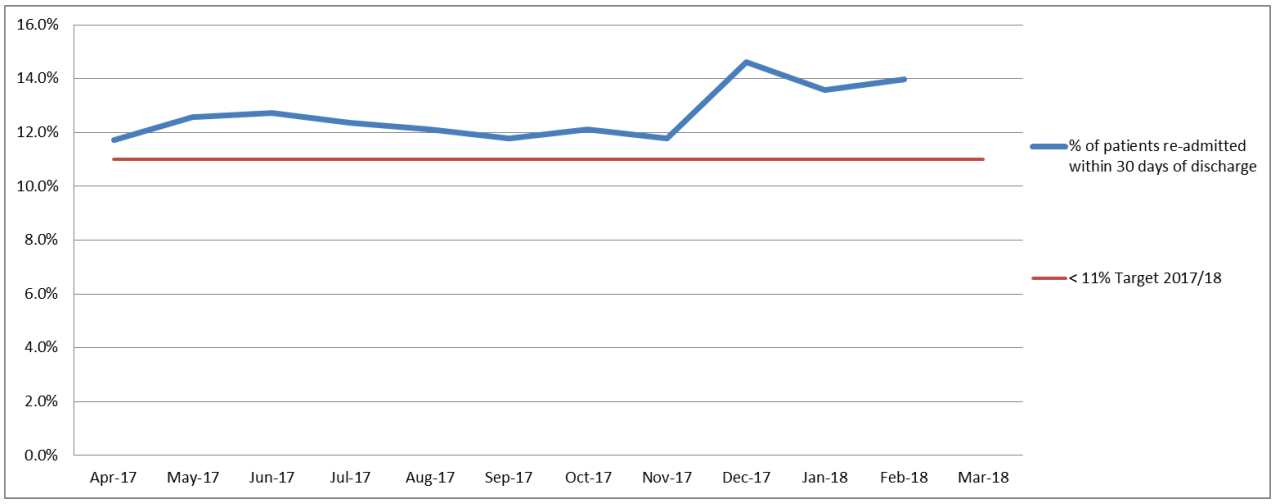
Readmission Rates

NHS Outcome framework 3: Treating and caring for people in a safe environment and protecting them from avoidable harm.	

The Trust Board monitors readmission rates for patients recently discharged from hospital as a Quality indicator. The Board performance report monitors 30 day readmissions as this is the Quality measure within the contract. The graph below demonstrates the performance this year. We are aiming to reduce readmission rates from both elective and non-elective patients.

We pledged to see a reduction in 30 day re-admission rates. We have not demonstrated further improvement this year. We continue to review readmissions to ensure that these are understood and that these are correctly captured in the context of the work to ensure timely discharge with the appropriate care support packages. We have further work to do to achieve the target rate which is being progressed through the service improvement workstreams.

Re-admission rates 2017/18



The Quality Account requires us to benchmark 28 day readmissions, and these are set out in the table below but have not been available nationally to report on.

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Comparison v. National	Improvement Banding
Age 16+								
Tameside	11.84	12.47	Data not available	Data not available	Data not available	Data not available	W	D
Best nationally	7.14	0.00	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Worst nationally	12.70	15.11	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Age 0-15								
Tameside	11.24	11.6	Data not available	Data not available	Data not available	Data not available	A5	D
Best nationally	6.26	0.00	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available
Worst	12.75	14.87	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available

nationally								

Key to The Health and Social Care Information Centre Comparison and improvement bandings

W = National average lies within expected variation (95% confidence interval);
D = Some deterioration (not significant)
A5 = Significantly poorer than the national average at the 95% level but not at the 99.8% level;

Notes:

- The readmission rate figures are standardised to persons 2006/07
- Indirectly age, sex, method of admission of discharge spell, diagnosis (ICD 10 chapter/selected sub-chapters within medical specialties) and procedure (OPCS 4 chapter / selected sub-chapters within surgical specialties) standardised rates
- Ages 16+
- Best and worse readmission rates selected from Trusts classed as “Small acute” or “Small acute or multi service categories”.
- Source: The Health and Social Care Information Centre

The Trust’s performance on this indicator is reported above for 2017/18 this is an average of 12.7%. This is an internal figure and subject to validation by HSCIC in the future.

Tameside and Glossop Integrated Care NHS Foundation Trust consider that this data is as described because the care and treatment provided by the Trust is still not being consistently provided to the standards required.

Tameside and Glossop Integrated Care NHS Foundation Trust has taken the following action to further improve this indicator and so the quality of its services by continuing to implement and monitor care pathways and ensure they are systematically implemented.

Improving Hospital Mortality

NHS Outcome framework 1: Preventing People from dying prematurely 2: Enhancing quality of life for people with long-term conditions	

We pledged to see reduction in mortality rates and implementation of a systematic review process to levels that are not statistically significant and show a reduction in the raw death rate and the implementation of a systematic review process.

We are continuing to undertake mortality reviews for every death occurring in hospital. The initial reviews within 14 days have systematically been achieved for each month of the year. Where an issue is identified we undertake a comprehensive MDT reviews and further investigation or external review as appropriate. These cases are systematically followed up and results reported through the Mortality Steering Group reporting to the Service Quality and Operational governance group.

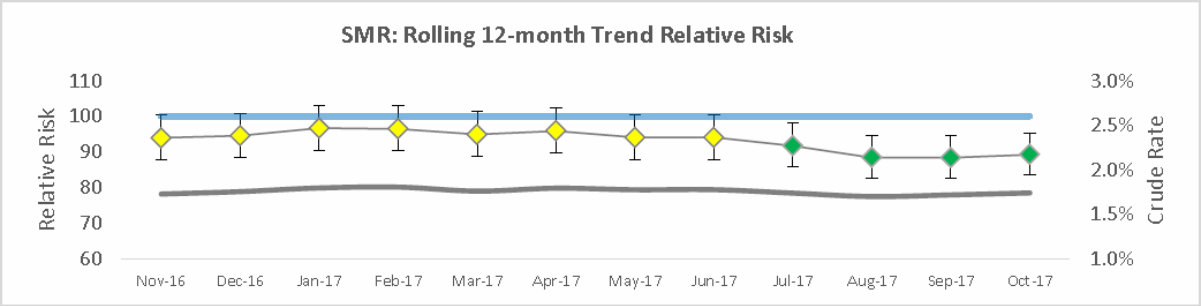
The Hospital Risk adjusted mortality indices HSMR (Hospital Standardised Morality Ratio) and SHMI (Summary Hospital-level Mortality Indicator) are routinely reported in the Trust Board papers available on the Trust website. These indicators are reported retrospectively the HSMR indicator has remained within normal limits during the year and the SHMI indicator score has reduced and has been within the "as expected" banding for the last four reporting periods and we anticipate that this position will be maintained

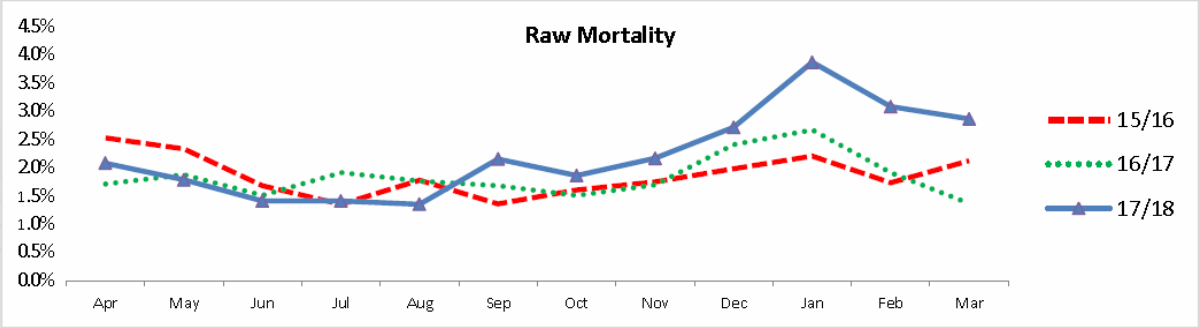
SHMI – *Summary Hospital-level Mortality Indicator*

	Jan 15 – Dec 15	Apr 15 – Mar 16	Jul 15 – Jun 16	Oct 15 – Sep 16	Jan 16 – Dec 16	Apr 16 - Mar 17	Jul 16 – Jun 17	Oct 16 – Sep 17
SHMI	115.00	114.00	110.00	111.00	109.00	109.00	108.00	108.00

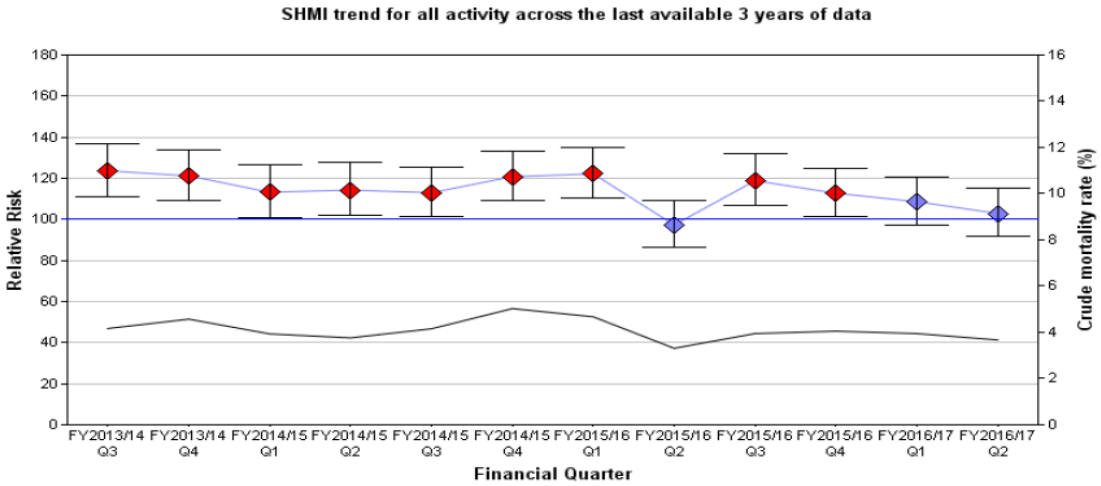
HSMR – *Mortality Rate All Diagnosis*

	Apr 16 – Mar 17	May 16 – Apr 16	Jun 16 – May 16	Jul 16 – Jun 16	Aug 16 - Jul 16	Sep 16 – Aug 16	Oct 16 – Sep 16	Nov 16 – Oct 17
HSMR	93.60	95.90	94.10	94.20	91.70	88.50	88.50	89.20





SHMI trend for all activity across the last available 3 years of data



The Trust continues to take the following actions to improve these indicators, and ensure our mortality rates reduce further and are not higher than expected:

We continue to

- Maintain an Executive clinically led mortality steering group to review intelligence available.
- Ensure that we report on our learning from deaths
- Routinely monitor and investigate and understand the areas that alert on the mortality indices.
- Analyse and understand our data and develop the capability of the clinical divisions to review and analyse the mortality data at specialty level in the clinical divisions
- Commission specific reviews/audits of areas of concern when required.
- Develop more care pathways and care bundles to improve standardisation and reliability of care delivery.

Tameside and Glossop Integrated Care NHS Foundation Trust considers that this data is as described because the because of the improvement programme put in place and the implementation of care pathways being implemented.

Tameside and Glossop Integrated Care NHS Foundation Trust is taking the following action to further improve this indicator and so the quality of its services by implementation of the Trust wide improvement programme agreed with key stakeholders and progress monitored by the Trust board, and in addition a work programme including:

The Palliative Care Coding rate compared to the national rate is displayed in the table below.

Indicator	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Tameside Palliative Care coding rate	4.8%	3.3%	3.76%	3.28%	3.55%	3.63%
National Palliative Care coding rate	2.6%	3.3%	3.57%	3.79%	4.03%	4.04%

The percentage of patient deaths with palliative care coded are:-

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Tameside	18.7	12.3	14.5	17.3	17.9	15.9
Highest Nationally	97.6	94.1	92.3	95	96.1	93.3
Lowest nationally	1.7	2.4	6.4	8	6.3	3.9
National average	17.6	20.7	23.3	26.2	28.6	29.7

The Table below demonstrates the current SHMI

	2012	2013	2014	2015	2016	2017
Tameside	118	112	118	114	110	108
Best Nationally	71	63	60	65	69	73
Worst nationally	125	116	120	118	116	125

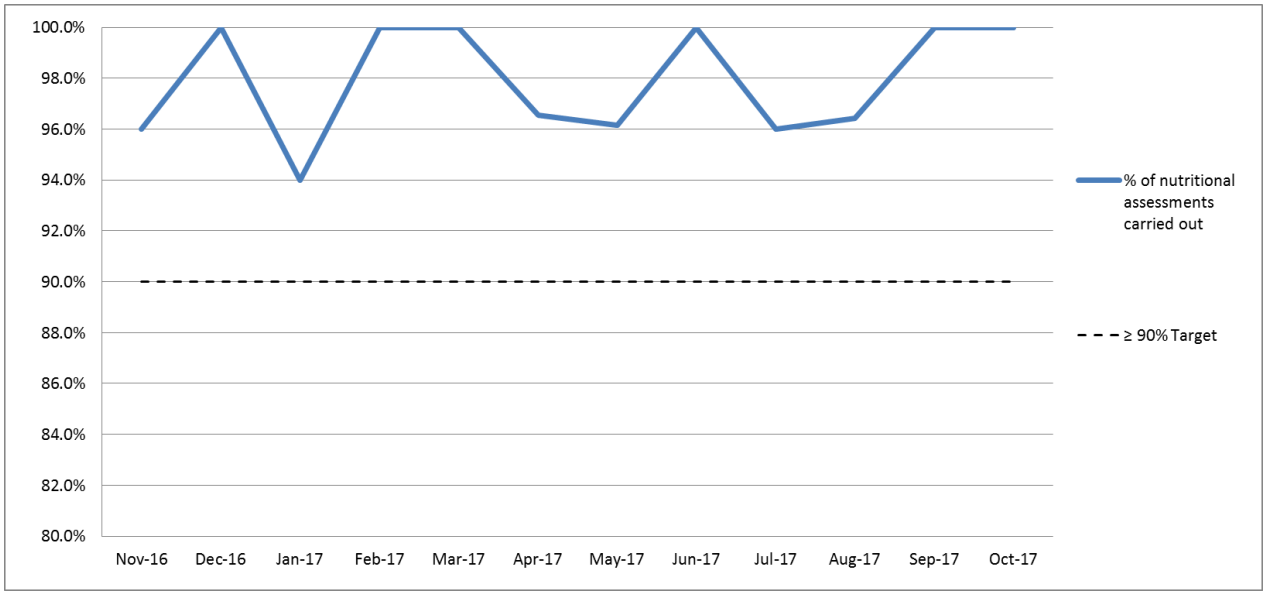
Improved nutritional care and hydration.

NHS Outcome framework 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	

We pledged to provide improved care in relation to nutrition and hydration

The Trust routinely undertakes a nutritional risk assessment for inpatients and this is reported to the Trust board. We have achieved and exceeded the standard set throughout the year.

Nutritional Risk Assessments



Other Important Patient Safety and Effectiveness Indicators

NHS Outcome framework 3: Helping people to recover from episodes of ill health or following injury	**See individual indicators below**

Patient Safety Indicator	2015/16 Performance	2016/17 Performance	2017/18 Performance
Failure of the safer-surgery process	0	0	0
StEIS Serious Incidents reported	27	38	87
Duty of Candour breeches	0	0	0
Never events reported	1	0	2
Coroners Section 28 letters	7	2	5

The Trust is aware of why the number of StEIS reported incident has increased. In April 2017 we changed the threshold for reporting of StEIS incidents following dialogue with the commissioners to better align local practice with other Trust as we were seen as an outlier in reporting incident on StEIS. The increased reporting of these cases does not indicate a higher level of harm but that we are making Commissioners and regulators aware of these incidents through the StEIS reporting system. The two reported Never Events related to low harm incident in theatre and have been reported through StEIS. These have been subject to Investigation and Root Cause Analysis to understand why these occurred and prevent recurrence. The learning form these is being implemented.

We have received 5 Coroners regulation 28 letters (PFD). These have all been responded to in detail with either the required additional information by the Coroner which was not heard or provided through Coronial process or our learning and evidence of the action taken by the Trust in response to these. We will continue to build and strengthen our relationship with the Coroner to ensure the process better assists and informs families through this process at a difficult time.

Trust Corporate Objectives 2018/19

Objective 1

To ensure our patients and users receive harm-free care by improving the quality and safety of our services though the delivery of our Quality and Safety programme.

Objective 2

To improve our patient and service user experience through the delivery of a personalised, responsive, caring and compassionate approach to the delivery of care.

Objective 3

To continue to recruit and retain talented individuals and how to develop our staff and future workforce to support the integration and transformation of our services.

Objective 4

To develop and support our five primary care neighbourhood hubs and key partners to enable them to deliver new integrated service models in order to improve user patient outcomes through supporting people:

- to prevent ill-health and live healthy, independent lives where possible;
- to manage any on-going health conditions more effectively in their own homes and communities;
- to facilitate easy access to joined-up services in the most appropriate location.

Objective 5

To deliver against the required national regulatory frameworks and agreed local standards, in terms of quality, access and financial performance.

Objective 6

To access available technologies and research to improve the outcome for our patients population.

Annex 1 - Comments from Other Agencies on the 2017/18 Quality Account

Statement from Tameside and Glossop CCG

Tameside & Glossop Strategic Commission welcome the opportunity to comment on the quality of services provided by Tameside & Glossop Integrated Care Foundation Trust. We welcome the progress the Trust has made in moving towards a more integrated health and care organisation. The commissioners are particularly pleased with the development of integrated neighbourhood provision, which is starting to bring care closer to people, working alongside primary care colleagues to improve outcomes for our population. During this year, the Trust has started to broaden its community scope by contracting for asset base approach services, early intervention in mental health and care navigators to support early intervention and prevention, helping people to self-care.

Over the past year, we have built upon the closer working relationships between commissioners and The Trust to support the delivery of good quality, safe services for our population. Commissioners are pleased to see the ambition from the organisation to become a CQC outstanding provider and will support the Trust in achieving this ambition. The Strategic commission acknowledge the continued improvement journey and the quality improvements that are outlined in this account are commendable.

Tameside & Glossop Strategic Commission have continued to work closely with The Trust to monitor the quality of services provided via contract meetings and monthly meetings focussed on quality and safety. The Strategic Commissions Director of Quality & Safeguarding continues to be invited as a regular participant to the Trusts internal quality and governance forum and participated in a quality visit to the flexible community bed base. The Strategic Commission would like to acknowledge the continued level of transparency and openness demonstrated by the Trust.

Patient safety

Within the quality account, the Trust outlines how they continue to work towards improvements in patient safety by the continuation of the Sign up to Safety Campaign. They demonstrate this commitment to safety by the development of a further 30 AQUA Patient Safety Champions across the organisation. The Strategic Commission acknowledges the considerable improvement work the Trust has built upon from the previous year in continuing to drive improvements in pressure ulcer prevention across the health and social care economy. Managing the deteriorating patient, reducing falls and increasing VTE and nutritional assessments. We also commend the continued work on medicines management, antibiotic stewardship and infection prevention that the Trust are now leading for the health and social care economy.

The Strategic Commission would like to specifically acknowledge the continued work the Trust has implemented in learning from mortality and the continued implementation of mortality reviews for people with a learning disability. We also commend the Trusts commitment to safe staffing and care contact time by having a continual focus on recruitment and retention.

Patient experience

The Strategic Commission acknowledge that the Trust continues to see significant improvement in patient's experience of services. This can be seen in both response rates for the Friends and Family Test and recommended score particularly in in patient and maternity setting. Where there are areas for improvement such as Accident and Emergency services, there is an improvement plans in place which the Strategic Commission will monitor via the quality, performance and contract meetings.

Commissioners are pleased to see the continued commitment on responding to complaints and the focus on learning from complaints across the organisation.

Staffing and Culture

The Trust have again received positive results from the annual staff survey. The results demonstrate that staff feel well trained and able to provide quality care. Where there are areas for improvement such as bullying and harassment and discrimination, in response the Trust has commissioned Conflict Resolution De-escalation training and specific work with its BME staff. The Commissioners will work with the trust in order to drive improvements in staff experience.

Patient Outcomes

The Trust has continued to participate in both national and local clinical audits; learning from these audits is implemented in practice and shared with the Strategic Commission.

The Trust continues to participate in the Patient Reported Outcome monitoring measures. The information provided demonstrates that in the main patients are reporting benefits from the outcomes of reviewed procedures carried out in the Trust,

Areas for improvement 2017/18

Tameside & Glossop Strategic Commission will continue to work with the Trust to support them in maintaining their overall CQC rating as good and their ambition to become a CQC outstanding organisation.

The Strategic Commission would like to see the Trust continue to deliver good quality, safe care to patients with a focus of delivery in neighbourhoods.

The Strategic Commission would like to see continued improvements in Urgent care performance, length of stay and delayed transfer of care. We acknowledge that they remain a challenge and the Trust have implemented initiatives such as discharge to assess, flexible community bed base and ticket home to assist with flow through the organisation. The Strategic Commission will continue to support these and further initiatives as a system.

The Strategic Commission would like to see further progress on the integration and transformation of community and social care services. Building upon the progress made this year.

The Strategic Commission would like to see greater focus on a patient journey view of quality and safety reflected in quality reporting going forward.

The strategic commission will support the trust in monitoring quality and safety of their commissioned services.

In conclusion the Single Commission are confident the Trust has demonstrated their commitment to quality, experience and safety in their continual improvement journey. We thank The Trust for the honest and open culture fostered within the organisation and their continued focus on putting patients first. We look forward to seeing the further transformation of The Trust on its integration journey and the continued commitment to system quality improvement.

Steven Pleasant MBE

Chief Executive, TMBC and Accountable Officer, CCG

Statement from the Healthwatch

Healthwatch Tameside value our strong partnership work with TGICFT and our ability to input into service improvements. We have strong relationships for this work from the CEO through to an operational level.

The continued openness to our Healthwatch Champions talking to people in any of the outpatients waiting rooms is particularly positive.

Summaries of all the stories and information collected by Healthwatch Tameside about a service or care provided by the TGICFT are shared on a regular basis. This information is then triangulated with Friends and Family and PALS comments received which is a valuable way to process public and patient feedback. This could be further improved by ensuring that Healthwatch Tameside hear feedback about whether any changes have been made as a result of this information. Posts on Care Opinion are responded to well which is excellent, but again where changes are made, this is not usually recorded online.

Regarding our work related to complaints handling we have recently given some detailed feedback on areas for improvement which has been responded to promptly including looking at how to more directly answer the questions raised by patients.

Our staff have attended the Patient Experience Group at the hospital and the staff who attend are committed to improving care and the services provided. There are new initiatives being discussed regularly which is encouraging. It continues to be vital to gather evidence of the difference this work makes which we can feedback to our members and the public.

In conclusion we are very positive about our work with TGICFT and feel that a continued focus on the feedback to Healthwatch Tameside, patients and the public about improvements to services, especially those improvements linked to patient and public engagement, would further strengthen this work.

Ben Gilchrist

Healthwatch Tameside Chief Executive

Statement from the Council of Governors

The Governors once again want to acknowledge the significant improvements and changes made in the Trust during the last year.

We also want to acknowledge the hard work, dedication and effort put in by all staff at the Trust.

The continued development with regard to the organisation is very pleasing.

Governors are satisfied to see evidence of the continued focus across many and varied areas ;with ongoing transformation of services, developments in service improvement and transformation within what we now recognise as an Integrated Care Organisation. Across the many highlighted in the Quality Report, we would note –

The home first focus

The neighbourhood development programme.

Community work to prevent people having to attend hospital.

Early signs of progress on digital health.

Development and progress in how intermediate care is to be offered.

The Quality Account continues to recognise that the improvement process is a continuous process, with further work and objectives to improve the health and wellbeing of the community. We remain confident that under the current leadership these will continue to be achieved.

The Council of Governors continue to receive regular updates from the Board on issues related to quality, both at formal meetings and through informal settings.

Designated colleagues also attend the meetings of the Quality and Governance Committee, giving Governors visibility of the more detailed discussions.

Having reviewed the draft, on behalf of Governors I am happy that the Quality Account provides representative and comprehensive coverage of services outlining the improvements during the year; and provides a balanced account of the activities the Trust has undertaken in this area during 2017/18.

John Phillips

Lead Governor
Tameside and Glossop
Integrated Care NHS Foundation Trust.

Statement from TMBC Health and Well being

Not received at the time of publication. We requested this feedback from TMBC Health and Wellbeing committee on 19th April 2018, which provided the time required for a response to be provided.

Annex 2 – Statement of Directors Responsibilities on the 2017/18 Quality Account

2017/18 Statement of Directors' responsibilities in respect of the Quality Report

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

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

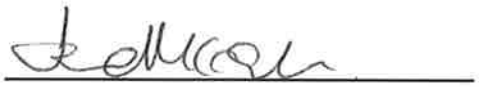
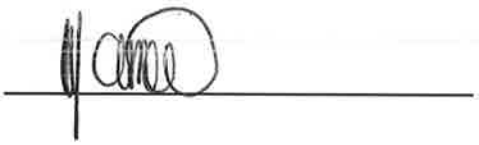
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2017 to March 2018
- papers relating to Quality reported to the board over the period April 2017 to March 2018
- feedback from commissioners dated 10th May 2018
- feedback from governors dated 15th May 2018
- feedback from local Healthwatch organisations dated 11th May 2018
- feedback from Overview and Scrutiny Committee requested on 19th April 2018
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3rd May 2018
- the 2016 national patient survey 31st May 2017
- the 2017 national staff survey 6th March 2018
- the Head of Internal Audit's annual opinion over the trust's control environment dated 23rd April 2018
- CQC inspection report dated 7th February 2017
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- the Quality Report has been prepared in accordance with NHS Improvements annual reporting manual (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

	Signature	Date
Chair		**23rd May 2018**
Chief Executive		**23rd May 2018**

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Tameside and Glossop Integrated Care NHS Foundation Trust to perform an independent assurance engagement in respect of Tameside and Glossop Integrated Care NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

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

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

- Board minutes and papers for the period April 2017 to March 2018;
- papers relating to quality reported to the board over the period April 2017 to March 2018;
- feedback from commissioners, dated 10 May 2018;
- feedback from governors, dated 15 May 2018;
- feedback from local Healthwatch organisations, dated 11 May 2018;
- feedback from Overview and Scrutiny Committee, requested on 19 April 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3 May 2018;

- the 2016 national patient survey, dated 31 May 2017;
- the 2017 national staff survey, dated 6 March 2018;
- Care Quality Commission Inspection, dated 7 February 2017;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 23 April 2018; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Tameside and Glossop Integrated Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Tameside and Glossop Integrated Care NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement

techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Tameside and Glossop Integrated Care NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

24 May 2018