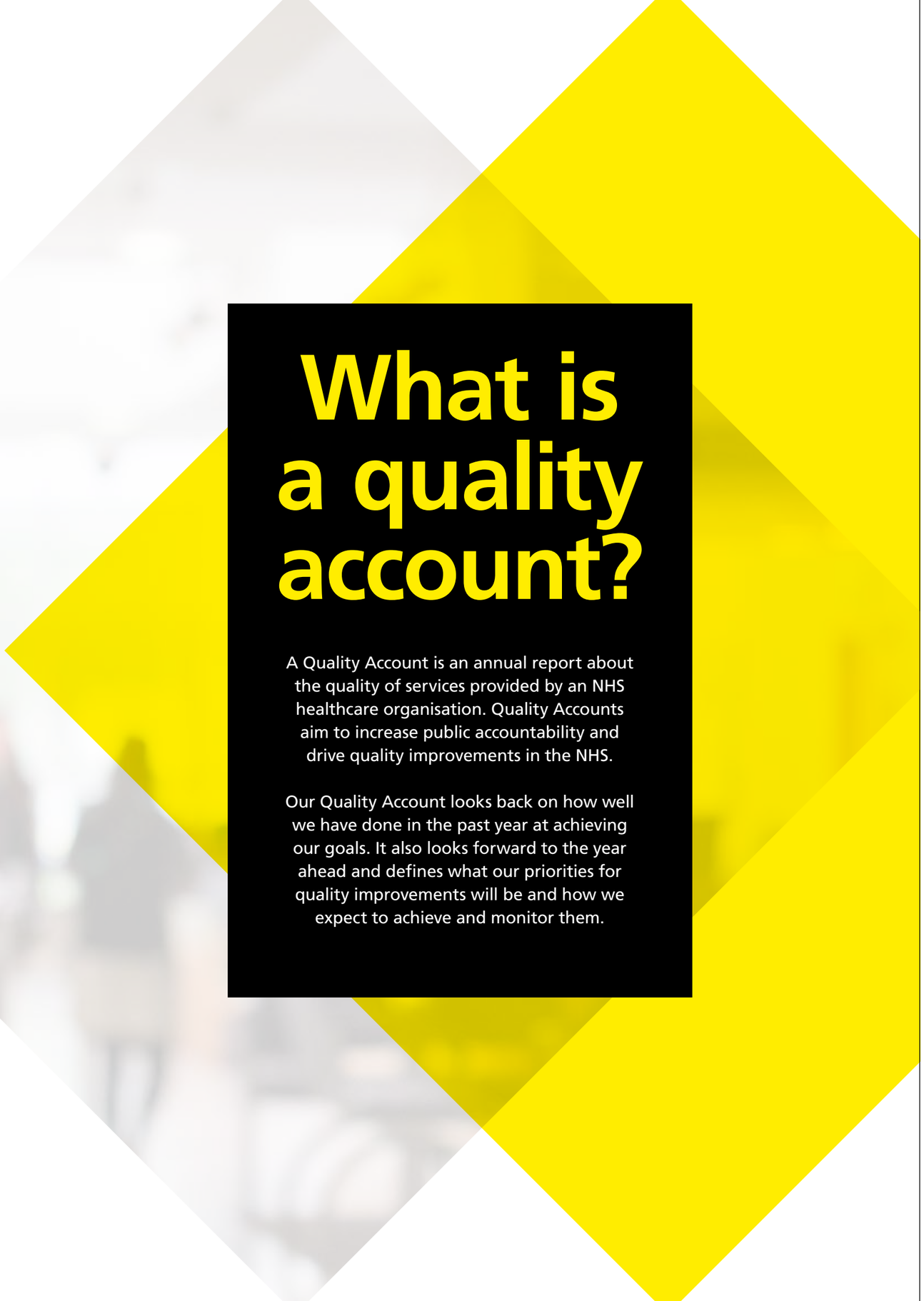
NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality Account

2019/20



What is a quality account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS.

Our Quality Account looks back on how well we have done in the past year at achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

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Part 1

Statement on quality from the Chief Executive

I am delighted to introduce this year's Quality Account, which sets out how the Trust has performed against the quality standards and priorities set both nationally by Government and locally by the Trust Board, in partnership with the One Gloucestershire Integrated Care System (ICS). Whilst NHS Trusts are required to publish a Quality Account, we aim to make this so much more than just a mandated report. It is about celebrating our achievements from the last year, showing where we have learnt and improved the experience of our patients, their families and our staff. Equally, it is an opportunity to shine a spotlight on our approach to Quality Improvement which, increasingly, is the way in which we support and enable our staff to address the challenges and seize the opportunities they encounter.

Inevitably, given the context in which the NHS is operating as I write this year's report, it is a Quality Account with a difference but equally, it feels important not to lose sight of what we have already achieved as well as prepare for the unprecedented times ahead.

The Year That's Gone

For many of us, 2018/19 was the year in which we achieved our Care Quality Commission (CQC) 'Good' rating. Following on from this theme, this last year has very much been characterised by the progress we have made on Our Journey to Outstanding. Whilst for many, outstanding is associated with the 'official' recognition by our regulator, the CQC, but for the Trust Board it is about living up to our own sense of what "outstanding" means to all of us. Personally, I like to think of the CQC outstanding rating as the minimum standard we should strive for, not a target to be met!

In the pages ahead, this quality account sets out the many, many things that we achieved in the last year but, as is always the case, there are a number of things that stand out in my mind, which I'd like to highlight.

Given the very busy nature of healthcare and acute hospitals in particular, taking time to look ahead to ensure that we have a bright and sustainable future is vital. With this in mind, under the leadership of Simon Lanceley, Director of Strategy

and Transformation, we listened to the views of more than a 1000 colleagues to develop a new five-year strategy for the organisation, and out of this came not only a clear direction and sense of ambition for the organisation but ten new strategic objectives. The team went above and beyond to ensure that these ambitions and priorities were clearly communicated and I'm especially proud of some of the ways we achieved this – a particular favourite is the cartoon-like animation which brings them to life!

One of the ten objectives describes our ambition for the way hospital services in Gloucestershire might look in the future and co-designing services, by involving and engaging the public, our patients and our staff, has been a feature of the past year particularly in our Fit for the Future programme. This programme of activities, under the banner of One Gloucestershire, brings together the thinking of all organisations in our Integrated Care System (ICS) to ensure that our urgent and emergency care services are joined up and respond to the needs of local people; this sits alongside an exciting strand of work, being led by this Trust, to work with local people and staff to explore what is the best configuration of services across our two acute hospital sites in Gloucester and Cheltenham. We have captured and expressed this thinking in a vision described as our Centres of Excellence – two thriving hospitals, each with their own distinct identity, bringing together related services, making the best use of scare resources and organised to ensure that you receive the very best care, in a timely way and with the aim of ensuring the very best outcomes for your health.

From my viewpoint, it feels like we are finally making real and significant progress towards our vision of developing best in class services, which embrace the opportunity that comes from having two separate hospital sites, whilst addressing the many challenges that run alongside this model such as increasingly scarce specialist staff and equipment. Experience tells me that we will encounter the inevitable 'bumps in the road' as we progress towards our goal but last year, firmly set us on our way.

> **"From my viewpoint, it feels like we are finally making real and significant progress towards our vision of developing best in class services"**
>
> ***Deborah Lee***

It may feel like an overused adage but it remains as relevant today, as it ever has: "our staff are our greatest asset". With this at the forefront of my mind, 2019/20 was a year when the Board and leadership team gave unprecedented amounts of thought to how we further develop our culture to reflect one within which staff flourish and patients receive the very best care. We refreshed our values and, perhaps more importantly, worked with our teams and individual colleagues to understand the sorts of behaviours which should underpin our values; taking this work forward will be a huge priority in 2020. Alongside this, never has the health and wellbeing of our staff mattered to me more. Increasingly, we are asking our teams to do more, and to do things differently, as demand for our services continues to increase.

One of the highlights of last year was the launch of the 2020 Staff Health and Wellbeing Hub, which has been operating since May 2019. Very much the "brainchild" of Emma Wood, Director of People, the Hub was a response to feedback from the previous year's national staff survey when colleagues told us that they lacked access to information and advice to remain well and provide support them when the need arose. Since its launch, the Hub has provided support to 3,503 colleagues, a staggering 43% of our workforce. Latest figures show that the Hub website and online resources have had 27,759 hits since its launch – all in all, an incredible resource that is supporting teams across our organisation. I'd like to say a special big thank you to Michele Pashley and Emily Hoddy at the Hub for their passion and drive to ensure the Hub was established so successfully and for their ongoing, wider focus on staff health and wellbeing.

Given our recent history with respect to information systems, I am immeasurably proud of what the Trust has achieved in the past year under the leadership of our Chief Digital and Information Officer, Mark Hutchinson.

Mark and his team, working closely with our clinical leaders, set out not just to recover from the legacy of our previous IT deployment but to seize the opportunity to go further, faster. With this goal driving our approach, this year we developed and approved our first ever Digital Strategy but more impressively, we also implemented two keys elements of it, in super quick time.

Just a few months in, this new system is realising our original vision of creating a fully electronic patient record (EPR) which enables increasingly safe and reliable care to be delivered to our patients, whilst releasing time for our clinicians to care and lead. The launch has been an unequivocal success and this is undoubtedly due to the phenomenal amount of engagement between the digital team and our clinical teams. Of particular note, in this first phase, has been the engagement and enthusiasm from nursing colleagues – one particular highlight for me has been the extent to which our Health Care Assistants (HCAs) have embraced this agenda and as a result have been drivers of our success. We now have the seven key nursing assessments live on EPR on all of our wards and, despite the timing, we held our nerve and implemented electronic observations in mid-March which gave us sight of our sickest patients, at a time when we most needed it.

Although we are still on our digital journey, this year has been a "game changer" in respect of our progress and has made more difference to the safety and quality of care, than anything I can remember – a HUGE thank you to everyone involved in making this happen for their engagement, hard work and enthusiasm.

One of the legacies from the IT challenges described above, was a significant increase in the numbers of patients waiting for care, both inpatients and outpatients.

Under the leadership of Rachael De Caux, Chief Operating Officer, with phenomenal support from operational managers and their teams, we have transformed this picture. These teams have worked tirelessly alongside clinical colleagues to redesign pathways of care, to validate tens of thousands of patient records and treat more patients (in more innovative ways). As a consequence, last year we achieved and sustained for six consecutive months, the national standard for the two-week cancer wait which, given 90% of patients will have cancer excluded following this initial assessment, is a huge boost to cancer patient experience. December 2019 also

saw the first month that we achieved the standard in all specialties, not just at an aggregate Trust level, since May 2013. From a high of 120 patients in August 2018, who had waited more than 52 weeks for their treatment, we achieved a reduction of 73.1% from January 2019 to January 2020. Finally, the seemingly intractable issue of backlogs in follow-up outpatient care is at long last moving forward considerably thanks to everyone's efforts in 2019/20. Our longest waiting patients overdue follow up, without a booked appointment, has reduced from a staggering 57,213 in January 2019 to 5,071 in January 2020. The total number of patients now on an active follow up has also reduced significantly (30,271) reflecting the focus on discharging those patients who can be safely cared for outside a specialist setting or for whom follow up is no longer necessary. We know, from our work with patients and local communities, that NHS waiting times remain one of the biggest public concerns and it is especially heartening therefore that we have achieved so much in this past year.

Exciting plans to transform our two hospitals as part of a £39.5m investment took a big step forward last year, when the Trust Board approved the Outline Business Case (OBC); I think it may only be, with the benefit of hindsight, that we appreciate what a huge milestone this was. Under these plans, Cheltenham General Hospital (CGH) will benefit from better day case surgery facilities with the development of two additional theatres and a Day Surgery Unit. The new facilities will improve patient experience, reduce waiting lists and result in fewer operations being cancelled. Gloucestershire Royal Hospital (GRH) will benefit from an improved Emergency Department and acute medical care facilities designed to speed up diagnosis, assessment and treatment. There will be a redesigned outpatients and fracture clinic accommodation for orthopaedic outpatients, additional x-ray capacity and a programme of ward refurbishment.

> **"I was especially proud therefore to be a member of a Board that not only recognised the threat but, in declaring a climate emergency, pledged to do something about it."**
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Once completed, colleagues will have a more modern, spacious environment in which to work, enabling them to achieve their ambitions of delivering even better patient care. In particular, the work at GRH will help to relieve crowding at ED during busy periods which is something both patients and staff have flagged as a priority.

The Full Business Case will be submitted to the Trust Board and NHSE towards the end of the year. Assuming that's successful, we anticipate construction work to begin in 2021 with the new facilities opening to patients in 2022/23 – exciting times ahead!

Thanks to the efforts of one very brave young woman, Greta Thunberg, 2019/20 felt like a watershed year when globally and locally people appeared to wake up to the threats facing us from climate change, with many commentators describing it as the greatest public health issue of the 21st Century. I was especially proud therefore to be a member of a Board that not only recognised the threat but, in declaring a climate emergency, pledged to do something about it. Under the leadership of Steve Hams, Director of Quality and Chief Nurse, the Trust held two "big green conversations" to explore what more it could do to contribute to the County's ambition of reducing carbon emissions by 80% by 2030. Colleagues from right across the Trust have engaged with this agenda in an unprecedentedly exciting way and numerous initiatives are already in place to make our Trust a cleaner, greener place to work and receive care.

Finally, nobody could have predicted the way in which 2019/20 would end with the advent of the COVID-19 coronavirus outbreak; the consequences of which will be felt for years to come. Sadly, with months to run it feels premature to comment too much at this time but equally it would feel wrong not to take the opportunity to acknowledge the phenomenal and unprecedented response from colleagues, partners and even strangers inside and outside the Trust. I am immeasurably proud of how this Trust has responded; under the superbly calm, clear and compassionate leadership of Medical Director, Professor Mark Pietroni, the Trust is well prepared for what lies ahead. Whilst none of us would ever have wished to encounter such difficult times, there will be some important silver linings which emerge from these times, which I am determined we embrace as we move into recovery and back to some form of "normal" – from the innovations that have surfaced through necessity to the sheer scale of human kindness I have seen my colleagues and communities show to each other. I couldn't be prouder to be associated with such a phenomenal institution as the NHS and such a caring community of people as I have encountered in Gloucestershire.

The Year Ahead

Given the current context, the next year looks uncertain and the usual description of aims and goals feels at odds with the time we are in, and the times which lay ahead. However, there will be a number of constants and one very important one will be the care of our staff and the compassion that we show to each other, during the most difficult times.

Before, the COVID-19 pandemic, the Board had signalled the importance of furthering the work on developing a culture that enables staff to be the very best version of themselves and this enables us to provide truly compassionate care, to everyone. Our recent staff survey confirms we are making positive progress in this regard but we have more to do to engage all of our teams and colleagues on our Journey to Outstanding. Having spent a lot of time in 2019/20 developing our new strategic objectives and vision, our focus for 2020/21 will be not be on the "what" but rather on the "how". Our values of caring, listening and excelling underpinned by the behaviours developed from the Board's work with culture guru Professor Michael West of attending, understanding, empathising and helping have been co-designed with colleagues, and provide a clear focus on kindness and compassion to ourselves, our colleagues and our patients. I asked Michael how he judges success, and what success might look like for me as an NHS Chief Executive; he shared his personal definition of culture which, for me, said it all culture is the way we do things around here, when nobody is looking.

Thank you

It serves for me to thank you the reader for everything that you have brought to the Trust, whether as a colleague, a governor, a partner, a public member or patient. We have achieved such a lot in the last year but are undoubtedly facing some of our greatest challenges in the year to come. I thank each and every one of you, from the bottom of my heart, for what you have done but moreover what you will do for us in the year to come.

Formal bit

And finally, the formal bit – I can confirm that to the best of my knowledge, the information included in this report has been subject to all appropriate scrutiny and validation checks and as such represents a true picture of the Trust's activities and achievements in respect of quality.

Deborah Lee
Chief Executive Officer

Part 2

Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following two sections are divided into four parts:

- **Part 2**
  - **Part 2.1**
    - **What our priorities for 2020/21 are:** explains why these priorities have been identified and how we intend to meet our targets in the year ahead.
    - **How well have we done in 2019/20:** looks at what our priorities were during 2019/20 and whether we achieved the goals we set ourselves. Where performance was below what was expected, we explain what went wrong and what we are doing to improve
  - **Part 2.2:**
    Statements of assurance from the Board
  - **Part 2.3:**
    Reporting against core indicators.
- **Part 3:**
  The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

Part 2.1

Our priorities

Our priorities for improving quality 2020/21

Our Quality Account is an important way for us to report on the quality of the services we provide and show our improvements to our services that we deliver to our local communities.

The quality of our services is measured by looking at patient safety, the effectiveness of treatments our patients receive, and patient feedback about experiences of the care we provided.

The quality priorities detailed in this report form a key element of the delivery of the Trust's objective to provide the "Best Care for Everyone".

Our consultation process

Our quality priorities have been developed following consultation with staff and stakeholders and are based on both national and local priority areas.

We have utilised a range of data and information, such as:

- **Analysis of themes arising from internal and external quality reports and indicators**
  - **Patient experience insights:** National Survey Programme data, Complaints, PALs concerns, Compliments, feedback from the Friends and Family Test (FFT), and local survey data, focus groups, experience stories to Board.
  - **Patient safety data:** safer staffing data, national reviews, incidents, claims, duty of candour, mortality reviews and Freedom to Speak up data.
  - **Effectiveness and outcomes:** Getting It Right First Time reports, clinical audits, outcomes data.
- Staff, key stakeholders and public engagement – seeking the views of people at engagement events.
- Engaging directly with our Governors on our quality priorities as they are required by law to represent the interests of both members of our Trust and of the public in Gloucestershire. Many of our Governors sit on steering groups and committees and so are able to influence and challenge quality of care.
- Review of progress against last year's priorities, carrying forward any work streams which have scope for on-going improvement.
- Ensuring alignment with national priorities and those defined by the Academic Health Science Network patient safety collaborative.
- Reviewing key policy and national reports.

As a result, we are confident that the priorities we have selected are those which are meaningful and important to our community.

Progress against these priorities will be monitored through the Quality Delivery Group, chaired by the Executive Director of Quality and Chief Nurse, and by exception to the Quality and Performance Committee (a Governor sits on our Quality and Performance Committee).

The Quality Delivery Group is responsible for monitoring the progress of the organisation against our quality improvement priorities.

The Group meets every month and reviews a series of measures which give us a picture of how well we are doing. This will allow appropriate scrutiny against the progress being made with these quality improvement initiatives, and also provides an opportunity for escalation of issues. This will ensure that improvement against each priority remains a focus for the year and will give us the best chance of achievement.

Priority quality indicator goals 2020/2021

WELL LED: **Continuous improvement**
Our COVID response

IMPROVE EQUALITY, INCLUSION and DIVERSITY
To improve how we meet the NHSI **learning disability** and autism standards.
To improve the numbers **safeguarding assessments** completed on our Electronic Patient Record (EPR)

EXPERIENCE: **Enhancing the way staff and patient feedback is used to influence care and service development**
To improve **cancer patient experience**
To improve **children and young people's** experience of transition to adult services
To improve **maternity** experience
To improve **Urgent and Emergency Care (ED)** experience
To improve **Adult Inpatient** experience

IMPROVE SAFETY
To enhance and improve our **safety culture**
To improve our **prevention of pressure ulcers**
To prevent **hospital falls with injurious harm**
To improve the **learning from our investigations into our serious medication errors**
To improve our **infection prevention and control standards** (reducing our Gram-negative blood stream infections by 50% by 2021)
To continue our **learning from deaths** programme

CLINICAL EFFECTIVENESS / RESPONSIVENESS
To improve our **care of patients whose condition deteriorates**
To improve **mental health care** for our patients coming to our acute hospital
To improve our care for **patients with diabetes**
To improve our care of patients with **dementia**
To improve **outpatient care**
To improve access to care by delivering the 10 standards for **seven day services**

Part 2.1

How well have we done in 2019/20?

Summary of quality indicator goals 2019/2020

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
Continuous quality improvement with the GSQIA To further enhance our quality improvement systems with support from the Quality Improvement by our Gloucestershire Safety and Quality Improvement Academy (GSQIA)	▸ 682 colleagues trained in Bronze ▸ 81 Silver projects started ▸ 11 new Gold QI coaches ▸ Quality Framework developed	▸ Continue as a Quality Indicator for 2020/21 ▸ Develop and roll out Human Factors faculty ▸ Continued roll out of Quality Framework across specialties ▸ Increasing number of Gold coaches – ambition to have 90 across the Trust
To continue to develop our speaking up systems and processes through Freedom to Speak Up	▸ Recruited three new Guardians ▸ Further developed links with Leadership and OD teams ▸ 56 number of contacts from colleagues	▸ Continue as a Quality Indicator for 2020/21 ▸ Recruit two consultants to join the team as Freedom to Speak Up Guardians ▸ Review speaking up training for colleagues ▸ Deliver improvement plan
To improve patient experience of our **discharge processes**	▸ The National Inpatient Survey 2018 showed that we are performing below average on a number of areas relating to discharge ▸ One particular area of the focus for the Trust this year has been about reducing Delayed Transfers of Care (DTOC), as this has a huge impact on patient outcomes and experience. The Trust has a target to keep DTOC under 3.5% and this has not been achieved in recent months due to lack of flow across the system and ward closures due to infection control. December 2019 to February 2020 were particularly challenging months for the Trust. ▸ National benchmarking around DTOC shows our position more favourably, with us ranking in the top third of Trusts check for accuracy	▸ There will be continued focus on reducing DTOC in 2020/21, in addition to the latest Inpatient Survey results being used to coordinate an improvement plan across the Trust focussed on improving discharge experience, particularly around the information provided to patients.

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To improve **cancer patient experience**	▸ The latest Cancer Patient Experience Survey 2018 scores were published in September 2019; the Trust scored 'about the same' as other organisations for 41 of the questions, above the upper limit in two questions and below the lower limit in eight of the questions. ▸ One of the challenges of the Cancer Patient Survey is the timeliness of the data, with the results being published a year after being collated. ▸ A new Lead Cancer Nurse has been appointed whose focus is on Patient Experience Improvement. A workshop was delivered in January 2020, with patients from across a range of cancer pathways, to understand our local patient experience	▸ Continue as a Quality Indicator for 2020/21, using the feedback from these sessions to develop an action plan for 2020/21, with some of the key themes including: ▸ Improving the oncology environment ▸ Improving written communications and health information ▸ Improving access to clinical teams in a timely fashion ▸ Improving signposting to support services and carers support ▸ Improving communication across divisions ▸ Improving engagement with seldom heard communities ▸ Continue to provide opportunities for patients to be engaged in development of services ▸ Advanced communication training around breaking bad news
To improve **outpatient experience**	▸ Attain were appointed to complete a 12-week assessment of four specialties to support development of outpatient improvement programme ▸ Four specialties involved in improvement work; Neurology, Dermatology, Rheumatology, Diabetes. Improvements achieved in these areas are included in report ▸ Plans to extend this work to beyond the four original specialties	▸ Continue as business as usual as part of our Outpatients Transformation Programme ▸ Additional programme support has been allocated from Transformation and Service Improvement, and the latest plans for 2020/21 can be seen in report. Of particular note and focus is the introduction of a digital offer, the roll out of which has been accelerated during the management of Covid-19.

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To improve **mental health care** for our patients coming to our acute hospital	▸ The Lead for Mental Health Liaison and our Emergency Department Matron have been working on a Quality Improvement project (Silver GSQIA project) that uses a modified Manchester Triage Tool to identify Priority 1 & 2 patients for an early mental health review. ▸ Trust has secured additional funding for Mental Health Nurses to deliver a mental health review response within 1 hour ▸ The average length of stay for people with mental health issues who were seen by the Mental Health Liaison Team is on average 53.7% lower than those Mental Health patients who were not seen, which is a reduction of 2.2 days per patient on average ▸ The re-admission rate is also lower for those patients who were seen by the Liaison Team (16.8% re-admission rate, compared with 18% for those who were not seen). Re-admission rates are steadily declining for all MH admissions.	▸ Continue as a Quality Indicator for 2020/21, to support the NHS Long Term Plan ▸ A recruitment campaign will be our focus for 2020 so that the Mental Health Liaison Team can deliver first assessments to inpatients within 1 hour from the time of referral to all patients with a mental health issue or diagnosis of mental health problems. ▸ There will be specific training given across the Trust to all nurses graded at Band 6's, 7's and junior doctors in the delivery of the modified risk assessment tool. ▸ An evaluation of the use of Mental Health nurses at triage will be undertaken which will enable co-streaming and assist in delivering a 1 hour response.
To develop a **real time patient experience survey programme**	▸ Recruited volunteers to deliver survey programme ▸ Reviewed and refined process to get more reliable data, with new schedule providing coverage of surgical and medical wards each month ▸ Data shows that our patients are responding with the same, or more positive, responses when benchmarked with our Inpatient Survey data	▸ Continue to review and refine the approach, including volunteer recruitment and understanding patient numbers on wards to ensure responses are representative ▸ Develop dashboards and reporting as business as usual, to be monitored through Quality Delivery Group and Quality and Performance Committee

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To enhance and improve our **safety culture**	▸ In September 2019, the SCORE Survey was selected as the validated tool to measure the safety culture across pre-operative, operative and post-operative settings in Gloucestershire Royal Hospital, Cheltenham General Hospital & Cirencester Treatment Centre. ▸ Focus groups beginning to analyse the data by work setting and staff group have begun across the theatres teams at all three sites.	▸ Continue as a Quality Indicator for 2020/21 ▸ Further focus groups to be held with anaesthetists and surgeons ▸ Plans to develop a multi-disciplinary improvement collaborative using the data and feedback collected, supported by GSQIA team ▸ The SCORE survey will be repeated in 2021 to determine the impact of the interventions undertaken.
To improve our patients beginning their **first treatment for cancer within 62 days** following an urgent GP referral for suspected cancer.	▸ Nationally Trusts are continuing to struggle to meet the 62-day standard with latest national performance of 78.9% (March – latest data available). April un-validated position for the Trust is 81%. ▸ COVID19 pandemic has impacted the delivery of cancer services. Cancer Services and specialties have had to adapt to new ways of working and pathways through March and April 2020.	▸ To support improvement during 2020/21 specifically aimed at improvement of 62-day treatment we have a Delivery Plan for each speciality area ▸ The main tumour site being supported in 2020/21 is Urology
To improve the issue of patients receiving delayed care	▸ Focussed improvement work on Ophthalmology Outpatient Patient Services following issues with implementation of Trak Care ▸ A number of actions have been taken, including clinical reviews, increase in staffing, increase of checks to improve data accuracy, close working with Central Booking Office, and increasing consultant capacity in Q4 ▸ With additional consultant time, it is anticipated 800 patients could be seen, leaving an estimated deficit of 1000 appointments rolling over into next year	▸ Work will continue into 2020/21in line with longer term plan, supported by regular review of data and progress on a monthly basis ▸ Service line to develop options paper and plan that would see them be 'best in class' by end of March 2021 and have no outstanding follow up's ▸ Learning from Ophthalmology to be shared with other specialties
To improve the **prevention of our patients developing pressure ulcers**	▸ Held Quality Summit in September 2019 to discuss pressure ulcer prevention improvement programme, with thirty-two staff attending ▸ We have co-designed a quality improvement programme with staff from all areas and a mix of specialities.	▸ Continue as a Quality Indicator for 2020/21, with the delivery of the pressure ulcer prevention quality improvement plan which is led by the Tissue Viability team ▸ Focus will be on how we use data, from a range of sources including the Electronic Patient Record (EPR) data, to see in real-time what staff are assessing and recording, and establishing measures to develop a single item quality report ▸ This will include setting appropriate ward and specialty level targets, understanding where our high-risk wards are and providing all clinical staff with training and equipment to facilitate pressure ulcer prevention

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To prevent **falls in hospital**	▸ This has been one of our CQUINs for 2019/20, and the ambition was to have achieved 80% of older inpatients receiving key falls prevention actions. We do not meet the lowest threshold and so this is an area for continued focus.	▸ Continue as a Quality Indicator for 2020/21, with the delivery of a quality improvement plan which is led by the Lead Nurse for Falls Prevention ▸ The implementation of the Electronic Patient Record has enabled us to have better oversight of falls risk assessments and prevention plans that are being put in place for our patients. ▸ This data will be used to develop measures for ongoing monitoring and to undertake learning events to improve care
To improve the **learning from our investigations into our serious medication errors**	▸ A pharmacist in Cheltenham ran a project look at facilitating self-administration of Insulin on Guiting Ward. Guiting Ward looks after patients needing vascular procedures, many of whom are diabetic patients who use insulin at home. ▸ The aim of the project was to increase the number of patients appropriately self-administering insulin by 50% over 4 months. ▸ The project showed a clear increase in the number of patients appropriately self-administering (12% at baseline to 73%). There is now the means to assess patients wishing to self-administer insulin on the ward, and patient-accessible safe storage is available. Location of insulin in use saw an improvement – from just 58% of it being stored securely to 82% by the end of the project.	▸ Continue as a Quality Indicator for 2020/21 with the Medical Division and Specialist Diabetes Team leading this work. ▸ The Trust will also be developing a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To improve our **care of patients whose condition deteriorates (NEWS2)**	▸ We audit the number of correctly calculated NEWS2 across various wards each month and these are reported on the Nursing Metrics. ▸ The current data highlights the need for education in this area with some wards only achieving 20% compliance and this is process is currently lead by the Resuscitation Lead for the Trust.	▸ This will continue as a Quality Indicator for 2020/21, with the following areas of focus: ▸ Introducing an electronic recording system for observations (eObs) as part of our Electronic Patient Record roll out at the end of March 2020. ▸ Early anticipatory planning and person-centred care ▸ Structured review of the risk of deterioration ▸ Reliable recognition of acute deterioration ▸ Structured response to acute deterioration ▸ Reliable communication and learning within and across multidisciplinary teams.
To improve our learning into action systems – learning from our own local investigations	▸ Testing of a new GSQIA Human Factors Faculty began with two half day sessions planned with colleagues across the Trust. The objectives of the Faculty are to improve: ▸ the technical assessment of serious incidents ▸ system redesign and testing with simulation ▸ understanding of human factors across the Trust. ▸ In December, we were successful in a bid led by the GSQIA in collaboration with the wider Gloucestershire system for some Q – Exchange funding, the award was £30,000 to deliver a project to test collaborative approaches to facilitating 'wicked' system wide problems	▸ Continue as a Quality Indicator for 2020/21 ▸ Deliver a programme of improvement collaboratives ▸ Deliver an education programme of Human Factors

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To improve our care for **patients with diabetes** in the perioperative period	▸ In April 2019, we retrospectively reviewed the GRH PQIP database to identify patients with Type 1 or Type 2 diabetes. The team then audited the perioperative management of diabetes against the key indicators detailed above to identify areas for improvement. ▸ From reviewing the elective cases 14 patients were identified with diabetes out of a database of 86 cases (16%). Of the 14 cases, 5 were treated with insulin, 5 with non-insulin glucose lowering medication and 4 were diet controlled. ▸ Across all 14 patients, none of the audit standards were met 100%.	▸ Continue as a Quality Indicator for 2020/21 ▸ The Trust has developed a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience. ▸ We have started pre-habilitation programme prior to major surgery which aims to improve pre-operative conditioning of patients to improve post-operative outcomes. This programme of work is aimed to assess the effect of pre-habilitation on post-operative outcome after major surgery and we hope to report on this work next year.

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To improve our care of patients with **dementia** (including diagnosis and post diagnostic support)	▸ When we moved to a new Patient Administration System (Trakcare) reporting for this indicator declined which suggested to us that the new digital system had created issues for clinicians reporting because in previous years we had been able to demonstrate that FAIR clinical assessments were being carried out. ▸ When carrying out the digital diagnostics, as to why our performance had declined, we found that the answers to the FAIR questions had to be recorded in different areas within the new record. To test this theory, that clinicians were carrying out the assessments but were just not recording it in an area where the data could be extracted, an audit was carried out and all admission documentation was amended to include the dementia case finding question. Our audit demonstrated that our theory was correct and our performance improved from 0.3% (May 2019 digital extraction) to 67% (manual audit June 2019). ▸ This data captured is reported monthly in the Trusts Quality and Performance Report (QPR), showing our compliance with the FAIR assessment tool.	▸ Early in 2020 NHS England and NHS Improvement held a consultation seeking views on the continuing suitability of the Dementia Assessment and Referral (DAR) data return. The consultation was open for eight weeks from Thursday 9th January until midnight 5th March 2020 but please note that due to the coronavirus illness (COVID-19) there will be a delay in the publication of the response to the consultation. ▸ Our plan for 2020/21 will be to await national guidance and once published we will focus on improving the accuracy of our data.

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To improve our **nursing care standards** through the Nursing Assessment and Accreditation Scheme (NAAS)	▸ All 39 ward areas have been assessed twice using NAAS framework ▸ In Round One, 33% of wards were red, 13% amber, and 54% green ▸ In Round Two, 0% were red, 13% amber and 87% green ▸ NAAS framework has been reviewed and refined to create NAAS2 framework, to support further improvements	▸ Rollout of NAAS2 accreditation schemes across the wards, supporting the introduction of shared governance and the American Nurse Credentialing Centre (ANNC) Pathway to Excellence® Programme ▸ Develop Maternity equivalent to NAAS2, as well as a paediatric equivalent
To improve our **infection prevention and control standards** (reducing our Gram-negative blood stream infections by 50% by 2021)	▸ All episodes of MSSA (Methicillin-sensitive Staphylococcus aureus) and Gram negative bacteraemia (E.coli, Klebsiella species and Pseudomonas aeruginosa) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements. ▸ Data reported for MSSA and Gram negative bacteraemia can be seen in tables within section	▸ Continue as a Quality Indicator for 2020/21 ▸ To achieve 3-5% reduction in hospital acquisition of Gram negative blood stream infections, focussing on the following areas: ▸ Hepatobiliary Tract ▸ Urinary Tract Infections ▸ Mouth Care Matters ▸ Surgical Site Infections
Rolling out of **Getting It Right First Time** standards in targeted standards	▸ Of the 39 + specialties monitored by GIRFT, 31+ relate to Gloucestershire Hospitals NHS Foundation Trust of which 26 services have been visited to date. ▸ An annual review with the executive team for each specialty has now been set up. Eleven services have completed this process presenting their progress, achievements and concerns; updates are included in this report	▸ Work will continue as business as usual to raise the profile of this work in the coming year. ▸ There will be ongoing work for all services to complete the recommendations by GIRFT. ▸ In addition, deep dive visits are arranged in the next few months for Cardiology and Rheumatology and dates for Respiratory, Neonatal medicine and Lung Cancer are imminent.
Delivering the 10 standards for **seven day services (7DS)**	▸ We have prioritised the delivery of standards 2, 5, 8 and 6 ▸ In June and November (to be validated by NHSI) 2019 our data confirmed that we are meeting standards 5 and 6, but not meeting standards 2 and 8 of the four priority standards. ▸ For daily review at weekends (Standard 8), Service Directors have been asked to re-review consultant job plans to support this standard, and we have made clear processes for the identification and documentation of patients not requiring daily review at the weekend. ▸ For consultant review < 14 hours of admission (Standard 2), we have undertaken the education of junior doctors about post take ward round documentation including documenting the time of review, as a lack of documented time accounted for 30% of our inability to meet this standard.	▸ We are awaiting formal feedback on our November 2019 submission, and continuing with ongoing recruitment into vacant Consultant Posts which will help with 7DS delivery (2 possible recruitments to Acute Medicine, 3 new recruitments to Care of the Elderly). ▸ Our 7DS delivery and our lack of compliance with priority standard 2 and 8 is in the process of being added to our Trust risk register as we are at risk of achieving these 2 standards. ▸ The Trust will be required to submit its next 7DS self-assessment to NHSI in spring 2020 (date pending) and our improvement work will continue, based on feedback from NHSI

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To deliver the programme of **Better Births** (maternity care) continuity of carer (CoC) improvement programme	▸ For 2019/20, Local Maternity Services (LMS) have been set a target of 35% of women at booking being placed onto continuity of carer pathways and **receiving continuity of the person caring for them during pregnancy, birth, and postnatally.** ▸ The overall percentage for Continuity of Care was 4.6%. ▸ Two pilot models of continuity of carer were continued to achieve 10% of women on a Continuity of Carer pathway, one of which was successful; ▸ Following the pilot, it was clear that to achieve the target a business case would be required. A business case was developed by the Multidisciplinary Team and was agreed by the Gloucestershire Clinical Commissioning Group (CCG) in March 2020.	▸ Continue as business as usual, with a Continuity of Carer Improvement programme ▸ This programme will have a particular focus on areas of highest deprivation and for our Black and Minority Ethnic (BAME) communities in Gloucester City and Cheltenham

Indicator	How have we performed in 2019/20?	Plans for 2020/21:
To improve our care of children **transitioning** to adult care	▸ Recognising the current gap in service provision around transition, one of the Adult Specialist Palliative Medicine consultants (ASPMC), who had a particular interest in this client group has over the years, provided care for several young people with life limiting/life threatening conditions (LL/LTC) into her caseload providing them with a 'helicopter' holistic medical service, undertaken as a non-commissioned pilot. ▸ The pilot undertaken by the ASPMC and the PNNS has shown that this model of care provides the young people and carers of this client group with a service that 'spans the gap' to adult services. ▸ A business case has been agreed to develop a transition pathway and identify an adequate resource to oversee the holistic transition of young people with LL/LTC that is not currently addressed using the Ready Steady Go Hello programme or current clinical services.	▸ In 2020/21, we will be focussing on setting up the new service outlined in the business case, to ensure that young people with a LL/LTC and their families will have an identified transitional medical and care co-ordinator who will navigate this part of their journey with them ensuring they are embedded into adult primary and secondary services ▸ Work on to improve transition will continue as a Quality Indicator for 2020/21, which will be informed by the scoping exercise commissioned to review all specialties of children transitioning from children to adult services to review what the process and care was given to young people through the transition pathway

To further enhance our quality improvement systems with support from the Quality Improvement by our Gloucestershire Safety and Quality Improvement Academy (GSQIA)

Background

We have a fully embedded systematic approach to quality improvement and now building on our successes in 2018/19 we chose to continue to intentionally design our quality improvement to be as inclusive and diverse as possible. We didn't want to just identify five or six big topics or areas for our improvement activity to focus on. We wanted everyone to feel that they could be part of this movement – 'the GSQIA way', and so we have allowed a lot of scope for our silver projects to join the Academy. We valued our colleagues' involvement and interest above all else realising that if we achieved enough joy and energy in our first years this would become a real driving force for our future.

Across the Trust there is an increasing belief in the systematic approach of quality improvement. Our evidence base is growing and we are learning that we can solve our own issues by deeply involving those closest to the issue in a process of discovery (insight), design (involvement) and improvement.

Now with the endorsement of our enabling Quality Strategy in December 2019 we are able to be explicit about what our strategic improvement priorities are, and we are going to form some light touch governance structures using the Quality Framework to ensure that Specialty Teams approve locally led projects to ensure that teams are tackling topics that are meaningful.

Quality Strategy

To continue to improve our approach to quality and learning we are establishing the Quality Framework at specialty and expert meeting level. The main focus in the coming year will be to establish the Quality Framework at Specialty level with key outcome objectives agreed in the Quality Strategy as follows:

50% of specialties and departments have:

a. An active improvement programme

b. Gold QI coach

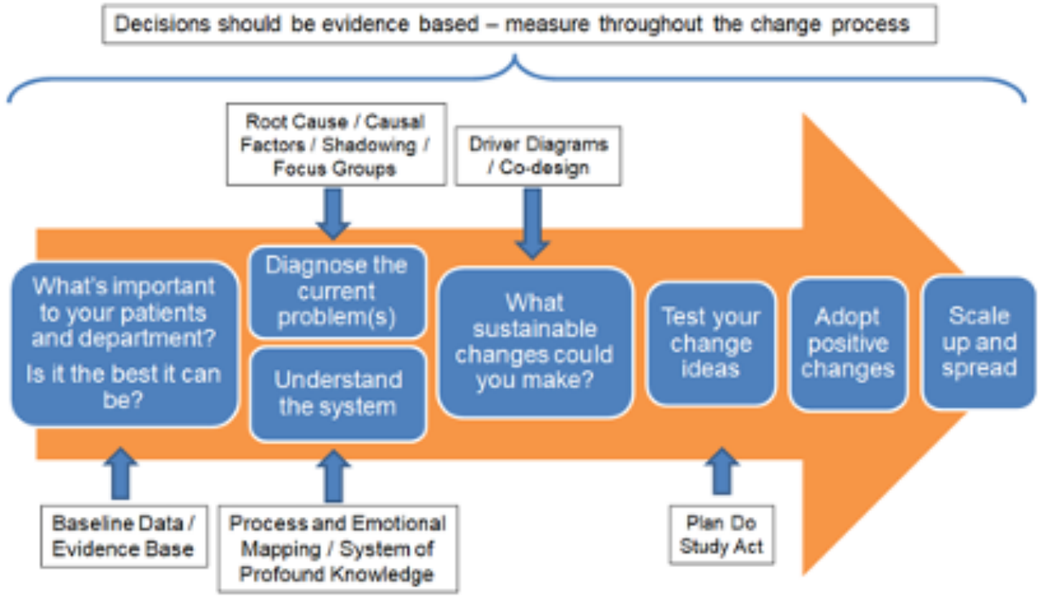
c. Identified local quality assurance indicators

Gloucestershire Safety and Quality Improvement Academy (GSQIA) Training Update

The GSQIA continues to increase the Trust's capacity and capability to undertake structured and evaluated quality improvement projects.

During 2019, there were a total of 39 Bronze level improvement courses. These provide an overview of various QI methodologies in an interactive way designed to apply the theory of QI into practice. These courses resulted in 682 new Bronze improvers.

The Silver courses continue to be extremely popular. Participants come onto the course with a problem from their own areas of work that needs to be improved and the methodologies from the Bronze course (along with some additional teaching) are applied to this specific problem. 81 Silver projects were started during 2019. In addition, 5 Silver graduations events took place allowing the completion of 46 projects to be shared and celebrated. 78 staff members graduated as Silver QI practitioners.



The GSQIA Way

In 2019, the Gold QI coaching programme allowed 16 trainee Gold coaches to begin their journey and 11 new Gold coaches graduated and were recognised at the Trust staff awards. The next cohort of Gold coaches start their programme in March with 15 applicants.

The wider GSQIA team were also delighted to be recognised at the staff awards as winners of the 'Quality and Innovation Award'.

GSQIA Developments

Training Review

A review of training materials has resulted in the redevelopment of the course workbook provided to each Bronze and Silver trainee. This new format is more sustainable than previous versions and has also resulted in a reduction in the time it takes to produce these materials.

Patient Experience Improvement Faculty

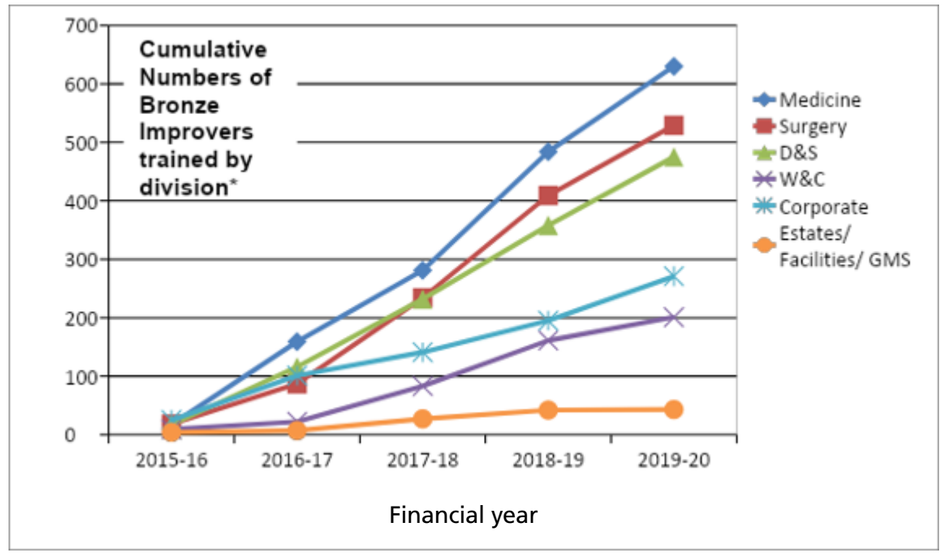
The Patient Experience faculty was launched on 2 March led by the Deputy Director of Quality and the Head of Quality (Patient Experience Improvement), to develop and facilitate one of the main drivers in the Quality Strategy.

"Building a culture of improvement with an expectation of co-design with patients and colleagues"

The Patient Experience team has produced a new module for both the Silver and Gold elements of the learning pathway. These modules provide training in methodologies that encourage involvement of patients, such as interviews, focus groups and questionnaire design. The most popular methodology has been the use of 'Emotional Mapping' for use in conjunction with 'Process Mapping' to show the emotional impact of each stage of the journey on patients, carers and staff, and use this to identify specific areas for improvement and co-design solutions.

Figure 1: Number of staff who have completed Bronze Quality Improvement training

Figure 2:
No. of staff who have completed Bronze Quality Improvement training by division



** As provided at point of booking (does not include preceptorship nurses, F1 or rotational doctors or bank staff)*

Figure 3: Silver Quality Improvement

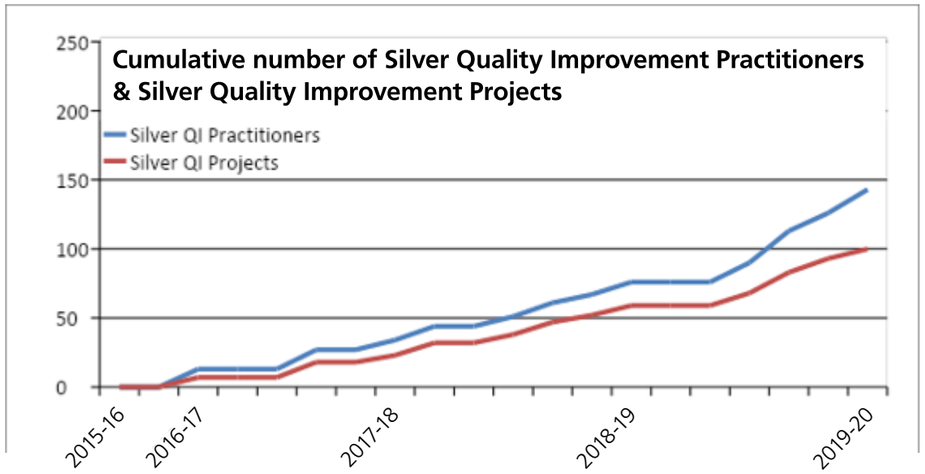
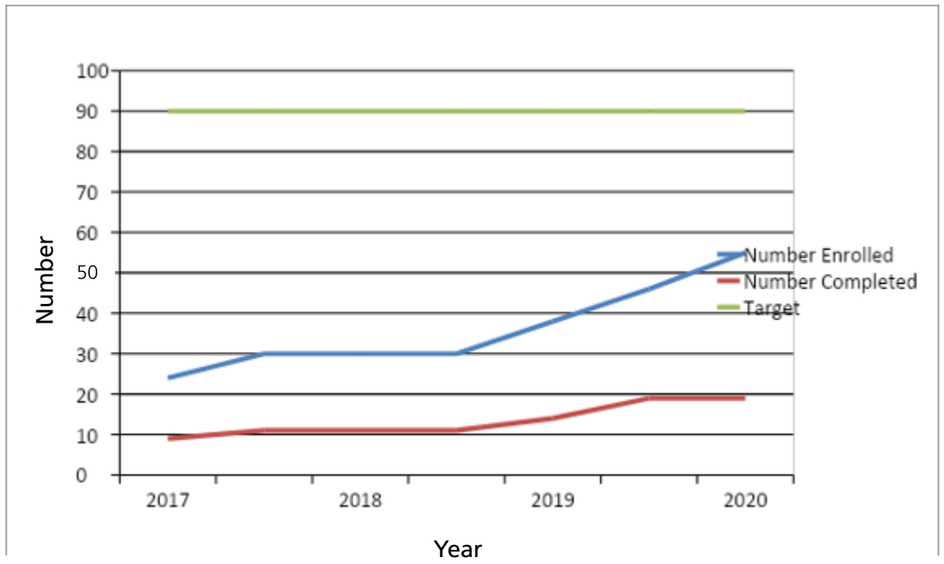


Figure 4: Gold Quality Improvement Coach training



Plans for improvement 2020/21

The GSQIA team are looking at virtual training options, to continue to deliver Bronze, Silver and Gold training while we are social distancing due to Covid, which will continue for a number of months

The work of the GSQIA will continue and information can be reviewed on our Trust website, with regular communications about our work on Facebook, Instagram, LinkedIn and Twitter.

GSQIA will support the delivery of the Quality Strategy across the Trust and measure our progress by monitoring our "Big Dot" metrics.

After developing our Human Factors programme to the GSQIA portfolio of training we will begin work on introduce our Patient Experience Faculty and build in patient experience improvement into our Silver and Gold programme.

To continue to develop our speaking up systems and processes through Freedom to Speak Up

Background

Effective speaking up arrangements protects patients and improve the experience of our colleagues. Having a healthy speaking up culture is an indicator of a well-led Trust. We now have 4 Freedom to Speak up Guardians:

- Suzie Cro, Deputy Director of Quality
- Katie Parker-Roberts, Head of Quality
- Sarah Brown, Voluntary Services Manager
- John Thompson, Lead Chaplain (Appointed March 2020)

Freedom to Speak Up Guardians are appointed and employed by the Trust, though their remit requires them to act in an independent capacity. Guardians are trained, supported and advised by the National Guardian Office. All Guardians are expected to support their Trust to become a place where speaking up becomes business as usual. The role, supporting processes, policy and culture are there to meet the needs of workers in this respect, whilst also meeting the expectations of the National Guardian's Office.

How we have performed 2019/20

To continue to improve our approach to Our data shows that there was a reduction in the number of concerns raised with the FTSUG from 26 in Q4 to 23 in Q1 and 2 but this has increased again in Q3.

Individual/team changes

The following lessons have been learned and improvements made for individuals/ teams as a result of staff raising concerns over the last 12 months:

- Support and coaching provided by the Leadership and OD Team to individuals.
- Team development sessions have been organised
- Extra support provided to a new staff member with additional needs (reasonable adjustments).

Organisational change

The following organisational lessons have been learned and improvements made:

- Work has begun on a staff behavioural standards charter after engagement sessions with over 100 staff.
- We have been proactively implementing the Gosport Inquiry recommendations.
- The research on how rudeness impacts on how individuals and teams function has been shared with leaders within the organisation.
- The Dignity at Work (bullying and harassment) Policy has been reviewed and updated by the HR team.

We are on a cultural improvement journey and learning lessons will be key to developing the right Speaking Up culture. Freedom to Speak Up is now an integral part of the 'Well Led' domain of CQC inspections. Whilst this is a recent initiative, listening and responding to people who speak up and tackling the barriers to speaking

Figure 5: How we have performed 2019/20

Concerns		End of year 2017/18	End of Year 2018/19	April – June Q1	July – Sept Q2	Oct – Dec Q3	Jan – March Q4	End of Year 2019/20
Total number of people raised directly with the Freedom to Speak Up Guardian		31	65	14	9	18	15	56
Number of issues raised anonymously		4	15	3	4	7	5	19
Nature of issue	**Patient quality issues**	17*	20*	3*	2*	2*	5*	12*
	Staff experience: unacceptable behaviour (bullying / harassment)	19*	47*	11*	8*	18*	5*	42*
Action		Support and advice	All staff provided with support and advice	Yes	Yes	Yes	Yes	Yes
Outside referral		0	0	0	0	0	0	0
Number of cases where people indicate detriment		1	0	None	None	None	None	1
Of the people asked in this quarter who would speak up again		The majority of individuals would speak up again.	Yes: 100%	Yes: 100%	90%	80% would	80%	87%

**One person may raise issues about quality and poor staff experience*

up, is an ingredient of good leadership and an area where we want to excel.

Our Trust Freedom to Speak Up Index Score

Gloucestershire Hospitals NHS Foundation Trust is listed at 79%, which is above the national average (Acute Trust average is currently 75%). This was calculated as the mean average of responses to four questions from the NHS Annual Staff Survey.

Plans for improvement 2020/21

- Recruit more Freedom to Speak Up Guardians including two consultant posts, to improve links with the medical workforce.
- Review speaking up training requirements for all staff.
- Deliver our Freedom to Speak Up Improvement plan.
- Plan a series of kitchen table events to support teams post Covid
- Work with Leadership and Organisational Development team to support roll out of values and behaviours, including Civility Saves Lives campaign, and connect with Freedom to Speak Up agenda.

To improve patient experience of our discharge processes

Background

Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. Over 2019/20 we have continued our safe and proactive discharge programme which was a Commissioning for Quality Improvement programme (CQUIN 2019/20). Our Adult Inpatient Survey data identified this as an area of improvement which was endorsed by our Governors.

How we have performed 2019/20

Improving experience of patients on discharge is one of the quality priorities for the Trust in 2019/20, with the Inpatient Survey 2018 showing that we are performing below average on a number of areas relating to discharge, with three key areas requiring particular focus; patients knowing what would happen next with care after leaving the hospital, patients being given written or printed information about what they should or should not do after leaving hospital, and patients being told the purpose of medications. More details with the scores can be seen in Figure 6.

One particular area of the focus for the Trust this year has been about reducing Delayed Transfers of Care (DTOC), as this has a huge impact on patient outcomes and experience. Gloucestershire Hospitals NHS Foundation Trust have a target to keep Delayed Transfers of Care under 3.5% and this has not been achieved in recent months due to lack of flow across the system and ward closures due to infection control. December 2019 to February 2020 were particularly challenging months for the Trust. NHS Benchmarking, however, shows our position more favourably nationally, as illustrated in Figure 8.

Plans for improvement 2020/21

Although national benchmarking has shown a more positive picture, our initial findings from the National Inpatient Survey 2019 results show that discharge is still an area of patient experience that we need to improve.

There will be continued focus on reducing DTOC in 2020/21, in addition to the latest Inpatient Survey results being used to coordinate an improvement plan across the Trust focussed on improving discharge experience, particularly around the information provided to patients.

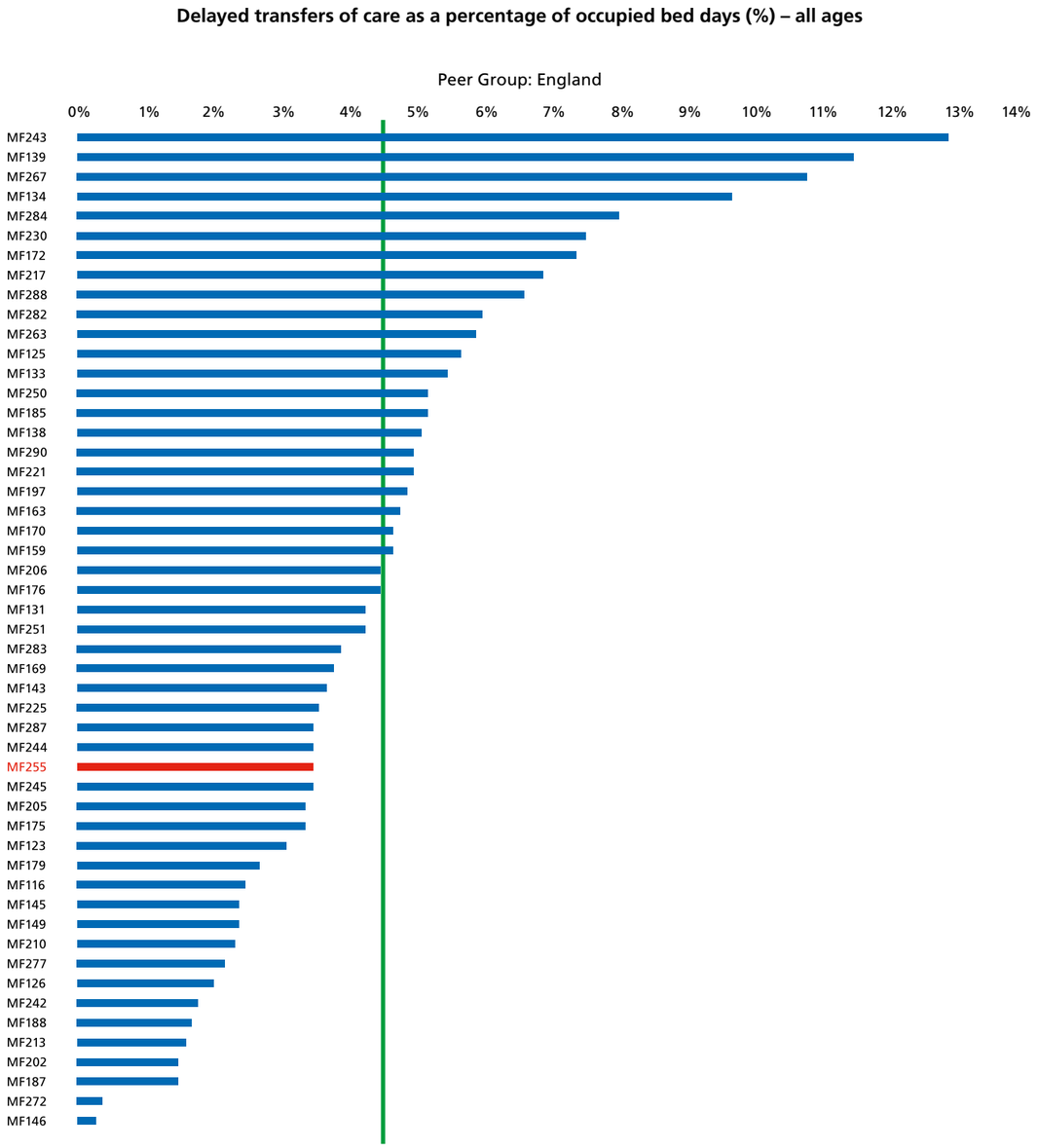
Figure 6: Discharge Indicators from Inpatient Survey 2018

Q	Indicator	2014	2015	2016	2017	2018	Avg	Org
Q48+	Discharge: felt involved in decisions about discharge from hospital	85%	84%	84%	82%	84%	84%	84%
Q49	Discharge: given enough notice about when discharge would be	87%	88%	87%	85%	84%	87%	84%
Q50	Discharge: was not delayed	63%	61%	63%	64%	62%	60%	62%
Q52	Discharge: delayed by no longer than 1 hour	14%	14%	20%	12%	10%	12%	10%
Q54+	Discharge: got enough support from health or social care professionals	—	81%	76%	77%	78%	78%	78%
Q55+	Discharge: knew what would happen next with care after leaving hospital	—	63%	82%	82%	80%	84%	80%
Q56	Discharge: patients given written / printed information about what they should or should not do after leaving hospital	63%	60%	60%	62%	54%	63%	54%
Q57+	Discharge: told purpose of medications	89%	92%	90%	89%	87%	91%	87%
Q58+	Discharge: told side-effects of medications	56%	57%	48%	57%	54%	57%	54%

Figure 7: Delayed Transfers of Care at Gloucestershire Hospitals NHS Foundation Trust in 2019

Month	Delays	DTOC%
January 2019	838	2.94%
Feburary 2019	718	2.79%
March 2019	899	3.15%
April 2019	1293	4.84%
May 2019	1067	3.87%
June 2019	612	2.29%
July 2019	933	3.42%
August 2019	1162	4.26%
September 2019	1192	4.51%
October 2019	1014	3.71%
November 2019	852	3.28%
December 2019	745	2.77%

Figure 8: National benchmarking for delayed transfers of care as a percentage of bed days



To improve cancer patient experience

Background

The Cancer Patient Experience Survey has been designed to monitor national progress on cancer care, to provide information to drive local quality improvements.

Cancer Patient Experience has been highlighted through the National Cancer Patient Experience Survey as an area of priority for the organisation, with the Trust having 9 'worse' than national average scores, and 3 'better' scores.

In order to achieve an 'Outstanding' rating for Cancer Services we want to co-ordinate our improvement work with staff and patients to where it is most needed.

How we have performed 2019/20

One of the challenges of the Cancer Patient Survey is the timeliness of the data, with the results being published a year after being collated.

The latest Cancer Patient Experience Survey 2018 scores were published in September 2019; the Trust scored 'about the same' as other organisations for 41 of the questions. Figure's 9 and 10 show where we performed outside of this range, either above or below.

A new Lead Cancer Nurse has been appointed whose focus is on Patient Experience Improvement.

A major challenge has been around getting colleagues to recognise this data as the experience of our patients, as the data in the National Survey includes questions related to care provided from GPs and satellite clinics. A patient experience workshop was delivered in January 2020, with patients from across a range of cancer pathways, to understand our local patient experience, and start to shape an improvement plan.

The workshop was made up of patients who had used/ or were still using the cancer services within Gloucestershire Hospitals NHS Foundation Trust in the last two years (2017-2019), recruited through social media and local cancer charities.

Plans for improvement 2020/21

Patients at the workshop reported a mostly positive experience.

Largely they felt care they received from staff, particularly the oncology team, was compassionate, involved them as patients in decision-making, and generally provided them with good emotional support.

Patients were keen to celebrate where teams have exceeded expectations and provided compassionate care, but felt some changes being made would make 'good care' become 'outstanding', as well as celebrate and continue to deliver areas of care that were already outstanding.

The feedback from these sessions has been used to develop an action plan for 2020/21, with some of the key themes including:

- Improving the oncology environment
  - offering more healthy food choices in outpatients
  - improving dignity and confidentiality
- Improving written communications and health information
  - reviewing and improving the website as currently difficult to navigate

Figure 9: Cancer Patient Survey 2018 scores above upper limit

Q	Question	No. of responses	2017 score	Lower limit	Lower limit	National average scores
20	Hospital staff gave information about support groups	1122	92%	83%	90%	86%
33	All staff asked patient what name they preferred to be called by	797	79%	60%	78%	69%

Figure 10: Cancer Patient Survey 2018 scores below the lower limit

Q	Question	No. of responses	2017 score	Lower limit	Lower limit	National average scores
11	Patient given easy to understand written information about the type of cancer they had?	1140	68%	71%	77%	74%
15	Patient definitely told about side effects that could affect them in the future	1239	51%	53%	59%	56%
16	Patient definitely involved in decisions about care and treatment	1347	76%	76%	81%	79%
17	Patient given the name of the CNS who would support them through their treatment	1312	85%	89%	94%	91%
34	Always given enough privacy when discussing condition or treatment	798	83%	83%	88%	86%
38	Given clear written information about what should/should not do post discharge	726	84%	84%	90%	87%
55	Patient given a care plan	1058	29%	32%	39%	35%
57	Length of time for attending clinics and appointments was right	1354	62%	62%	76%	69%

- partnership working with the Trust Library and Knowledge services
- reviewing patient information provided for use of health jargon and plain English

- Improving access to clinical teams in a timely fashion
- Improving signposting to support services and carers support
- Improving communication across divisions
- Improving engagement with seldom heard communities
- Continue to provide opportunities for patients to be engaged in development of services
- Advanced communication training around breaking bad news

Improvement work has been put on hold due to COVID-19, but will be reinstated in Q2 following the publication of the Cancer Patient Experience Survey scores in June.

This action plan will be monitored through Quality Delivery Group throughout the year.

Figure 11: Cancer Patient Survey scores trends

Trend	2015	2016	2017	2018	Trend
Number of scores better than national average	21	32	14	12	↓ 2
Number of scores the same as national average	2	2	8	12	↑ 4
Number of scores worse than national average	26	18	30	28	↓ 2
No comparison	3	0	7	0	

Figure 12: Patients who attended the workshop in January

Cancer site	Male	Female	Completed treatment	Still in treatment	Total No. of patients
Secondary Breast Cancer	—	5	—	5	**5**
Haematological Cancer	1	2	2	1	**3**
Breast Cancer		9	7	2	**9**
Upper GI	1		1		**1**
Lower GI	1	2	3		**3**
Gynaecological		3	2	1	**3**
Prostate	2		2		**2**

To improve outpatient experience

Background

With the aim of improving outpatient experience across 'One Gloucestershire' Gloucestershire Clinical Commissioning Group secured funding to drive an improvement programme. An external company 'Attain' were appointed. Over a 12-week period Attain gathered available information, questioned patients, engaged with clinical and non-clinical staff and reviewed their findings against examples of best practice to co-produce a list of improvement options (relating to patient satisfaction, staff engagement and value for money) across four specialities.

Their assessment also identified a number of 'cross-cutting' themes (relating to booking pathways, workforce and communication) which if not addressed had potential to slow an improvement programme.

How we have performed 2019/20

The four specialities involved in the initial improvement work were

- Neurology
- Dermatology
- Rheumatology
- Diabetes

Feedback gained from the wide range of methodologies used by Attain e.g. staff engagement groups, patient questionnaires, patient emotional mapping questionnaires resulted in four action plans which the respective specialities within the Medical Division (with Transformation and Service Improvement Programme support) were responsible for delivering.

Key achievements in year include:

- Improved clinic outcome data
- Production of monthly clinic wait reports (by Consultant)
- Outstanding clinic change requests actioned by clinical systems team
- Commitment to the start of a physiotherapist led inflammatory arthritis clinic in 2020
- Initiation of pilot non-face to face clinics e.g. telephone calls
- Redrafting of outpatient appointment letter, with launch September 2019.
- Redrafting of all other patient letters; to be circulated from 2020 after user training sessions completed
- Text reminders changed to 14 and 3 days (reminder) prior to appointment
- Referral Assessment Service started in Gastroenterology
- 'One Gloucestershire' introduction of Cinapsis software for GPs to forward photos as part of 'Advice and Guidance'
- GP's now able to order anti cyclic citrullinated peptide (CCP) test prior to referral for an Early Inflammatory Arthritis appointment
- Targeted GP training e.g. Rheumatology / rheumatic disease

Figure 13: Attendance rates with initiative inputs

Attendances	Threshold	Aug '19		Sep '19	Oct '19		Nov '19	Dec '19		Jan '20
First Attendance	-	19,952	New appointment letter format	22,358	25,504	Text reminder changes	23,417	20,032	Changes to all OP letters 16.01.20	24,368
First DNA	-	1,666		1,932	2,048		1,806	1,740		1,999
Follow-up Attendance	-	38,045		39,937	44,441		42,337	37,716		44,481
Follow-up DNA	-	2,641		2,949	3,039		2,932	2,582		3,182
First DNA Rate	5%	7.71%		7.96%	7.44%		7.16%	7.99%		7.58%
Follow-Up DNA Rate	8%	6.49%		6.88%	6.40%		6.56%	6.41%		6.68%
First Attendance Discharged Rate	-	23.70%		22.12%	21.25%		21.59%	21.85%		25.72%

Figure 13 shows the attendance numbers and Did Not Attend (DNA) rates for outpatient services from August 2019-January 2020, including when different initiatives were introduced.

Plans for improvement 2020/21

It is recognised that outpatient departments are spread across and within all clinical divisions, and so the Trust steering group provides strategic lead to the optimisation and improvement of services.

In November, the programme of work underwent a revision to focus improvements to specific activities, extending improvement implementation beyond the four initial specialties. Additional programme support has been allocated from Transformation and Service Improvement, and the latest plans for 2020/21 can be seen below.

Of particular note and focus is the introduction of a digital offer, the roll out of which has been accelerated during the management of Covid-19.

Patient experience feedback is being gathered to help evaluate and improve our virtual outpatient offer.

Figure 14: Outpatient transformation programme 2020/2021

Workstream:	Key tasks:	
Improve clinic utilisation	▸ Review of service level utilisation and plans to address ▸ Develop booking rules at speciality level ▸ Determine, capture and capitalise impact of Gastroenterology RAS	
Reduce F2F attendances	▸ Patient advice lines / services ▸ Increase telephone clinics and capture existing activity ▸ Patient initiated follow-up ▸ Variation: new: follow-up ratio	
Referral Assessment Service (RAS)	▸ Develop Gynaecology RAS ▸ Develop Dermatology RAS ▸ Implement Prostate RAS ▸ Develop Cardiology RAS	▸ Develop Respiratory RAS ▸ Monitor Gastroenterology RAS ▸ Evaluate options for future roll out
Optimising Workforce	▸ Out patient nursing and associated staffing review	
Booking and Utilisaton	▸ Review appointment types ▸ Improve missing outcomes ▸ Correct vetting errors	▸ Booking review: centralisation benefits realisation
Patient correspondent	▸ New format for letters ▸ Improve text reminders	▸ Support access policy with correspondence ▸ Email correspondence
Increase digital offer	▸ Develop virtual clinics ▸ Remote monitoring ▸ Attend Anywhere video consultations	▸ Digital blood monitoring: DMARDS ▸ 2-way text (links to 6)
Efficiency and productivity	▸ DNA reduction ▸ Improve clinic charge process ▸ Advice and guidance to GPs	▸ Increase use of Cynapsis ▸ DrDoctor
Division activity	▸ Quality improvement: Radiology booking ▸ Enhanced Physio Ank S Service Rheumatology	▸ Pharmacist led patient education (Dermatology / Rheumatology) ▸ Evaluate impact

Quality priority: To improve mental health care for our patients coming to our acute hospital

Background

Our mental health care model is to ensure that people presenting at the emergency department with mental health needs have these needs met more effectively through an improved, integrated service. We also have the aim of reducing future attendances. People with mental health problems coming to the Emergency Department in crisis will be aware that timely treatment can be difficult to deliver consistently and with our effective quality improvement programme we aim to make changes and monitor the impact of our changes.

How we have performed 2019/20

The Lead for Mental Health Liaison and our Emergency Department Matron have been working on a Quality Improvement project (Silver GSQIA project) that uses a modified Manchester Triage Tool to identify Priority 1 & 2 patients for an early mental health review. This is being run concurrently with the Royal College of Emergency Medicine who has also undertaken a Quality Improvement project but using a different tool. Below is the data for the numbers of patients who were triaged at Gloucestershire Royal Hospital by an Emergency Department (ED) nurse on arrival.

Training in the use of this Triage Tool has been given to all Band 6 nurses within Emergency Department.

The Trust now has secured £480,000 additional funding, on the Gloucestershire Royal Hospital site, and £345,000 at Cheltenham General Hospital site to recruit Mental Health nurses for the acute setting in order to deliver a mental health review response within 1 hour. The recruitment to these posts will help the Trust meet the national "CORE 24 standards" which is the initiative to provide a 24-hour service for mental health patients.

The average length of stay for people with mental health issues who were seen by the Mental Health Liaison Team is on average 53.7% lower than those mental health patients who were not seen, which is a reduction of 2.2 days per patient on average. This is more significant in that the average patient seen by the Liaison Team is 'higher intensity' and higher cost than the no contact cohort (average cost of Liaison contact spell = £557, average cost of non-contact mental health patient=£428).

The re-admission rate is also lower for those patients who were seen by the Liaison Team (16.8% re-admission rate, compared with 18% for those who were not seen). Re-admission rates are steadily declining for all mental health admissions.

There is still more work to be done on accurately recording data, such as developing the inpatient mental health definition further to ensure that we are accurately capturing the correct cohort of patients. The switch to the new Emergency Care Data Set (ECDS) should enable an accurate baseline level of activity.

Current service improvements are seeking to improve patient flow, however, patients who require a medical admission for treatment still require that treatment irrespective of when a Mental Health Liaison Team assessment takes place. Current ED practice includes artificial barriers to referral which have been

Figure 15: Mental health triage by ED nurse on arrival

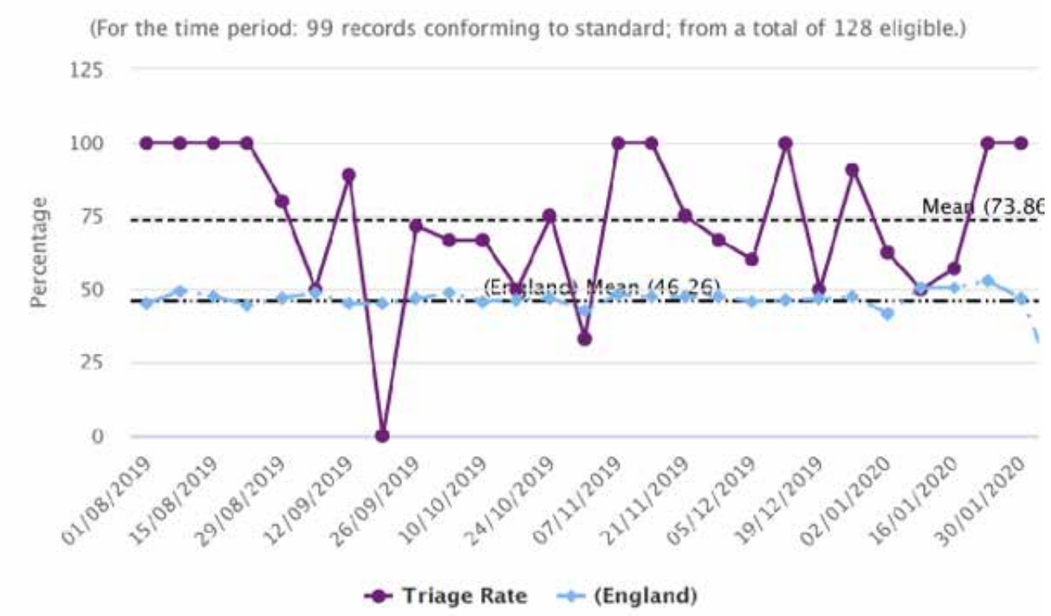
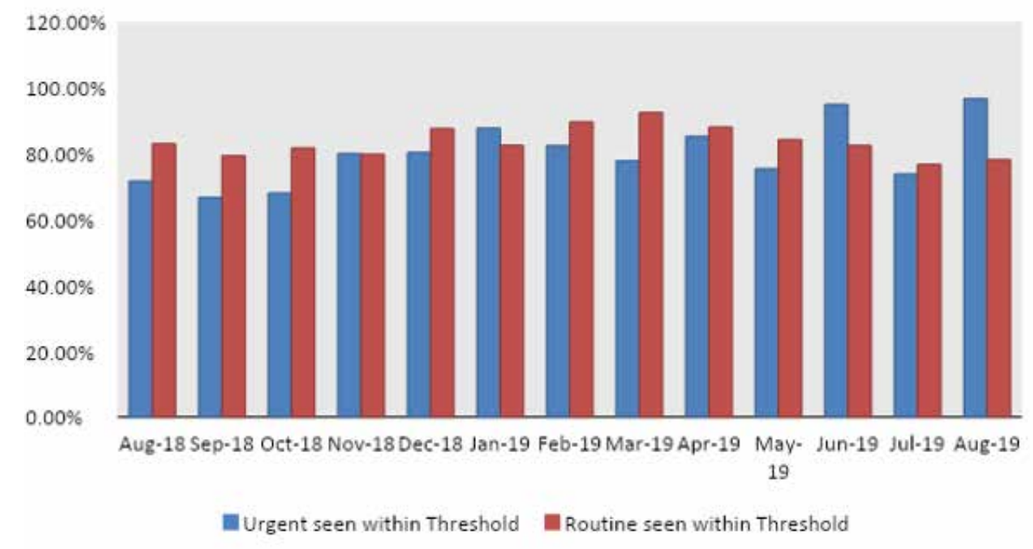


Figure 16: Percentage of urgent referrals seen within threshold compared with rountine referrals seen within threshold



improved upon and could be further through upstreaming that assessment to impact on flow and length of stay. Improved triage, earlier senior review and adoption of the "medically fit for assessment" principle (rather than medically fit for discharge) are already having significant impact. Simultaneous streaming and robust mental health triage will result in drastically improved patient flow and experience, enabling time and cost saving potentials to demonstrate return on investment.

Plans for improvement 2019/20

The NHS Long Term Plan includes the Mental Health Implementation Plan which runs over the next 5 years (2019/20 – 2023/24). By 2020/21 all acute hospitals will have Mental Health Liaison Services that can meet the specific needs of all ages and 50 % of liaison services will be meeting the CORE 24 Standards.

A recruitment campaign will be our focus for 2020 so that the Mental Health Liaison Team will deliver first assessments to inpatients within 1 hour from the time of referral to all patients with a mental health issue or diagnosis of mental health problems.

There will be specific training given across the Trust to all nurses graded at Band 6's, 7's and junior doctors in the delivery of the modified risk assessment tool. Also, an evaluation of the use of Mental Health nurses at triage will be undertaken which will enable co-streaming and assist in delivering a 1 hour response. The Mental Health Liaison Team will continue reducing unnecessary admissions where safe to do so.

Quality priority: To develop a real time patient experience survey programme

Background

Our National Adult Inpatient 2018 Survey scores tell us that patients would like more opportunities to provide us with feedback on how we can improve, and our staff survey data tells us that staff would like access to more real time patient experience data.

Real-time surveys were launched across the Trust in April 2019 in order to track real-time experience on key areas identified in Inpatient Survey as areas for improvement.

How we have performed 2019/20

Figure 17 shows the real-time responses of patients, including the Inpatient Survey response in 2018 as a benchmark.

Since launching in April 2019, there have been challenges with getting consistent and reliable data for real time surveys, due to issues with the tablets and also struggling to recruit volunteers to deliver the surveys, which makes analysing and understanding individual anomalies more difficult. Originally, the volunteers were completing surveys on one division per month, which gave an overall picture for each division, but did not provide enough detail at ward level to provide meaningful insights for improvement.

The Patient Experience Improvement Manager has been working with the volunteers to review this, and has a new plan for delivering real-time surveys for 2020. The schedule for volunteers combines surgical and medical wards at each site every month.

This will move focus away from Women's and Children's (W&C) and Diagnostic and Specialties (D&S) wards. This should ease pressure on the volunteers conducting the surveys and give us more consistent month-on-month responses for the medical and surgical divisions.

Plans for improvement 2020/21

Due to Covid, we are unable to continue with the real-time survey programme temporarily as this is delivered by volunteers on the wards. We will continue working with the Business Intelligence team to estimate how many patients are on a particular ward at any time, to help guide our Real-Time survey delivery and gauge how representative it is. We hope this could give us an aim as to how many patients we should be speaking to each month, and in turn plan resource accordingly. The schedule above also gives us more consistent responses across a range of wards in both surgical and medical divisions each month, giving us data we can track over time more reliably.

We also plan to meet up more regularly with the volunteers on both sites, both to encourage and gratify them for their efforts. This will also give them the opportunity to feedback to us on how they find conducting the surveys. Volunteers get a regular schedule as above and reports showing the feedback that is received from patients, so they can see the impact they are having with the information they are collecting.

We have launched the Patient Experience Faculty, and the team are working closely with divisional leads to improve access to data, reporting and analysis, to support teams to use this feedback to drive improvement in their service areas.

Figure 17: Real time response of patients

Real Time survey Question	Q1	Q2	Q3	Q4	2019/20 average score	Inpatient Survey 2018 scores
How much information about your condition has been given to you?	77%	81%	79%	81%	**80%**	**79%**
Are you involved as much as you want to be in decisions about your care and treatment?	93%	93%	90%	93%	**92%**	**89%**
Do you feel that you are treated with respect and dignity by all staff caring for you?	96%	99%	99%	99%	**98%**	**97%**
Do you feel well looked after by staff treating or caring for you?	98%	100%	98%	100%	**99%**	**98%**
Have you been asked to give your views on the quality of your care?	—	—	10%	9%	**9%**	**5%**
Do you know who you could talk to about any concerns or complaints you may have about your treatment?	91%	87%	75%	69%	**81%**	**—**
Do you get enough help from staff to wash or keep yourself clean?	97%	100%	90%	93%	**95%**	**87%**
Do you get enough help from staff to eat your meals?	90%	96%	83%	81%	**88%**	**74%**
In your opinion, how clean is the ward or area that you are in?	98%	99%	99%	99%	**99%**	**95%**
Are you bothered at night by noise from hospital staff?	—	76%	78%	74%	**76%**	**74%**
Are you bothered by noise at night from other patients?	—	61%	59%	57%	**59%**	**55%**

Quality priority: To enhance and improve our safety culture (SCORE Survey)

Background

Safety culture refers to the way patient safety is thought about and implemented within an organisation and the structures and processes in place to support this.

Measuring safety culture is important because the culture of an organisation and the attitudes of teams have been found to influence patient safety outcomes. Using validated tools, we are able to measure this culture, identify areas for improvement and monitor change over time.

How we have performed 2019/20

A variety of culture surveys were reviewed and the SCORE (Safety, Communication, Operational Reliability & Engagement Survey) survey by Safe and Reliable Care was selected.

SCORE is an internationally recognised and scientifically validated way of measuring and understanding the culture that exists within organisations and teams.

Through a number of specifically targeted questions it provides an assessment across a variety of domains including:

- Improvement readiness
- Local leadership
- Resilience / burnout
- Teamwork
- Safety climate
- Engagement

The survey was undertaken in September 2019 across pre-operative, operative and post-operative settings in Gloucestershire Royal Hospital, Cheltenham General Hospital & Cirencester Treatment Centre.

62% of staff surveyed responded, which was above the quantity required for the results to be considered representative of the surveyed staff groups.

An overview of the results was reviewed with the surgical management team and representatives from Safe and Reliable Care. Representatives from across the work settings participated in training on the reporting platform to enable them to view their data.

Focus groups beginning to analyse the data by work setting and staff group have begun across the theatres teams.

Plans for improvement 2020/21

Planning is currently under way for the outstanding surgical and anaesthetic focus groups, which have been postponed due to Covid. Conversations are ongoing with surgical leads to continue this work.

Once completed the next step of the process will be to develop a multi-disciplinary improvement collaborative using the data and feedback collected. This will utilise Quality Improvement methodologies and with the support of the Gloucestershire Safety & Quality Improvement Academy (GSQIA) involve the staff in developing and testing improvements in the identified areas.

The SCORE survey will be repeated in 2021 to determine the impact of the interventions undertaken.

Steps completed:

- Survey mapping to staff groups and work settings
- Survey completion
- Data overview and debrief

In progress

- Staff group and work setting focus groups

Step outstanding

- Improvement collaborative: Test and learn
- Re-survey

Quality priority: To improve our patients beginning their first treatment for cancer within 62 days following an urgent GP referral for suspected cancer

Background

The NHS Constitution sets out a number of pledges and commitments to the public about the access to services and people's rights. One of these pledges is "The NHS commits to provide convenient, easy access to services within the waiting times set out in the handbook to the NHS Constitution." This means that patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly. Organisations' performance is monitored across all waiting time pledges, including a national target for Trusts to ensure that 85% of patients to begin their first definitive cancer treatment following urgent GP referral within 62 days.

How we have performed 2019/20: 62-day performance

Nationally Trusts are continuing to struggle to meet the 62-day standard with latest national performance of 78.9% (March – latest data available). April un-validated position for the Trust is 81%. COVID19 pandemic has impacted the delivery of cancer services. Cancer Services and specialties have had to adapt to new ways of working and pathways through March and April 2020.

Impact of COVID-19

In April 2020, total number of patients seen and respective performance was affected due to COVID-19. Number of patients seen has decreased by approx. 55% in April compared to pre COVID-19 period (January 2019 to March 2020). Total patients seen in April (-59%) and May (-45%) was considerably less than forecast. April is the first month since September 2019 GHNHSFT Cancer services missed the performance target (93%) by achieving 90.6%, of note this still was 2.6% above national average.

In March 2020 there were 207 new cancer diagnoses from 2292 2 week wait referrals first appointments with a conversion rate of 9% compared to 220 in March 2019 with a conversion rate of 10.4%. In April 2020 there were 90 new cancer diagnoses with a similar conversion rate of 9.9% compared to 198 diagnoses with a 9.6% conversion rate in April 19. In May 2020 there were 122 diagnoses with a conversion rate 9.2% compared to 219 diagnoses from a conversion rate 9.3%.

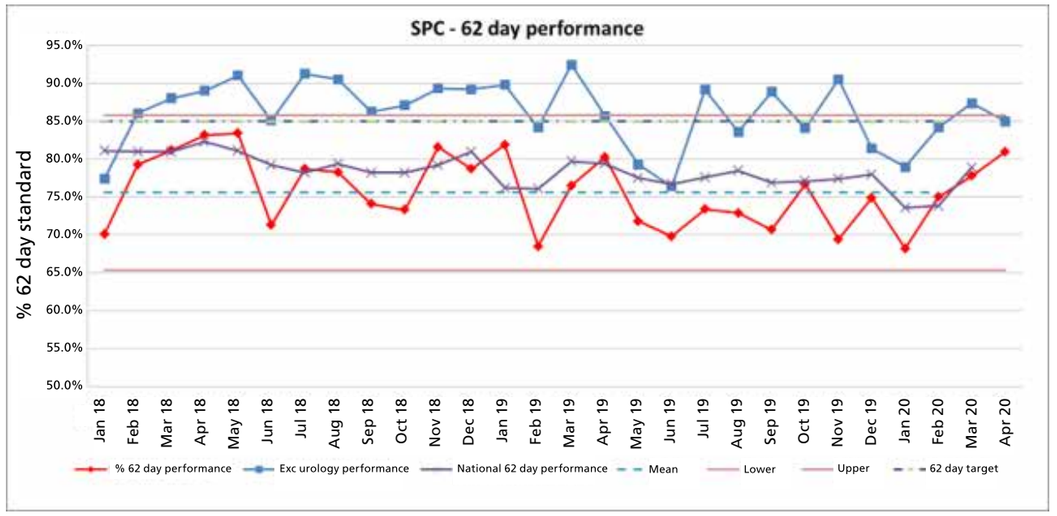
Analysis of 62 day GP referred treatment levels during the pandemic are promising with 24% additional patients treated in March compared to March 2019. In April treatment activity was down by 16% compared to April 2019 however this compares favourably with the national picture of 20% reduction. If taking both months activity together, treatment activity actually increased on 2019 activity by 3.5% compared to a 3% reduction nationally.

The Trust met 5 out of 8 cancer wait times standards in April 2020 with all 9 cancer wait times Standards (inc 62 day upgrades) achieving higher than the national average for the same time period. The Trust performed 3.7% higher than national average for 62 day GP referral treatments.

Plans for improvement 2020/21

To support improvement during 2020/21 specifically aimed at improvement of 62-day treatment we have a Delivery Plan for each speciality area.

Figure 18: SPC 62 day performance



Corporate actions

- Radiology and Pathology Coordinators have been recruited and will now allow us clear support for escalation of patients who are not meeting timed targets on respective tumour site pathways.
- Videoconferencing equipment across all three rooms (Oncology seminar room, Sandford Education Centre and Redwood Education Centre). The first room has now been completed (Sandford Education Centre) the other two rooms are on course for completion before mid-March which will support effective use of clinical time between sites.

The main tumour site that we are supporting for 2020/21 is Urology.

Urology

- Executive led Task and Finish group established focusing on implementation of RAPID prostate pathway
- Reduce timeframes and additional processes by:
  - Straight to Magnetic Resonance Imaging (MRI) pathway with reduced timeframes (request to report) – go live TBC – Revised prostate proforma and pathway submitted to Clinical Commissioning Group colleagues
  - Prostate cancer specific clinics
  - Consultant training for local anaesthetic template biopsies: completed
  - Improve pathology turnaround times: turnaround times monitored for technical and clinical approval
- Task and Finish group for Bladder and Renal to be initiated

Improvements we have made in the latter part of March 2020 also will support a sustainable improvement, namely:

Gynaecology

- Consultant led pathway review completed in September with plans to:-
  - Implement consultant triage to ensure patient is booked the most appropriate diagnostic in a timely fashion
  - Implement see and treat hysteroscopy service: now live
- Six hysteroscopes to support see and treat service funded through cancer transformation have now arrived and in operation

Head and Neck

- Review multi-disciplinary team (MDT) function in respect to operational delivery and implementation of MDT effectiveness interventions.
- Additional neck lump clinic trialled (1 in November and 2 in December)
- Additional Head and Neck Cancer Nurse Specialist (CNS) and Support Worker – Support Worker recruited, CNS out to advert again
- Bone Saw which was highlighted as major requirement for pathology following pathway session approved through Capital Control and to be delivered before Christmas

Haematology

- Demand and capacity review across routine and 2 week waits
- Utilise additional clinic space in Edward Jenner Unit (EJU) to create two additional consulting rooms
- Project focusing on inter specialty referral
- Currently out to recruitment for additional full time Consultant Haematologist
- Joint pilot Oncology and Haematology lymphoma clinic established with increased Nurse led bone marrow biopsy capacity

Pathology

- Access arranged for pathology colleagues to update patient records to reduce time between reported case and next action
- Additional capacity to support team

Radiology

- Improved escalation process and intelligence regarding patients waiting for event or report and by specialty. Data is now being collected to show longitudinal performance
- New Pathway Coordinator funded by Cancer Transformation now embedded and radiology huddle to be formed

Figure 19: Cancer site performance

Cancer site	Treated	Breaches	Performance
Urology	137	80	41.6%
Lower GI	56.5	23	59.3%
Skin	139	14	89.9%
Head and Neck	30.5	10	67.2%
Lung	33.5	5.5	83.6%
Breast	92	2.5	97.3%
Gynae	31	7.5	75.8%
Haematology	23	3	87.0%
Upper GI	40.5	6.5	84.0%
Other	5.5	1.5	72.7%
Acute leukaemia	0	0	—
Testicular	4	0	100%
Sarcoma	1.5	0	100%
Brain	1	0	100%
Trust wide (unvalidated)	**595**	**153.5**	**74.2%**
Trust wide (exc Urology)	**458**	**73.5**	**84.0%**
Trust wide performance with modelling of 65% performance for Urology	**458**	**121.5**	**79.6%**

Quality priority: To improve the issue of patients receiving delayed care

Background

Referral to treatment is a national target and is a term used to describe a standard for delivery of care in the NHS that no patient should wait longer than 18 weeks from to the start of their first treatment.

Once a patient has started their treatment they usually attend follow up outpatient appointments so that we can monitor their condition and if necessary change or update treatment plans.

To manage our Outpatient Follow Up appointments we use a Patient Tracking List (PTL) as this is an established, forward-looking, management tool so we know who needs follow up and can plan their appointments. Following the implementation of a new digital Patient Administration System, Trak Care, in December 2016, our operational teams had less visibility of people needing follow up appointments as we temporarily lost the ability to track patients on outpatient lists who were waiting for an appointment.

Immediately we implemented a recovery plan to digitally 'find' our patients and what we found was that that there were patients who were delayed on both Referral to Treatment and follow up pathways. In this section, we will describe the improvements that we have been working on for our Ophthalmology Outpatient Patient Services.

Data

Figure 20 sets out the national picture for the number of providers vs the number of patients on a glaucoma and medical retina pathway with a delayed follow up in the last 12 months. The inclusion of benchmarking information is being sourced for future reports to support further challenge to the service(s) where appropriate, but this remains difficult as approximately 30% of Trusts do not publish their individual reports, as illustrated in Figure 20.

Figure 21 on the next page sets out for Gloucestershire Hospitals NHS Foundation Trust Ophthalmology services the un-booked patients within each chronological cohort. Since January 2019 the service has eliminated all the 2017 cohort of patients and in addition has significantly reduced the 2018 cohort, from the start of last year.

Our improvement plan was discussed with the Ophthalmology Service Team and an update on our progress is set out in Figure 22 on page 69.

Figure 20: Number of Providers vs number of patients on a glaucoma pathway with a delayed follow up in the last 12 months (GIRFT data)

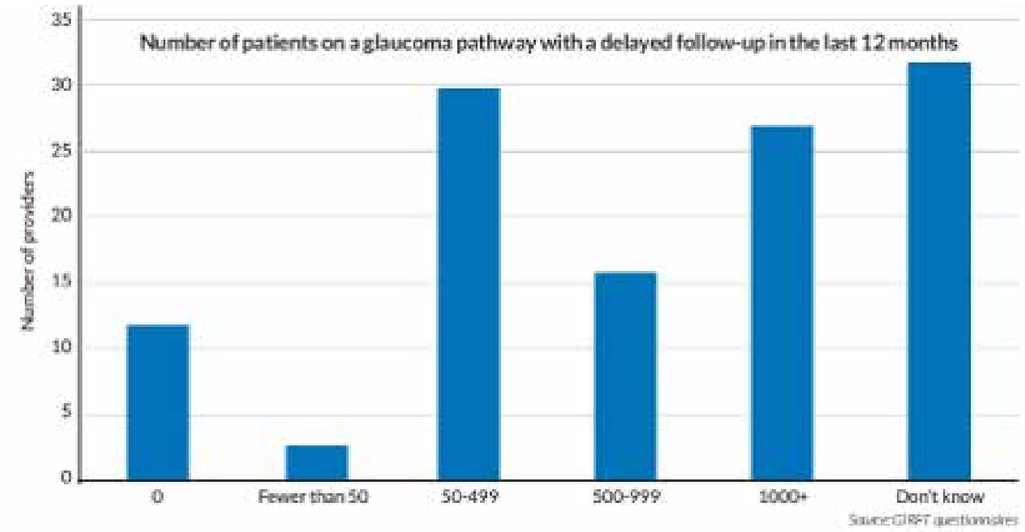


Figure 21: Number of Providers vs number of patients on a medical retina pathway with a delayed follow up in the last 12 months (GIRFT data)

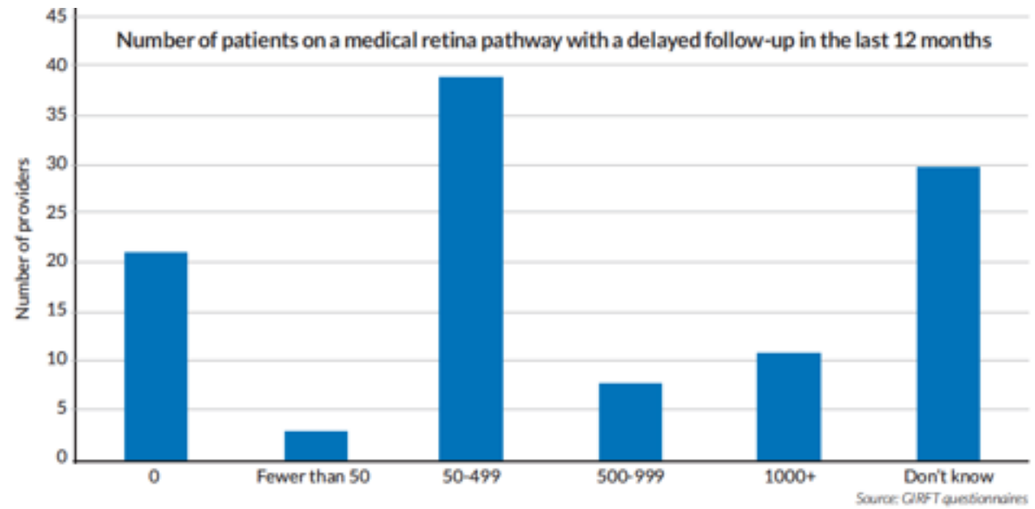


Figure 22: Numbers of service users waiting for follow up treatment by year

	2015 F/U	2016 F/U	2017 F/U	2018 F/U	2019 F/U	2020 F/U
October 2018				9914	3621	
January 2019	0	14	34932			
April 2019	0	0	2852			
September 2019	0	0	—	3986		
December 2019	0	0	81	2460	6564	
January 2020	0	0	0	2025	5799	7961

Figure 23: Actions taken to improve care for people having delayed care

Improving our capacity	Action	January 2020 Progress Update
We have increased our Medical Staffing for the Ophthalmology clinics	The team have recruited to two additional consultants. One individual commences before Christmas in 2019 and one individual (p/t) to commence February 2020.	In place
We have carried out clinical reviews for patients who have had delayed appointments to see if there has been any potential or actual harm caused by the delay	The Clinical Review for Harm Policy was approved was November 2019 and now being implemented in respect of delayed care for all services.	The review of Datix indicates, there were 23 safety incidents, of which 1 had serious harm; 8 had moderate harm; 2 had minor harm. All patients have been notified through our Duty of Candour processes
We have created additional support to check the accuracy of our data	Additional validation from Central team identified to support service line team.	Moved to 2019 as admin validation of 2018 less successful
We have been checking which patients need to be seen and when by carrying out additional clinical validation checks	Voluntary at present – significant validation undertaken for glaucoma patients and cataracts	In place At time of writing, 800 patients clinically validated
We have been working closely with our appointment booking Team in the Central Booking Office	Additional meeting to be set up before 30/12/19 given recent progress of clinical validation	In place Additional clinics being built and set up
We have improved our system for logging patients who could be discharged from the service	Support for clinical use of correct discharge process including eye casualty clinics (following review of these records may be over-inflating the position)	Advice given to junior colleagues Further work to be undertaken by service director to publish processes
We have considered the reduction of elective operating capacity to convert to clinic follow up slots and will review efficiency of theatre lists	Consideration of conversion of elective lists to mitigate the risk	Not required as yet

Figure 24: Actions taken to improve care for people having delayed care

Improving our capacity	Action	January 2020 Progress Update
We have put in place a plan for additional Paid Sessions in January to March (Q4 19/20) to support having additional capacity	SD to email consultant colleagues for capacity in Q4	Service Director meeting with all consultants Clinics planned for April / May
We have produced a longer-term plan for 2020/21 to make sure that we continue to have enough appointments for people who need them	Service line to provide options paper /plan that would see them be 'best in class' by end of March 2021 to have no outstanding follow up's	D&C work underway.
We are considering introducing a Navigator role to support people with chronic eye conditions	Based on the model in Head and Neck to support patients to be considered	Being investigated within the administrative function

Plans for improvement 2020/21

At the time of writing this, in December 2019, for our 2018 group of patients waiting for a follow up appointment, we need to find additional capacity to deliver a further 1,800 appointments. With the additional consultant time in December and February it is anticipated that 800 patients could be seen. This would then leave an estimated deficit of 1,000 appointments rolling over into the next year.

The Ophthalmology Team will continue to assess their data and progress monthly. They have challenged themselves to think further of ways they can mitigate both future and existing demand for appointments and will be developing an options appraisal with the aim of sorting the back log of appointments by the end of 2021. The service's main improvement priorities are:

- To move forward is to work on the development and publication of protocols to prevent recurrent appointment issues and to support colleague training.
- To move to a more 'clinical risk-based' approach to follow up appointment management
- To review recurrent demand so that we have enough capacity.
    - To work with Business Intelligence team to see if there is a tool to support the identification of high risk patients
    - To include the 'rolling' clinical validation/virtual review of patients waiting.

These actions, alongside the learning the department is gaining, will ensure a more robust approach to any 'capacity shocks' in the future. Ultimately the department is currently working to ensure that the risk is mitigated that those patients who are high risk are known to the team, including those patients who are high risk because of they do not attend their appointment for any reason or non-compliance with treatment plans, so that they will not be delayed.

The department is keen to support learning across specialties such as Neurology, as there is much learning to spread across the Trust.

Quality priority: To improve the prevention of our patients developing pressure ulcers

Background

A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful".

Pressure ulcers can affect anyone from newborns to those at the end of life. They can cause significant pain and distress for patients. They can contribute to longer stays in hospital, increasing the risk of complications, including infection and they cost the NHS in the region of more than £1.4 million every day. They are mostly preventable.

The national Stop the Pressure programme led by NHS Improvement has developed recommendations for Trusts in England. These support a consistent approach to defining, measuring and reporting pressure ulcers. Pressure ulcers are one of our key indicators of the quality and experience of patient care in our Trust.

How we have performed update

We are committed to reduce the number of pressure ulcers developing in patients in our care. On 22 September 2019, we held our first Quality Summit to discuss our pressure ulcers prevention improvement programme. Thirty-two staff joined us to review "where we are now" and "where we want to get to by when". The half day event gave staff time to think about our issues then learn a little about improvement methodologies also to spend time developing change ideas. The end result was that we developed a driver diagram which will be the basis of our improvement plan. At our Quality Summit we asked ourselves: "If most of hospital acquired pressure ulcers are preventable then how can we prevent them?"

We used our 3 Quality Strategy aims to as a framework for the event

1. Improve our understanding of quality by drawing insight from multiple sources **(Insight)**

2. Equip patients, staff and partners with the opportunity to co-design with us to improve **(Involvement)**

3. Design and support programmes that deliver effective and sustainable change **(Improvement)**

The summit helped the Tissue Viability team with the continued development of their education and audit. It also facilitated a structured learning from investigating in the form of the Preventing Harm Hub.

Figure 25: our current data for category 2-4 and unstageable Hospital Acquired Pressure Ulcers/1000 bed days

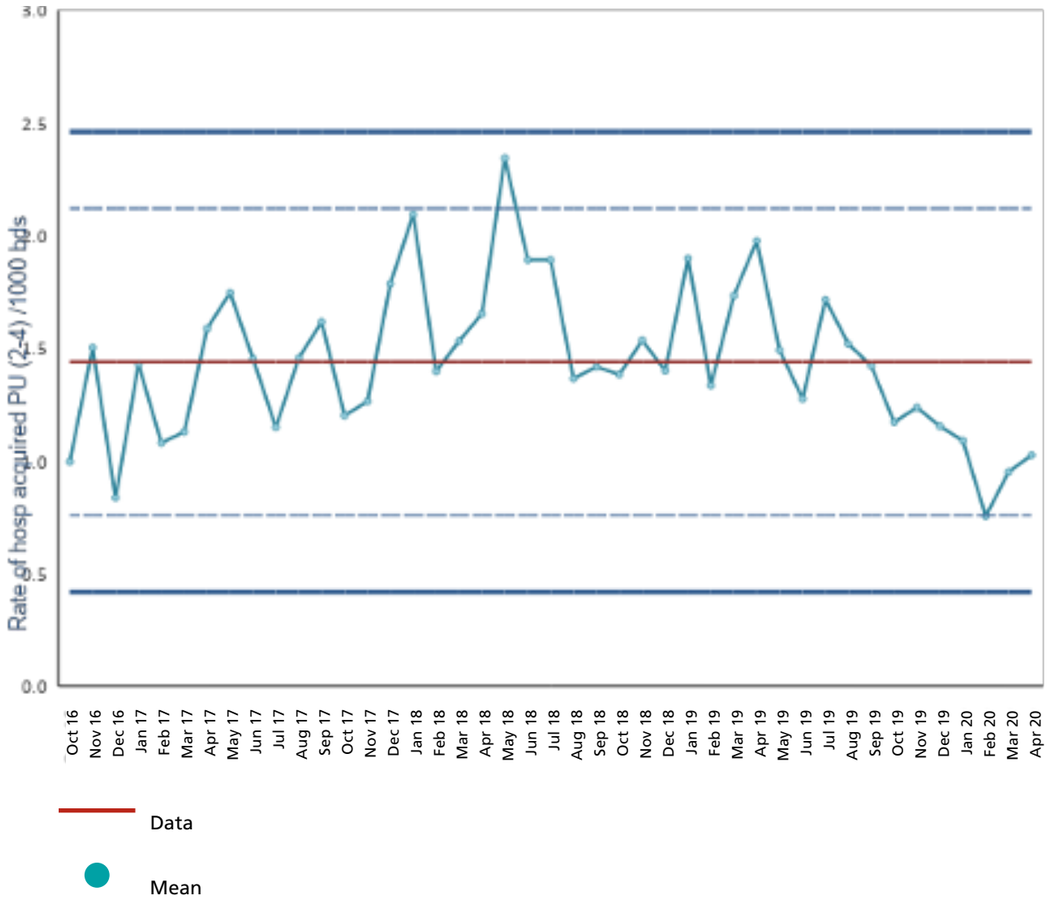
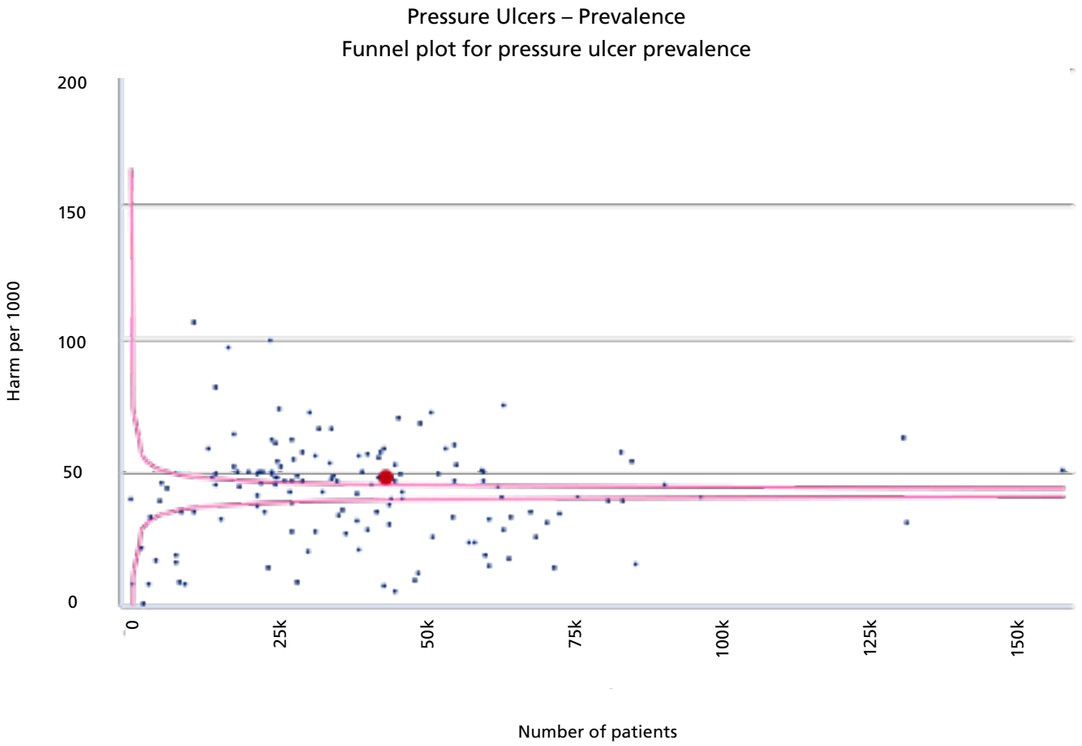


Figure 26: Funnel plot diagram for pressure ulcer prevalence



Plans for improvement 2020/21

After our summit, we have developed a pressure ulcer prevention quality improvement plan which will be led by the Tissue Viability Team. Our first programme of work will be completing in depth diagnostic work of our data to turn this into insights so we can prioritise our improvement work. The implementation of the Electronic Patient Record has enabled us to have better oversight of pressure ulcer risk assessments and prevention plans that are being put in place for our patients.

Our work will focus on:

- Review our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording.
- Establishing a programme of measurement from wards and relevant departments (connect this to preventing harm work streams).
- Map all our current data sources so that we can develop a single item quality report.
- Develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues.
- Regularly monitor data and undertake learning to improve care – develop quick feedback loops.
- Set ward level targets appropriate for their area.
- Develop speciality level data for pressure ulcers.
- Include pressure ulcers data at Divisional level reports in SPC charts.
- Map where the high-risk wards are and provide focused improvement work in these areas.
- Provide all clinical staff with educational resources for pressure ulcer prevention
- Ensure that all areas have access to equipment to facilitate pressure ulcer prevention
- Set up a network of tissue viability link nurses to support the trusts improvement plans.

Quality priority: To prevent falls in hospital

Background

Falls are the most commonly reported type of patient safety incident in healthcare. Around 250,000 patients fall in acute and community hospitals each year (NHS England, National Reporting and Learning System, 2013, 2014). Over 800 hip fractures and about 600 other fractures are reported as a result of falls.

Nationally

- There are 130 per year deaths associated with falls.
- Although most falls do not result in injury, patients can have psychological and mobility problems as a result of falling.
- Falls cause distress and harm to patients and put pressure on NHS services.
- Evidence from the Royal College of Physicians suggests that patient falls could be reduced by up to 25 to 30% through assessment and intervention.
- Older patients are both more likely to fall and more likely to suffer harm – falls among this group also have a disproportionate impact on costs as they account for 77% of total falls and represent around 87% of total costs. If inpatients falls are reduced by as much as 25-30%, this could result in an annual saving of up to £170 million

This CQUIN incentivised and encouraged us to focus our improvement efforts on the delivery of three high impact actions for falls prevention in hospital. These actions required nursing, pharmacy, medical and physiotherapy input. Each year almost 3,000 falls in hospital in England result in hip fracture or brain injury, typically subdural haematoma. Costs for patients are high in terms of distress, pain, injury, loss of confidence, loss of independence and mortality, and costly in terms of increased length of stay to assess, investigate or treat even modest injury.

A fall in our hospital often affects plans for a patient to return home or to their usual place of care as it impacts on the person's confidence and the confidence of their family and carers. NICE Clinical Guideline 161 sets out recommendations for preventing falls in older people with key priorities for implementation for all older people in contact with healthcare professionals, and preventing falls during a hospital stay.

The CQUIN applied to all patients aged 65 years and over who are admitted to an inpatient bed for more than 48 hours. The three key actions (Blood Pressure (BP), medications, mobility) were all audited:

1. Lying and standing blood pressure to be recorded
2. No hypnotics or anxiolytics to be given during stay OR rationale documented
3. Mobility assessment and walking aid to be provided if required.

The ambition was to have achieved 80% of older inpatients receiving key falls prevention actions.

How we have performed

Figure 27: Overall CQUIN performance for high impact interventions – falls prevention:

Quarter	Number of patients audited	Percentage compliant (Min 25% maximum 80%)
1	100	27%
2	101	28%
3	100	29%
4	Quarter not completed due to Covid-19	Quarter not completed due to Covid-19

Figure 28: CQUIN performance for individual actions

Actions	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Action 1: Patients who had lying and standing BP taken once during stay	50%	57%	61%	Quarter not completed due to Covid-19
Action 2: Patients given hypnotics during stay did not have rationale recorded in notes	14/16 **(88%)**	6/8 **(75%)**	9/14 **(64%)**	Quarter not completed due to Covid-19
Action 3: **a)** Patients had a mobility assessment within 24 hours of admission **b)** Eligible patients received walking aids within 24 hours	**a)** 60% **b)** 42/48 (88%)	**a)** 61% **b)** 22/74 (29%)	**a)** 73% **b)** 35/62 (56%)	Quarter not completed due to Covid-19

Improvement actions taken

- Initial multidisciplinary team meeting to discuss improvement plan including medical staff and pharmacists
- Teaching for nurses to enable staff to assess for a mobility aid.
- Networking with other Trusts who are doing this well in the South West to see what they are putting in to place to make improvements.
- Education packages have continued around the reasons and the importance of recording a lying/standing BP (slight increase in recording or a rationale if not being recorded).
- Lead for Care of the Elderly (COTE) and Lead for Stroke having conversations with medical staff about documenting reasons for medication prescribing.
- Work continuing with the therapists providing a mobility assessment within 24 hours/providing walking aid – and recording this.
- Focused training on high risk wards (Cote, Stroke wards and 3a – Orthopaedics).
- There has been an increase in the number of procedures having been recorded.
- Introduction of Electronic Patient Record with the ability to now view risk assessments and falls data across the whole Trust.

Plans for improvement 2020/21

We have developed a quality improvement plan which will be led by the Lead Nurse for Falls Prevention. The start of our programme of work will be focus on completing in depth diagnostic work of our data to turn this into insights so we can prioritise our improvement work. The implementation of the Electronic Patient Record has enabled us to have better oversight of falls risk assessments and prevention plans that are being put in place for our patients.

Our work will focus on:

- Review our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording.
- Establish a programme of measurement from wards and relevant departments (connect this to preventing harm work streams).
- Map all our data sources.
- Develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues.
- Regularly monitor data and turn this into insights
- Undertake learning events to improve care – develop quick feedback loops.
- Set ward level targets appropriate for their area – for e.g. number of days since last fall.
- Develop speciality level data for falls prevention.
- Include falls data in Divisional level reports in SPC charts.
- Map where the high-risk wards are and focus improvement work in these areas.

Quality priority: To improve the learning from our investigations into our serious medication errors

Background

As the incidence of diabetes increases both locally and nationally, insulin use can reasonably be expected to increase, and the mistakes will no doubt increase as well. Insulin is a very powerful medication, and some of these mistakes will require immediate urgent medical attention. Diabetes emergencies are mostly avoidable whilst an inpatient. The insulin omission, and other insulin errors can cause harm leading to further interventions and a longer length of stay in hospital. For the patient with diabetes, it can mean a poor patient experience and journey.

How we have performed 2019/20

A pharmacist in Cheltenham ran a project look at facilitating self-administration of Insulin on Guiting Ward. Guiting Ward looks after patients needing vascular procedures, many of whom are diabetic patients who use insulin at home.

When in hospital, these patients often want to continue self-administering their insulin and managing their condition as independently as possible. This should be encouraged, as self-administration of insulin is proven to result in better patient outcomes. However, patients should only be injecting themselves unsupervised if they are competent to do so. They should also be storing their insulin somewhere securely, in line with medication safety laws.

Previously there was no formal process for assessing the competence of patients, and patients could not access their bedside lockers, meaning they either had to ask a nurse to retrieve their insulin or leave it out at the bedside. Patients were unhappy with this arrangement and it was unsafe to have insulin lying about.

The aim of the project was to increase the number of patients appropriately self-administering insulin by 50% over 4 months. “Appropriately” here means there is documented assessment of self-administration if needed and the insulin in use is stored securely.

The team tested three different changes during this project:

- **Change 1:** Ward staff education and reminder cards stuck to bedside lockers.
- **Change 2:** Introduction of Trust documentation to assess patients as well as a separate prescription chart, designed to be filled in by patient (2 x PDSA cycles).
- **Change 3:** Provision of lockable boxes, accessible to patients and to be kept at bedside, to keep insulin and equipment in (2 x PDSA cycles).

The lockable bedside boxes were obtained from Bristol Maid, using a donation kindly gifted by Cheltenham and Gloucester Hospitals Charity. Huddles were held with the nursing staff to teach them about the new documentation and boxes.

Data was collected daily during pharmacist ward visit and recorded on a proforma. Data was gathered through examination of the prescription chart and observation of patient bed space. The location of insulin in use was also recorded.

From this initial project, there was a clear increase in the number of patients appropriately self-administering (12% at baseline to 73%). There is now the means to assess patients wishing to self-administer insulin on the ward, and patient-accessible safe storage is available. Location of insulin in use saw an improvement – from just 58% of it being stored securely to 82% by the end of the project. There was a positive response by both patients and staff.

The 50% target set within the aim was achieved, though it was difficult to sustain. The project ran over the 4 months originally intended. The team are now planning to work with other wards across the Trust to share some of the learning from this pilot.

Plans for improvement 2020/21

The Trust will examine the issue of self-administration further once the National Diabetes Audit data is published.

The Trust will also be developing a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.

Quality priority: To improve our care of patients whose condition deteriorates (NEWS2)

Background

Failure to recognise or act on signs that a patient is deteriorating is a key patient safety issue. It can result in missed opportunities to provide the necessary care to give the best possible chance of survival. Recognising and responding to patient deterioration relies on a whole systems approach and the revised NEWS2, published by the Royal College of Physicians, reliably detects deterioration in adults, triggering review, treatment and escalation of care.

The National Early Warning Score (NEWS)

The NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital.

Six simple physiological parameters form the basis of the scoring system:

1. respiration rate
2. oxygen saturation
3. systolic blood pressure
4. pulse rate
5. level of consciousness or new confusion*
6. temperature

**The patient has new-onset confusion, disorientation and/or agitation, where previously their mental state was normal – this may be subtle. The patient may respond to questions coherently, but there is some confusion, disorientation and/or agitation. This would score 3 or 4 on the GCS (rather than the normal 5 for verbal response), and scores 3 on the NEWS system.*

A score is allocated to each parameter as they are measured, with the magnitude of the score reflecting how extremely the parameter varies from the norm. The score is then aggregated and uplifted by 2 points for people requiring supplemental oxygen to maintain their recommended oxygen saturation.

This is a pragmatic approach, with a key emphasis on system-wide standardisation and the use of physiological parameters that are already routinely measured in NHS hospitals and in prehospital care, recorded on a standardised clinical chart – the NEWS2 chart.

How we have performed 2019/2020

We audit the number of correctly calculated NEWS2 across various wards each month and these are reported on the Nursing Metrics.

The current data highlights the need for education in this area with some wards only achieving 20% compliance and this is process is currently lead by the Resuscitation Lead for the Trust.

Figure 29: The basis for patient safety in relation to NEWS2 is around '5 R's

Record	Have the vital signs be recorded in a timely fashion, is the data set complete (no missing variables) and have the totals been correctly added up to make the NEWS2 score
Recognise	Does the staff member know when to call for help and from whom
Report	Has the staff member reported appropriately every time it is required
Response	Has the response been timely and appropriate, does patient need transefer, if so was that in timely manner
Reassess	Have interventions made an appropriate difference to patient

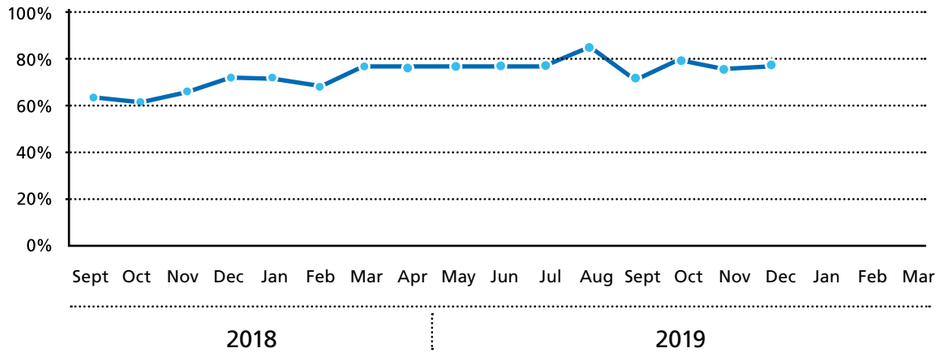
Figure 30: Recording vital signs and recognising deterioration

The graphs below demonstrate that data sets became more complete with fewer variables missing. However there was little improvement in accuracy of calculation of total score.

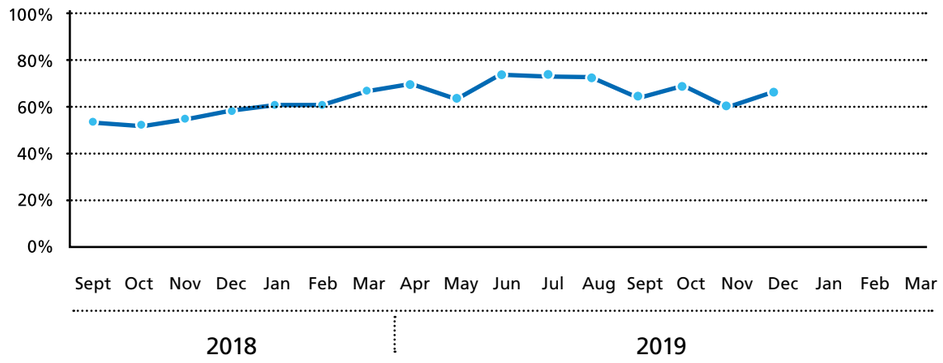
It was difficult to make serious inroads into addressing these problems until electronic vital signs were introduced.

Figure 30: NEWS2 Results, year to date

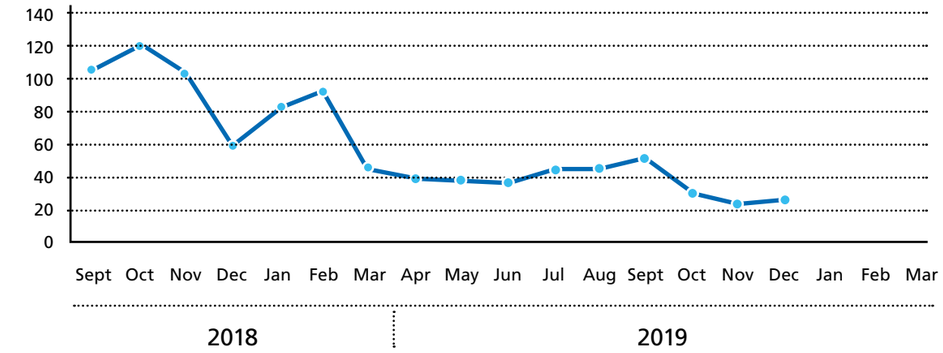
6 parameters and O2 therapy recorded



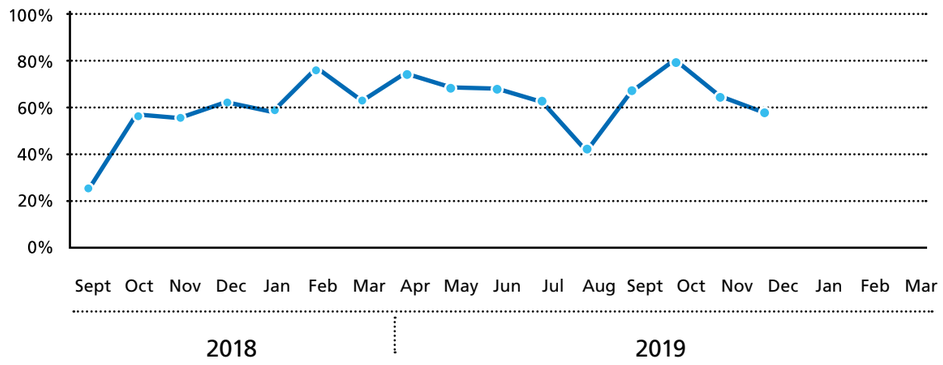
NEWS correctly calculated?



Total missed obs



Is nursing escalation/response to red/NEWS ≥5 documented on reverse of chart?



Plans for improvement 2020/2021

Further areas of focus throughout 2020/21 will be:

- Introduction of Electronic Vital Signs was part of the role out Electronic Patient Record (EPR) and took place in March 2020 early in the Trust's response to the COVID-19 pandemic.

- Recording

  In relation to 'recording' the e-system addresses the completeness as it will not allow incomplete sets to generate a score, in addition the score is automatically calculated so is always present and correct. The system will also determine when the vital signs should be repeated with the frequency determined by the score.

  This alerts staff to when vital signs are due and flags on the system when they are overdue. In time this data will used increasingly to ensure that observations are more likely to be completed with appropriate frequency.

  This real time data will be visible on EPR and on the interactive whiteboard.

  At present the e-system is not yet introduced to the Emergency Department (ED), Department of Critical Care (DCC) and theatres/ recovery but in time there will be increased coverage across these areas.

- Recognising

  The electronic system, based on the score derived, alerts staff members to the potential actions required, these include alerting medical team or the acute care response team. In effect recognising what is required. This is a guide for staff and different patients will need different responses.

  In time, as other systems are brought into EPR this will become more sophisticated – see below

- Reporting

  Staff members are required to report their concerns to appropriate personnel via the phone or bleep system.

  However the system does generate lists for the Acute Care Response Team (ACRT) which will identify to them all patients in the Trust with a score of 7 or above, or 5-6, this in time will aid the management of deteriorating patients, but alerts via the bleep or phone remain necessary in an emergency

  (Automated alerts may be possible in future but these are not possible at this present time.)

- Response

  The ACRT have been described as the canary in the coalmine as they cover every area of the Trust, across all specialities. In time they will become the first response to deteriorating patients and the team is being developed to ensure the service the team delivers can respond to all emergencies.

  This year the ACRT will use the data that electronic vital signs provides to aim to improve the response to vulnerable and deteriorating patients.

Actions in 2020/21

- Work with ward teams to ensure that they are aware of how to determine frequency of vital signs for all their patients, how to effectively escalate and how to record that escalation has taken place
- Work with EPR team to tweak the information and reports derived from e-vital signs to optimise patient care. For example to ensure that all patients have the correct frequency set for their NEWS2 score and that all vital signs are recorded in appropriate timescale
- Work with EPR on layout, graphs etc to optimise presentation and maximise effectiveness of information generated
- Identify aspects of data collection that could be included that had not been considered at the planning stage
- Plan for EPR to include notes entries and patient records – after which time of response/interventions will be recorded electronically and will not reply on paper records being scrutinised
- Plan for Fluid Balance to become part of EPR. This important element of patient care will become more accurate, with data more accessible, than on paper. For example the patients weight will be on the system and will determine the patient's urine output if the two variables can be amalgamated
- Results of blood tests amalgamated with e-vital signs will add even greater accuracy and completeness to the patient picture. Sepsis for example relies on NEWS2 and blood results combined.

Quality priority: To improve our learning into action systems: learning from our own local investigations

Background

Most conceptualisations of the learning organisations seem to work on the assumption that 'learning is valuable, continuous, and most effective when shared and that every experience is an opportunity to learn' (Kerka 1995). The following characteristics appear in some form in the more popular conceptions.

Learning organisations:

- Provide continuous learning opportunities
- Use learning to reach their goals
- Link individual performance with organisational performance
- Foster inquiry and dialogue, making it safe for people to share openly and take risks
- Embrace creative tension as a source of energy and renewal
- Are continuously aware of and interact with their environment (Kerka 1995).

How we have performed 2019/20

How we have improved the organisational learning capability:

Investigation: Human Factors Faculty

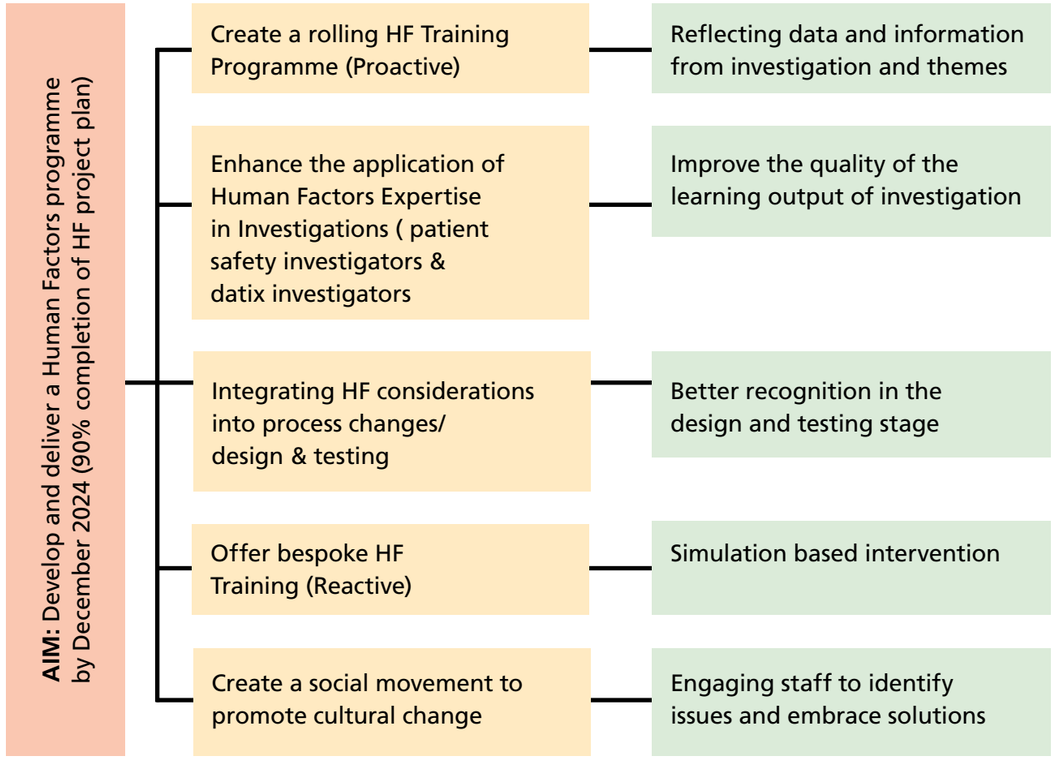
2019 saw the start of the Gloucestershire Safety and Quality Improvement Academy (GSQIA) journey to introduce a Human Factors (HF) Faculty. Through funding provided by the Hospital's Charity and subsequent 'Expressions of Interest,' 15 Faculty members successfully underwent Human Factors 'Train the Trainer' Training from an external training provider. This was part of the Trust's Quality Strategy, which identified the following key objectives:

Develop a Human Factors (HF) Faculty that improves:

- the technical assessment of serious incidents.
- system redesign and testing with simulation.
- human factors understanding across the Trust.

As with the GSQIA philosophy, it is not intended that the offer is solely training and through collaboration with the Faculty a HF driver diagram has been created to map the overarching Trust approach.

Figure 31: Our quality improvement driver diagram for human factors training



In order to utilise and embed the newly acquired skills of the HF Faculty and to start building a HF following, training is being tested through 4 half day sessions during March and April 2020. These have been advertised through the website, Twitter & 'This Week' and out of the 48 places on offer, only one place currently remains unfilled. Feedback from the training will be assessed and the HF offer will continue to be adapted and tested.

A full list of Faculty members and other information can be found on the website: https://intranet.gloshospitals.nhs.uk/departments/corporate-division/safety/Human-Factors/

Improvement Collaborative

Following the success of the Better Births collaborative, GSQIA have three new collaboratives programmed in for 2020 covering Patient Experience Improvement in Cancer Services and in CYPS (Children's and Young Peoples Services) as well as working with the Chief Registrars on a Deteriorating Patients Collaborative.

Additionally, the University of Gloucester approached us to work in collaboration with the 3rd year Student Nurses who for the first time this year will be joining a Silver project for part of the duration to gain an understanding of Quality Improvement in practice, and will be writing their dissertation on their experience and understanding of QI.

Network learning and sharing

The main function of GSQIA external work is to establish networks to share and learn quickly and effectively. One of the main networks is the Health Foundation Q network; we are currently one of the top 5 Acute Trust's in the country for membership.

GSQIA also promotes the sharing and development of all things QI. The GSQIA "Delivery Improvement Network' involves 30-40 different NHS organisation across the country involved in the network with meetings four times a year to share, learn and support QI practice.

There have been 5 #QIHour tweet chats hosted by GSQIA with four more planned this year. The chats are led by the GSQIA Coordinator and Trainer, and have had great engagement with a host of national leaders of improvement involved. The last network chat had over 6million impression on Twitter, and this work has been recognised as a "super-connector" in the QI community by Helen Bevan.

In December, we were successful in a bid led by the GSQIA in collaboration with the Clinical Commissioning Group and Gloucestershire Health and Care NHS Foundation Trust for some Q-Exchange funding, the award was £30,000 to deliver a project as follows:

To test collaborative approaches to facilitating 'wicked' system wide problems, from diagnosis through to improvement, whilst building QI capacity & capability through learning by doing.

The project stretches across the ICS and will use the End of Life team as the clinical platform for the project. The project was nationally reviewed and then selected through the Health Foundation Q network who voted for their preferred projects.

Plans for improvement 2020/21

1. Deliver an education programme of Human Factors

2. Through Human Factors approaches enhance the identification of causal factors for incidents, complaints and claims.

3. Create a programme of Quality Collaboratives for key quality initiatives

Quality priority: To improve our care for patients with diabetes in the perioperative period

Background

The Perioperative Quality Improvement Programme (PQIP) is a programme that aims to improve outcomes after surgery. One of our quality improvement programmes that was supported by our Gloucestershire Quality Improvement Academy (GSQIA) looked at the perioperative management of diabetic patients at the Gloucestershire Royal Hospital site (GRH).

Management of glycaemic levels in the perioperative setting is critical, especially in diabetic patients. The effects of surgical stress and anaesthesia have unique effects on blood glucose levels, which should be taken into consideration to maintain optimum glycaemic control. Each stage of surgery presents unique challenges in keeping glucose levels within target range. Additionally, there are special operative conditions that require distinctive glucose management protocols. It is known that careful glycaemic management in perioperative patients, reduces morbidity and mortality and also therefore improves surgical outcomes.

As a Trust, we have collected data on patients undergoing major surgery as part of PQIP since 2018 and diabetes management was identified as a key area for improvement.

The key indicators included:

- measuring glycated haemoglobin (HbA1c) on all diabetic patients before major elective surgery so that consideration of postponing non-urgent surgery if HbA1c>8.5% (HbA1c is your average blood glucose (sugar) levels for the last two to three months. A high HbA1c means you have too much sugar in your blood. This means you're more likely to develop diabetes complications, like serious problems with your eyes and feet).
- measuring blood glucose regularly and aiming for blood glucose levels of 6-12 mmol/l throughout surgery.

How we have performed 2019/20

In April 2019, we retrospectively reviewed the GRH PQIP database to identify patients with Type 1 or Type 2 diabetes. The team then audited the perioperative management of diabetes against the key indicators detailed above to identify areas for improvement.

After reviewing our Trust diabetes guidelines and PQIP recommendations, the following standards were set:

- 100% of patients will have an HbA1c measured before major elective surgery
- Postponing non-urgent surgery will be considered if HbA1c>8.5% in 100% of cases
- 100% patients will have a capillary blood glucose (CBG) measured on admission
- 100% of patients will have CBG measured hourly in the perioperative period
- Blood glucose levels will be kept at 6-12 mmol/l throughout surgery in 100% cases
- Variable rate insulin infusions (VRII) will be used if blood glucose >12 mmol/l in 100% cases

From reviewing the elective cases 14 patients were identified with diabetes out of a database of 86 cases (16%). Of the 14 cases, 5 were treated with insulin, 5 with non-insulin glucose lowering medication and 4 were diet controlled.

Overview: across all 14 patients, none of the audit standards were met 100%.

Figure 32: Audit results for perioperative care for diabetic patients

Audit standard measures	Results from audit
100% of patients will have an HbA1c measured before major elective surgery	Only 71% had an HbA1c measured, and in 29% the HbA1c was >8.5%.
Postponing non-urgent surgery will be considered if HbA1c>8.5% in 100% of cases	Out of the 4 cases with an HbA1c>8.5%, 3 were not delayed due to surgical urgency.
100% patients will have a capillary blood glucose (CBG) measured on admission	71% had a CBG measured on admission.
100% of patients will have CBG measured hourly in the perioperative period	None recorded hourly perioperative CBG's.
Blood glucose levels will be kept at 6-12 mmol/l throughout surgery in 100% cases	29% maintained CBG between 4-12 in the perioperative period
Variable rate insulin infusions (VRII) will be used if blood glucose >12 mmol/l in 100% cases	43% had a VRII appropriately commenced when CBG>12 mmol/L.

The case reviews showed:

The results have identified intraoperative measurement and documentation of CBG requires significant improvement. No cases recorded hourly perioperative glucose measurement. Several cases had no documentation at all throughout surgery. We have also identified not all patients had an HbA1c measured. Comparing our data with the national PQIP data, GRH has a higher proportion of diabetic patients (16% vs 13%) and those with an elevated HbA1c (29% vs 20%).

In order to improve practice, we introduced pre-operative assessment nurse training sessions, are establishing a nurse champion to assist with diabetic queries pre-operatively, referring high risk cases for post-op diabetic nurse follow up and forming a joint working group with diabetic liaison nurses to review the current pathway and assess impact of new insulin regimes and pumps.

Plans for improvement 2020/21

The Trust has developed a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.

We have started pre-habilitation programme prior to major surgery which aims to improve pre-operative conditioning of patients to improve post-operative outcomes. This programme of work is aimed to assess the effect of prehabilitation on post-operative outcome after major surgery and we hope to report on this work next year.

Quality priority: To improve our care of patients with dementia (including diagnosis and post diagnostic support)

Background

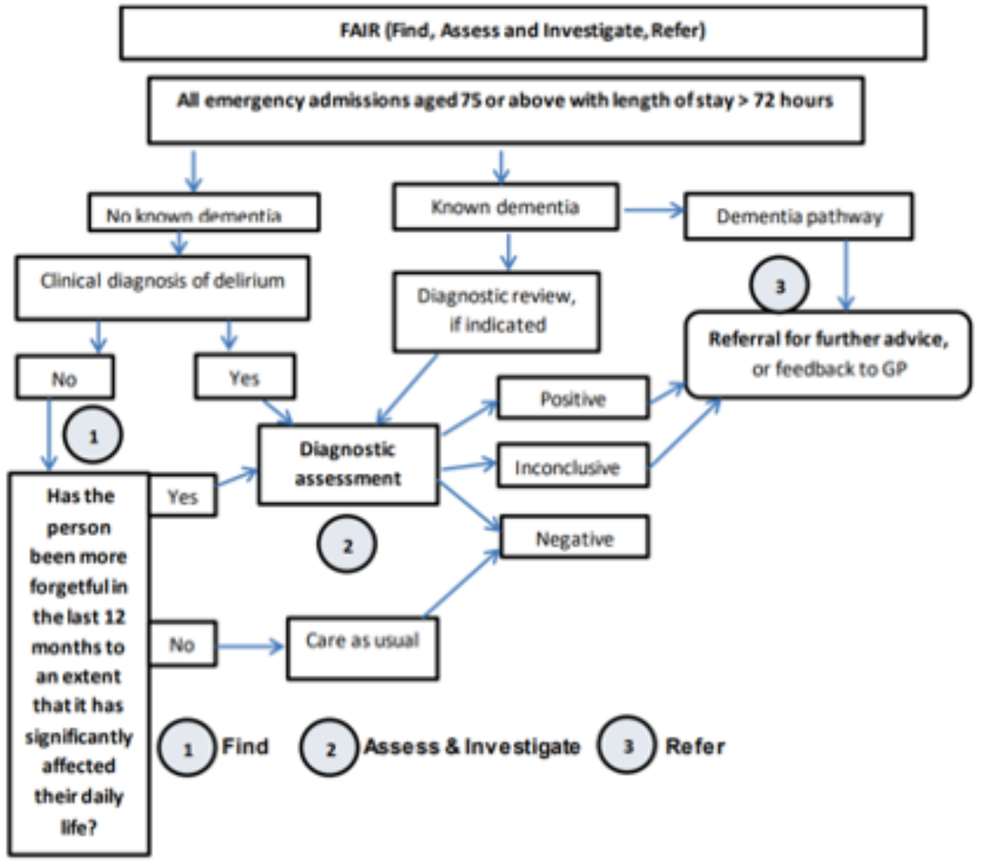
Dementia is an umbrella term used to describe a range of progressive neurological disorders. Alzheimer's disease and vascular dementia are the most prevalent, accounting for 79% of all diagnoses. Other forms include frontotemporal, Lewy body, Parkinson's dementia, corticobasal degeneration, Creutzfeldt-Jakob–Jakob disease and young-onset dementia (Alzheimer's Society 2017, Dementia UK 2017). Symptoms include change of thinking speed, mental agility, language, understanding, judgement as well as memory loss (NHS Choices 2017), but each affected person will experience dementia differently.

We report nationally on some quality indicators and dementia is one. This indicator reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been identified as potentially having dementia, who are appropriately assessed and who are referred on to specialist services. This is described with the acronym FAIR (Find, Assess/Investigate, Refer).

Figure 33: Quality indicator data components

Indicator	Data description and targets
Find	The case finding of at least 90 per cent of all patients aged 75 and over following emergency admission to hospital, using the dementia case finding question and identifying all those with delirium (using a clinical assessment of delirium) and dementia (that is, with a known diagnosis of dementia). This has to be completed within 72 hours of admission.
Assess and investigate	The diagnostic assessment and investigation of at least 90 per cent of those patients who have been assessed as at risk of dementia from the dementia case finding question and/or presence of delirium. The provider should carry out a diagnostic assessment including investigations to determine whether the presence of dementia is possible.
Refer	The referral of at least 90 per cent of clinically appropriate cases for specialist diagnosis of dementia and appropriate follow up, in accordance with local pathways agreed with commissioners. This may include referral to an old age psychiatry liaison team, with the person assessed in hospital, or it could be referral to a memory clinic or to the GP to alert that an assessment had raised the possibility of the presence of dementia.

Figure 34: Dementia FAIR Flow Chart



How we have performed 2019/2020

When we moved to a new Patient Administration System (Trakcare) reporting for this indicator declined which suggested to us that the new digital system had created issues for clinicians reporting because in previous years we had been able to demonstrate that FAIR clinical assessments were being carried out.

When carrying out the digital diagnostics, as to why our performance had declined, we found that the answers to the FAIR questions had to be recorded in different areas within the new record. The collection of the data was no longer simple and had become an additional burden to staff and therefore were not being completed. To test this theory, that clinicians were carrying out the assessments but were just not recording it in an area where the data could be extracted, an audit was carried out and all admission documentation was amended to include the dementia case finding question. Our audit demonstrated that our theory was correct and our performance improved from 0.3% (May 2019 digital extraction) to 67% (manual audit June 2019).

This data captured is reported monthly in the Trusts Quality and Performance Report (QPR), showing our compliance with the FAIR assessment tool.

Figure 35: Quality and Performance Report Dementia FAIR test screening.

Dementia Screening	18/19	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
% of patients who have been screened for dementia (within 72 hours)	1.9%	1.9%	0.8%	0.6%	0.4%	0.3%	67.0%	66.0%	85.0%	63.0%	62.0%	50.0%	37.0%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.9%	40.0%	0.0%	33.3%	100%	50.0%	0.0%	0.0%	N/A	50.0%	0.0%	0.0%	18.0%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	N/A	50.0%	N/A	N/A	0.0%

Plans for improvement 2020/2021

Early in 2020 NHS England and NHS Improvement held a consultation seeking views on the continuing suitability of the Dementia Assessment and Referral (DAR) data return. The consultation was open for eight weeks from Thursday 9th January until midnight 5th March 2020 but please note that due to the coronavirus illness (COVID-19) there will be a delay in the publication of the response to the consultation.

Our plan for 2020/21 will be to await national guidance and once published we will focus on improving the accuracy of our data.

Quality priority: To improve our nursing care standards through the Nursing Assessment and Accreditation System (NAAS)

Background

Evidence demonstrates that high quality nursing care is central to delivering the highest standards in our Trust and is essential to delivering the commitments made in our strategic objectives. We have developed standards against which quality and achievement of outcomes are measured to gain accreditation at ward and unit level. Accreditation brings together key measures of nursing and clinical care into one overarching framework to enable a comprehensive assessment of the quality of care at ward, unit or team level. When used effectively by the leaders of these areas, it drives continuous improvement in patient outcomes, and increases patient satisfaction and staff experience at ward/unit level. With a clear direction and a structured approach, it creates the collective sense of purpose necessary to help communication, encourage ownership and achieve high standards of care on a ward.

Our NAAS programme has been in place at the Trust since April 2018. The aim of the programme was to describe what "outstanding care" looked like and allowed individual areas to be measured against this. There are 13 quality standard (metrics) assessment areas within NAAS.

Standards included within the NAAS assessment programme

- Wards are organized and well managed
- Infection Control
- End of Life Care
- Safeguarding
- Safety: Vital Signs
- Safety: Environment
- Medicines Management
- Pain Management
- Nutrition and Hydration
- Person Centred Care
- Pressure Ulcers
- Elimination
- Communication

Figure 36: Key benefits of a positive practice environment

Key benefits of a positive practice environment	
Quality	Reduces unwarranted variation by providing an evidence-based, standardised approach to supporting the delivery of care and improving quality.
Safety	Provides a platform for shared learning so that wards and units can learn from safety incidents and each other.
Leadership	Provides ward-to-board assurance on the quality of care and demonstrates compliance with fundamental standards which enables preparedness for external inspections.
Wellbeing	Increases staff engagement, encourages team working and improves staff morale.
Professional development	Creates a culture of pride and accomplishment and supports collective leadership, personal and professional development.
Shared decision making	Creates a platform for continuous improvement in patient safety and patient experience, and encourages staff engagement in local quality improvement projects.

Data

The NAAS team visits the ward or unit on the assessment day to carry out the assessments. This assessment team comprises two to three assessors. The assessors are given clear written guidance on carrying out the review and use our assessment tool. The assessment takes place in one working day. The assessment team meets mid-review to discuss progress, cross-check findings and discuss any issues identified up to that point. The ward or unit manager is the final person to be interviewed so that any questions arising from any of the assessments, observations or the assessment team can be asked and clarification sought. The assessment team then meets for a final time to discuss findings, cross-check the evidence and agree the final assessment outcomes.

The standards documentation includes the identified measures and examples of the evidence required for the assessment. Each standard is given a rating using a red – amber – green (RAG) rating system. A set of rules was developed to assess the overall achievement of the ward accreditation.

These are:

Assessment final outcomes	
Red	At least 5 red individual standards
Amber	3-4 red individual standards
Green	1-2 red individual standards
Blue: Area of Outstanding Care (AOC)	Assessed as green on 3 consecutive assessments and all standards met

There were 39 clinical areas that were included in the first NAAS programme of assessments. The first round of assessments was completed in January 2019 and the second round of assessments were completed in August 2019 with most areas showing an overall improvement.

A written accreditation report was prepared and distributed to the ward/unit manager, matron, and divisional director of quality and nursing within a few weeks of the assessment. Where required, the ward or unit manager, supported by the matron, prepared and then submitted an improvement plan within a few weeks of receiving the report and support was provided to the ward. The ward was then reassessed within a mutually agreed timescale.

Figure 37: Final NAAS assessment outcomes for wards for round 1 and 2

Ward outcomes	Red	Amber	Green	Blue
Round 1	33%	13%	54%	0%
Round 2	0%	13%	87%	0%

Figure 38: Results of Round 2 assessment outcomes by Division and site

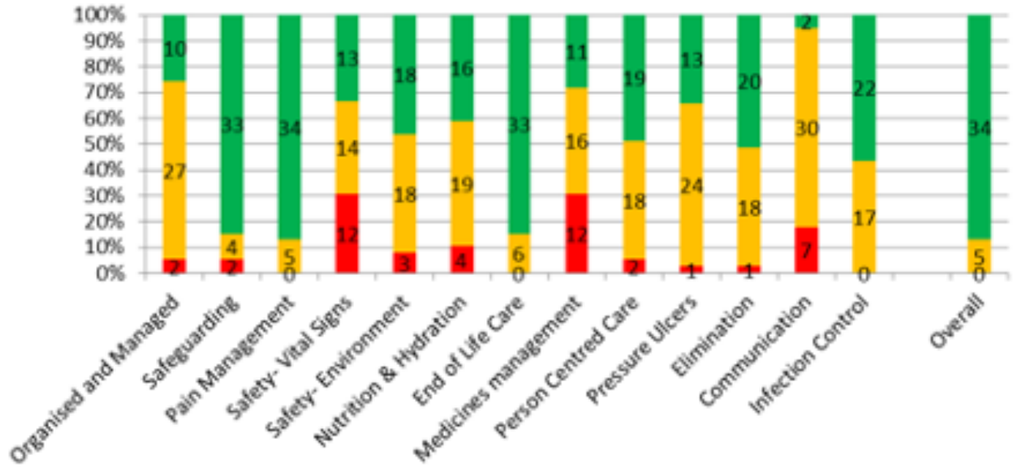
Medical Division			
GRH		**CGH**	
4A		ACUC	
4B		Avening	
6A		Cardiac	
6B		Emergency Dept.	
7A		Knightsbridge	
7B		Ryeworth	
8A		Snowshill	
8B		Woodmancote	
9B			
AMU			
Cardiology			
Emergency Dept.			

Diagnostic and Specialty Division			
GRH		**CGH**	
Gallery		Lilleybrook	
		Rendcombe	

Surgical Division			
GRH		**CGH**	
2A		Alstone	
2B		Bibury	
3A		Chedworth/Kemerton	
3B		Dept. Critical Care	
5A		Dixton	
5B		Guiting	
Dept. Critical Care		Prescott	
Mayhill			

Women and Children's Division (GRH)		
GRH		**CGH**
Gallery		

Figure 39: Round 2 NAAS breakdown of outcomes by standard



Work on reformatting the assessment tool used has been ongoing throughout 2019/2020 as a response to conversations generated throughout the Trust as a result of the initial implementation phase. The new tool (now labelled as NAAS2) has considered our current position and describes the next milestone in our journey towards outstanding care in our ward areas. Our new "NAAS" tool has been trialled across 3 clinical areas. Areas within the current programme are currently completing a self-assessment and the first Round 3 assessments are booked to take place in 2020/21. There will be a drive across the Trust to have our first 'Blue' wards whilst achieving 60% 'Green' wards across both sites.

When a ward achieves Blue Assessment, this will mean that they have achieved accreditation and those wards will be awarded a certificate. Ward accreditation will be celebrated throughout the trust and certificates will be proudly displayed.

Plans for improvement 2020/2021

One of our key objectives in 2020/21 is introduce the American Nurse Credentialing Centre (ANNC) Pathway to Excellence Programme. This programme provides a framework which we will use to create healthy workplaces for our nursing and midwifery staff. Pathway to Excellence also supports the implementation of shared governance – the harnessing of collective nursing and midwifery leadership to influence and drive change. We see ward accreditation as a key enabler of the introduction of our new shared governance approaches.

Work on a Maternity equivalent to NAAS2 will begin April 2020 as well as discussions for developing a paediatric equivalent. There will be a case study written for the Chief Nursing Officer of England's "Shared Governance: Collective Leadership" Atlas of Shared Learning.

Figure 40: Final NAAS assessment outcomes for wards for round 1 and 2

	Red	Amber	Green	Blue
Ward outcomes	0%	30%	60%	10%

Quality priority: To improve our infection prevention and control standards by reducing our Gram-negative blood stream infections

Background

The Secretary of State for Health has launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021. Gram-negative bloodstream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015.

How we have performed 2019/20

All episodes of Gram negative bacteraemia (E.coli, Klebsiella species and Pseudomonas aeruginosa) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements. The Department of Health and Social Care (DHSC) has required Trusts to submit mandatory surveillance data on Escherichia coli bloodstream infections since June 2011.

Escherichia coli is part of the normal bacterial flora carried by all individuals. It is the commonest cause of clinically significant bloodstream infection. E. coli bacteraemia represents a heterogeneous group of infections. E.coli constitutes the most common Gram-negative bacterium detected from clinical microbiology samples; in Gloucestershire there are on average 22 E.coli bacteraemias each month. Most E. coli bacteraemia are not a reflection of Health Care Associated Infection (HCAI); most occur in patients due to underlying disease and are related to common infections such as urinary tract infection, intra-abdominal sepsis and biliary tract infection. Most of these infections commence in the community (but being detected when patients are admitted for investigation and treatment). A proportion of the E. coli bacteraemia are healthcare-associated and are related to recent previous hospitalisations and invasive interventions performed on patients, the most important of which is urinary catheterisation. A full break down on monthly E. coli bacteraemia cases can be seen in the below table. Monthly incidence of E. coli cases is seen in Figure 39. It is now necessary to report patient episodes where blood cultures have yielded Klebsiella species and Pseudomonas aeruginosa and these figures can be seen in Figure 41 and Figure 42.

Figure 41: Monthly number of E. coli cases Day 0 is taken as day of admission

Month	Time of E. coli bacteraemia acquisition	
	Day 0+1 CASE	After day 0+1
Totals 2019/20	**225**	**44**
April 2019	10	5
May 2019	21	4
June 2019	23	5
July 2019	13	1
August 2019	21	4
September 2019	9	3
October 2019	18	2
November 2019	13	5
December 2019	20	9
January 2020	8	3
February 2020	15	3
March 2020	14	2
Total 2019/20	**185**	**46**

Figure 42: Monthly number of Klebsiella sp. cases Day 0 is taken as day of admission

Month	Time of Klebsiella bacteraemia acquisition	
	Day 0+1 CASE	After day 0+1
Totals 2019/20	**52**	**31**
April 2019	3	1
May 2019	5	3
June 2019	7	1
July 2019	3	1
August 2019	3	3
September 2019	4	2
October 2019	4	1
November 2019	4	1
December 2019	3	1
January 2020	2	1
February 2020	1	2
March 2020	2	1
Total 2019/20	**41**	**18**

Figure 43: Monthly number of Pseudomonas aeruginosa cases

Day 0 is taken as day of admission

Month	Time of Pseudomonas bacteraemia acquisition	
	Day 0+1 CASE	After day 0+1
Totals 2019/20	**19**	**12**
April 2019	1	1
May 2019	0	0
June 2019	0	0
July 2019	2	2
August 2019	0	1
September 2019	0	0
October 2019	2	1
November 2019	2	0
December 2019	1	0
January 2020	2	3
February 2020	2	0
March 2020	0	1
Total 2019/20	**12**	**9**

Plans for improvement 2020/21

To achieve 3-5% reduction in hospital acquisition of Gram negative blood stream infections, a focus of our 2020/21 infection prevention and control strategy will be to address key areas for improvement using our insights/data. The following projects have been identified:

- Hepatobiliary Tract

  The Gram-negative blood stream infections associated with a hepatobiliary tract source; a source not addressed in previous plans at Gloucestershire Hospitals NHS Foundation Trust. Reviews of cases of Gram negative blood stream infections with a hepatobiliary source during 2019/20 will be undertaken to identify whether Cholecystectomy on first presentation of Cholecystitis could have prevented a Gram-negative blood stream infections. This will be used to explore consideration for a 'hot gallbladder' pathway to support appropriate and prompt cholecystectomy in line with NICE guidance.

- Urinary Tract Infections

  The plan will also continue to address Gram negative blood stream infections related to urinary tract infections and catheter associated urinary tract infections with the Trust wide launch of 'Alert before you insert', which is a process to guide staff on appropriate catheter insertion. This will also be supported by education and training for Nurses and Medical staff to competently insert catheters using an aseptic technique. A pilot across the Trust is also planned in which Chlorhexidine 1% sterile wipes will be used for meatal cleaning on catheter insertion, which has been evidenced to reduce catheter associated urinary tract infections. Engagement of the Trust will continue in the countywide urinary tract infection group which delivers system wide actions to prevent and manage urinary tract infections and catheter associated urinary tract infections effectively.

- Mouth Care Matters

  The mouth care matters programme will be enhanced so it can be delivered across the system to support reductions in Pneumonia and associated Gram negative blood stream infections.

- Surgical Site Infections

  The Trust will also continue to participate in the 'PreciSSIon' West of England Academic Health Science Network collaborative; which delivers an evidence-based bundle to reduce colorectal surgical site infection and is supported by an enhanced Surgical Site Infection surveillance programme.

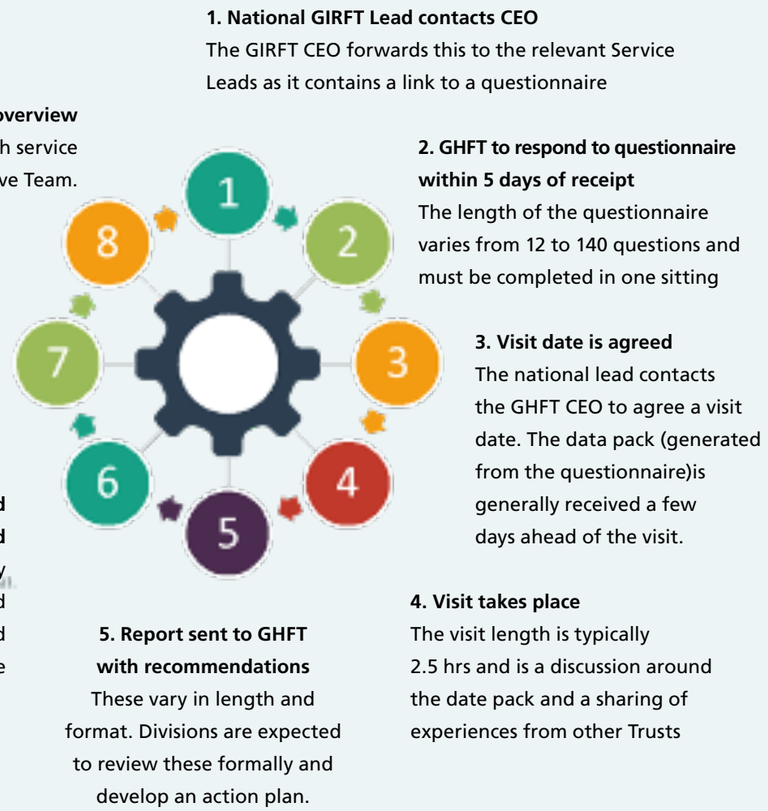
Quality priority: Rolling out of Getting It Right First Time standards in targeted standards

Background

Getting It Right First Time is a national programme founded by Professor Tim Briggs, GIRFT Chair & National Director of Clinical Improvement at NHSI, and is designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between Trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and sometimes resultant cost savings.

A process for the implementation of the GIRFT actions has been set up within the Trust. There is a clinical lead and manager who work with the specialties to support the completion of the actions and who organise the initial deep dive meetings and have now started the executive report. The GIRFT implementation team report progress in to our Trust Quality Delivery Group.

Figure 44: GIRFT Process for Services at GHNHSFT



How we have performed 2019/2020

Of the 39 + specialties monitored by GIRFT, 31 + relate to Gloucestershire Hospitals NHS Foundation Trust of which 26 services have been visited to date.

An annual review with the executive team for each specialty has now been set up as some of the actions required are not only within the gift of each service but have implications to service redesign and sometimes countywide input. Eleven services have completed this process presenting their progress, achievements and concerns.

Key progress to note:

- A litigation report has been prepared for the Trust, which is currently being validated by the legal department; all specialties are keen to have regular feedback of litigation as the majority were unaware of a number of claims against them.
- The Ophthalmology service has been an identified as an exemplar of good practice in pioneering non-medical injectors for age-related macular degeneration and diabetic retinopathy in Gloucestershire. This has been adopted by the Royal College of Ophthalmology.
- The Trauma and Orthopaedic service has been used as an example of good practice in enacting a "Hot/Cold" site split for elective and trauma work. Other Trusts have been directed to Gloucestershire to observe how this has been done.
- The quality of coding has been identified as an area across all specialties with significant opportunities to improve both data quality and income. A standardised approach for review of opportunities for improvement, using a PDSA approach has begun.
- Specialties have all engaged with the process and are identifying QI opportunities. Specialties are also identifying their own areas of priority for improvement/action, based on data not reviewed, or more contemporaneous than that used by GIRFT.
- A Medical Forum for review of shared learning is being established for medical specialties that have embarked on the GIRFT process. The aim of this will be to use the diversity of approaches taken by the national specialty teams to enrich our own understanding of patient quality and safety issues, and identify common opportunities for improvement.
- The Paediatric Surgery specialty is the first to complete all the GIRFT recommendations.
- There has been a surgical site infection audit organised by the GIRFT team, and the Trust has contributed for Breast and Orthopaedic Surgery.
- GIRFT is also championing the veteran's aware process; this is to ensure that ex forces personnel are able to access expert care within the NHS and are not disadvantaged by moves to different areas. GIRFT Veteran's Covenant Hospital Alliance accreditation was achieved in April 2019.
- The Trust have been working to raise the profile of GIRFT with staff, and an intranet page specifically relating to GIRFT is now displayed as part to the Trust intranet site.

The following services have had GIRFT reviews and have started working on the recommendations:

Figure 45: GIRFT reviews of Services at GHNHSFT

Speciality	Date of Deep Dive Visit	No. of GIRFT recommendations /actions	No. of National recommendations /actions	No. GIRFT recommendations completed	No. GIRFT Actions Making progress/ on track	No. GIRFT Actions that will be delivered late	No. Off track no plan to recover	No. of local actions
Acute and General Medicine	18/11/2019	27	0	0	0	0	0	0
Anaesthetics & Perioperative Medicine	23/11/2018	8	2	2	6	0	0	2
Breast Surgery	28/05/2019	13	0	0	13	0	0	0
Dermatology	19/12/2018	18	0	0	18	0	0	0
Diabetic Medicine	22/01/2019	15	0	1	14	0	0	0
Emergency Medicine	11/10/2018	7	0	2	5	0	0	0
Endocrinology	02/11/2018	6	0	0	6	0	0	0
Ear Nose & Throat Surgery	21/04/2017	10	0	4	6	0	0	0
Gastroenterology	16/08/2019	18	0	0	0	0	0	0
General Surgery	13/03/2018	5	23	16	11	1	0	2
Geriatric Medicine	05/11/2019	17	0	1	16	0	0	0
Hospital Dentistry	20/09/2019	13	0	0	0	0	0	0
Imaging & Radiology	09/12/2019	28	0	0	28	0	0	0
Litigation	N/A	0	4	3	1	0	0	0
Neurology	24/06/2019	8	0	0	8	0	0	0
Obstetrics & Gynaecology	29/11/2017	13	0	11	1	1	0	1
Oral and Facial	21/04/2017	7	18	8	17	0	0	1
Ophthalmology	30/08/2017	7		3	1	3	0	0
Orthopaedics	10/01/2017	28	25	49	3	1	0	4
Paediatric Surgery	11/08/2017	9	0	9	0	0	0	2
Renal Medicine	11/01/2019	9	0	1	8	0	0	0
Spinal Surgery	23/11/2016	7	20	13	13	1	0	0
Stroke Medicine	06/06/2019	16	0	3	13	0	0	0
Trauma Surgery	10/01/2018	28	15	39	2	2	0	3
Urology Surgery	21/06/2017 10/02/2017 revisit	12	18	10	2	0	0	0
Vascular Surgery	13/12/2019	17	34	28	21	2	0	0

Plans for improvement 2020/21

Work will continue to raise the profile of this work in the coming year. There will be ongoing work for all services to complete the recommendation by GIRFT. In addition, deep dive visits are arranged in the next few months for Cardiology and Rheumatology and dates for Respiratory, Neonatal medicine and Lung Cancer are imminent.

There are a number of actions that are very challenging and will require multiple agency working. Reconfiguration of General Surgery continues with public engagement.

The GIRFT national teams are also publishing national reports with generalised recommendations for all Trusts. So far reports for Orthopaedics, General Surgery, Vascular Surgery, Oral and Maxillofacial Surgery, Spinal Surgery, Ear Nose and Throat Surgery, Ophthalmology and Urology have been received. Work will continue to check that we are compliant with these recommendations.

The early reports were within the surgical division and many of the actions were within the gift of the specialty. Over the past year many of the deep dive presentations have involved the medical specialties. Many recommendations for medical specialties involve multidepartment collaboration and a Medical Forum for review of shared learning is being established for medical specialties that have embarked on the GIRFT process. The aim of this will be to use the diversity of approaches taken by the national specialty teams to enrich our own understanding of patient quality and safety issues, and identify common opportunities for improvement.

Quality priority: Delivering the 10 standards for seven day services (7DS)

Background

There is a national driver to deliver hospital services seven days a week and this improvement programme is called Seven Day Services (7DS). 7DS provision is about equitable access, care and treatment, regardless of the day of the week. The level of service provided should ensure that the patient has a seamless pathway of care when accessing services, no matter what day of the week.

Ten clinical standards for **seven day services** in hospitals were developed in 2013 through the **Seven Day Services** Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care.

Figure 46: The Ten 7DS Standards with descriptions

No.	7DS Standard	Description
1	Patient experience	Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.
2	Time to first consultant review: **priority**	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.
3	Multidisciplinary team Review	All emergency inpatients must have prompt assessment by a multi-professional team to identify complex or on-going needs, unless deemed unnecessary by the responsible consultant. The multi-disciplinary assessment should be overseen by a competent decision-maker, be undertaken within 14 hours and an integrated management plan with estimated discharge date to be in place along with completed medicines reconciliation within 24 hours.
4	Shift handovers	Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.
5	Access to diagnostic tests: **priority**	Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and their reporting will be available seven days a week: ▸ within 1 hour for critical patients; ▸ within 12 hours for urgent patients; and ▸ within 24 hours for non-urgent patients
6	Access to consultant directed interventions: **priority**	Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: ▸ critical care; ▸ interventional radiology; ▸ interventional endoscopy; and ▸ emergency general surgery.
7	Mental health	Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: ▸ Within 1 hour for emergency* care needs ▸ Within 14 hours for urgent** care needs
8	Ongoing review by consultants twice daily if high dependency patients daily for others: **priority**	All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.
9	Transfer to community, primary and social care	Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.
10	Quality improvement	All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

7DS four priority standards (2, 5, 6 & 8)

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- **Standard 2** – Time to first consultant review
- **Standard 5** – Access to diagnostic tests
- **Standard 6** – Access to consultant-directed interventions
- **Standard 8** – Ongoing review by consultant twice daily if high dependency patients, daily for others.

7DS standards for continuous improvement (1, 3, 4, 7, 9 & 10)

The remaining six clinical standards are collectively referred to as the 7DS Standards for Continuous Improvement, and taken as a whole, impact positively on the quality of care and patient experience.

Monitoring improvement

Our Trust is required to provide an update to NHS Improvement about how we are progressing. We have previously completed a bi-annual self-assessment survey and this process changed to a self-assessment called a board assurance framework. The new tool was launched in November 2018. The new measurement system consists of a standard template that all trusts complete with self-assessments of their performance against the 7DS clinical standards, supported by local evidence. This self-assessment was then formally assured by our Board. Our Board then decided on appropriate improvement processes, trajectories, details and timetables.

How we have we performed 2019/20 and data

This section shows how we are performing and our self-assessment, identifies the gaps we have in 7DS provision and shows where we are going to focus for improvements. The board assessment template provides an assessment of the priority clinical standards and a narrative of the clinical standards for continuous improvement (1, 3, 4, 7, 9, 10).

We have submitted data in the new format to NHSI:

- Trial run Jan – Feb 2019
- Spring June 2019
- Autumn November 2019

Four priority standards

In June and November (to be validated by NHSI) 2019 our data confirmed, of the 4 priority standards,

- We are meeting standards 5 and 6.
- We are not meeting standards 2 and 8.

7DS Clinical Standards for Continuous Improvement

The remaining six clinical standards are collectively referred to as the 7DS Standards for Continuous Improvement, and taken as a whole, impact positively on the quality of care and patient experience. The Trust is required to provide narrative against each standard to explain work being undertaken in relation to their delivery and overall improvement. There is no requirement for evidence or assessment of meeting the standards.

Figure 47: Summary of results

No.	7DS Standard	June 2019	July audit for Nov 2019
1	Patient experience	Narrative provided	
2	Time to first consultant review (priority)	Not met	Not met
3	Multidisciplinary team Review	Narrative provided	
4	Shift handovers	Narrative provided	
5	Access to diagnostic tests (priority)	Met	Met
6	Access to consultant directed interventions (priority)	Met	Met
7	Mental health	Narrative provided	
8	Review by consultants twice daily if high dependency patients daily for others (priority)	Not met	Not met
9	Transfer to community, primary and social care	Narrative provided	
10	Quality improvement	Narrative provided	

A summary of our improvement work

- Daily review at weekends
  - Service Directors have been sent the assessment findings and have been asked to re-review consultant job plans to ensure their provision is adequate in order to reliably and consistently meet this clinical standard including the need for additional staff if necessary
  - We have made clear processes for the identification and documentation of patients not requiring daily review at the weekend.
- Consultant review < 14 hours of admission
  - Ward round practice is being reviewed to ensure that new patients are seen earlier
  - Focused work with particular specialities with poorer performance including reviewing the need for additional staff
  - We have undertaken the education of junior doctors about post take ward round documentation including documenting the time of review – a lack of documented time accounted for 30% of our inability to meet this standard.

Plans for improvement 2020/2021

The Medical Director met with a member of the NHSI South West team in November 2019 and discussed current position and plans for improvement. We are awaiting formal feedback on our November 2019 submission. We are continuing with ongoing recruitment into vacant Consultant Posts which will help with 7DS delivery (2 possible recruitments to Acute Medicine, 3 new recruitments to Care of the Elderly).

Our 7DS delivery and our lack of compliance with priority standard 2 and 8 is in the process of being added to our Trust risk register as we are at risk of achieving these 2 standards.

The Trust will be required to submit its next 7DS self-assessment to NHSI in spring 2020 (date pending) and our improvement work will continue.

Areas we will be reviewing and focusing on, as suggested by NHSI include:

- patient Length of Stay (LOS) for admitted at weekend vs weekday,
- updated Hospital Standardised Mortality Ratio (HSMR) weekend versus weekday,
- updated patient feedback & complaints directly related to the weekend, and
- an overview of ongoing projects which relate to 7DS (e.g. patient flow board round project and our criteria led discharge project).

Quality priority: To deliver the programme of Better Births (maternity care) continuity of carer (CoC) improvement programme

Background

On 22 December 2017, the Maternity Transformation Programme published Implementing Better Births: Continuity of Carer, to help our Local Maternity Systems (LMS) plan and deploy continuity of carer models in our services. The evidence shows that women want and benefit from continuity of carer. The Cochrane research review (2016) found that women who received midwife-led continuity of care were less likely to experience preterm births or lose their baby in pregnancy or in the first month following birth. The research evidence showed that women were:

- 16% less likely to lose their baby
- 19% less likely to lose their baby before 24 weeks
- 24% less likely to experience pre-term birth.

Equally, safety is not just about whether their baby lives or dies; safety for childbearing women and their partners and families also means emotional, psychological, and social safety. This holistic sense of safety is what they receive through continuity models of care.

Being a recipient of continuity of care from the same one or two midwives is very different to experiencing the care delivered through more traditional models of midwifery which in some areas can mean meeting a different midwife at every appointment. Becoming comfortable with someone, building a relationship with them which grows and deepens over time, enables trust to develop and women begin to share their deeper anxieties and insecurities as well as enjoying the more positive aspects of growing knowledge and confidence through a supported journey of discovery.

Midwives benefit too. For a midwife, getting to know the woman, and developing a trusting relationship with her during her pregnancy, is the best way to help her have a safe, positive and empowering experience of pregnancy birth and parenthood, whilst maintaining and strengthening clinical expertise across all areas of maternity care.

In a continuity model, in close collaboration with her colleagues from across the multidisciplinary team, midwives have a critical role to play in ensuring that women are physically and psychologically well, so that they can develop a responsive and nurturing relationship with their children.

How we have performed 2019/20

To help generate momentum and ensure that the NHS is on track to deliver the ask that most women receive continuity of carer by March 2021, Refreshing NHS Plans for 2018/19 requires LMS to ensure that from March 2019, 20% of women at booking are placed onto continuity of carer pathways and receive continuity of the person caring for them during pregnancy, birth, and postnatally.

Figure 48: Percentage of women booked on Continuity of Carer pathways April – March 2019/20

Target	Q1	Q2	Q3	Q4	YTD Total
> 35%	7.8%	8.2%	11.7%	*4.6%	8.0%

** Stroud no longer included in CoC from January 2020 onwards*

Figure 49: Annual summary of continuity of Carer pathways actuals and targets

Year	National Target %	Trust Projected Trajectory %	Actual figures achieved %
2018/2019	20	10.29	10.3%
2019/2020	35	10.54	8.0%
2020/2021	50	30.00	
2021/2022	50	35.00	
2022/2023	50	40.00	
2023/2024	50	51.07	

During 2019/20, the Better Births clinical team has engaged with staff in a number of ways regarding Continuity of Carer and the requirement to meet the national target of 50% of women to be on a continuity of carer pathway.

Two pilot models of continuity of carer were continued to achieve 10% of women on a Continuity of Carer pathway; unfortunately, one of the models was not sustained while one model continues. Following the pilot, it was clear that to achieve the target a business case would be required. A business case was developed by the Multidisciplinary Team and was agreed by the Gloucestershire Clinical Commissioning Group (CCG) in March 2020.

Plans for improvement 2020/21

In addition to focussing on increasing the number of women who are on a Continuity of Carer pathway in 2020/21, the implementation of Continuity of Carer Improvement programme will be focused in areas of highest deprivation and for our Black and Minority Ethnic (BAME) communities in Gloucester City and Cheltenham.

Quality priority: To improve our care of children transitioning to adult care

Background

Following some work around the Transition CQUIN in 2015-2017, a significant gap in service provision was identified, particularly in relation to young people with Life Limiting (LL) and Life Threatening Conditions (LTC). With the advances in medical knowledge and intervention these young people are now surviving into adulthood presenting with complex medical, social and educational needs. Transitioning to adulthood for any young person presents its challenges but for this group it was identified that there were many additional hurdles to face.

In order to meet national guidelines and recommendations during transition, all aspects of the young person's care need to be considered and co-ordinated. This is called the pentagon of support and includes healthcare, social care, education, housing and work/life balance. With current data, we are estimating that there will be 10-15 young people that will fall within this group per year, however it is recognized nationally that this number will be increasing year on year. Currently the following areas have been identified as risks or issues:

- This group of patients present with life-limiting, multi-systemic medical problems and, although not exclusively, a profound learning disability. The complex nature of these young people makes their care in adult services difficult due to the multiple clinicians that need to be involved and a lack of a 'helicopter' clinician who can provide holistic, symptomatic care.

- Due to this complexity, these young people require a different skill set and additional layers of support that is not currently available from an adult clinician or their team. As many of these young people have potentially life-limiting conditions which fall into a broader range than traditionally seen in Adult Specialist Palliative Medicine, the skill base of these clinicians can easily be transferred to managing this caseload providing the holistic 'helicopter' service that is required.

- As these young people transition to adult services they will need to access various teams/services. Each service has a different age at which they will engage with the young person. For example, the adult learning disability team will not accept a referral until the young person is 17.5 years old and their service is commissioned from 18 years. The transitional process cannot therefore take place and the young person is transferred to adult care.

- Equipment – the provision, supply and adaptation of equipment is different in adult services, and equipment also 'gets lost' during transition. There are also the challenges of available equipment in acute adult services e.g. hoists, communication aids

- Training needs for adult colleagues, particularly around medication such as paraldehyde and clinical interventions such as the use of Porta Catheters.

How we have performed

Recognising the gap in service, one of the Adult Specialist Palliative Medicine consultants (ASPMC), who had a particular interest in this client group has over the years, provided care for several young people with LL/LTC into her caseload providing them with a 'helicopter' holistic medical service, undertaken as a non-commissioned pilot. The Trust also appointed a new and innovative role of a Paediatric Neurodisability Nurse Specialist (PNNS). They have worked closely with the ASPMC on individual cases resulting in the provision of high quality transitional care for this client group.

The pilot undertaken by the ASPMC and the PNNS has shown that this model of care provides the young people and carers of this client group with a service that 'spans the gap' to adult services.

A business case has been agreed to develop a transition pathway and identify an adequate resource to oversee the holistic transition of young people with LL/LTC that is not currently addressed using the Ready Steady Go Hello programme or current clinical services.

Our proposal is for a commissioned service consisting of 2 posts:

1. Medical co-ordinator who will work with consultant paediatricians and adult specialties providing a holistic medical overview of health care needs during the transitional period ensuring that robust primary and secondary teams are in place

2. Transitional care co-ordinator who will work closely with the medical co-ordinator ensuring that all aspects of transition for these young people are identified and addressed

The aim of the new service would be that all young people between the ages of 14 – 25 years with a LL/LTC with complex medical, social and educational needs will have:

- An identified transition care coordinator

- A medical professional to co-ordinate medical care across specialities, primary and secondary care

- A personalised transition plan in place

- A treatment escalation plan / ReSPECT form in place

- Improved experience of transition for themselves and their families

- Confidence in their new teams

Plan for improvement 2020/21

In 2020/21, we will be focussing on setting up the new service, the benefits of which include:

- Young people with a LL/LTC and their families will have an identified transitional medical and care co-ordinator who will navigate this part of their journey with them ensuring they are embedded into adult primary and secondary services

- Increased competence and confidence of adult services to manage the medical, social and educational complexity of these young people

- Using a new and innovative approach to address a nationally recognised need

- Commissioner will have a better understanding of the numbers and needs of this group of young people transitioning to adult services

This will be done in partnership with Trust Paediatric and Adult leads, as well as the Clinical Commissioning Group Lead for Transition, to develop the transition work within the Trust further whilst maintaining the progress achieved following the CQUIN implementation of the Ready Steady Go Hello pathway.

In addition to the business case, a scoping exercise was commissioned to look at all specialties of children transitioning from children to adult services to review what the process and care was given to young people through the transition pathway. The specialty review against the NICE Standard's 5 statements can be seen below. This review will form the baseline that shows the number of services currently starting transition at year 9, which will form the basis for our improvement programme in 2020/21.

Figure 50: Results of speciality review against NICE Standard's 5 Statements

Specialty	Statement 1 Ready, Steady Go started at 14?	Statement 2 Documented annual review (or transition clinic?)	Statement 3 Keyworker?	Statement 4 Meet adult consultant/ team?	Statement 5 Chased if DNA?
Asthma	Specific few patients	No unless at GP's	CNS	Consultant/ CNS Majority GP care	Yes
Allergy	No	3yrly OPA's	CNS	N/A: GP care	N/A: GP care
Bladder & Bowel	No	Yes	CNS	CNS to CNS	Yes
Children's Community Nursing/ Complex Care (GHC)	No	May be documented as part of TAC/EHCP review	CNS of co-morbidity e.g. Neuro-disability takes lead	CCN to Integrated Care Team (Adult District Nurses)	No
Congenital Cardiology	Yes, if seen at BCH, no at GRH	Yes, at BCH otherwise Informal	CNS at BCH	At BCH GRH: Consultant letter only	No
Cystic Fibrosis	Yes	Yes	CNS	Yes, MDT in Bristol	Yes, by Bristol
Dermatology	No (but willing to start)	informal	CNS	Yes	Yes
Diabetes	Yes	Yes	CNS/Dietician	Yes MDT: Young Person's Clinic	Yes
Endocrine	No	Informal	CNS	Some sub-specialities only	No
Epilepsy	Yes	Yes	CNS	Yes	Yes
ENT	?	n/a	n/a	Same team	No
Enteral Feeding Team	No	Informal	CNS/Dietician	CNS/Dietician	Yes
Gastro-enterology	No	Informal	No	Consultant to Consultant	No
Haematology	No	n/a	No Pead's CNS	? Consultant letter	No
Hepatology	No	n/a	No Pead's CNS	No	No
Immunology	No	n/a	No Pead's CNS	Visiting Bristol Consultant, adult CNS/ Sister Edward Jenner	No
Long Term Ventilation (Respiratory)	Yes, If co-morbidity	informal	CNS BCH CNS GRH	BCH to BRI or GRH to adult respiratory	Yes
(Complex) Neurodisability	n/a: work with parents	With parent/ carer/ TAC/ EHCP	CNS/MDT	CNS/MDT	Yes
Oncology	No	Informal	CNS	Young person clinic Bristol	Yes

Specialty	Statement 1 Ready, Steady Go started at 14?	Statement 2 Documented annual review (or transition clinic?)	Statement 3 Keyworker?	Statement 4 Meet adult consultant/ team?	Statement 5 Chased if DNA?
Pain e.g. Chronic Fatigue	No	No	CNS/ consultant	No handover from Specialist Children's Services (Bath) to local pain team	No
Physiotherapy (GHC)	Yes	n/a	Physio	GHC physio to GHFT physio	No
Primary Ciliary Dyskinesia (Respiratory)	Yes, by Tertiary CNS	Yes	CNS (Tertiary So'ton)	Specialist MDT to GRH Resp Consultant	Yes
Pulmonary Hypertension	Only if seen in Bristol	informal	Bristol or GOSH CNS	CNS & Consultant	Yes
Renal	Yes, by Tertiary CNS	Yes	Bristol CNS	Yes, MDT	Yes
Rheumatology	Yes	Yes	CNS	CNS/ Consultant/ Physio	Yes
Specific Neuro e.g. NMD	Yes, but Tertiary CNS	Yes if in BCH/ Southmead	CNS: BCH	CNS spans ages MDT handover	Yes
Severe Learning Disability	Not suitable aimed at parents	Informal	CNS/ MDT	Partially, MDT, CLDT Nurse	Yes
Transplant e.g. heart, lung, liver	Yes, by Tertiary Service	Informal	Tertiary CNS	Tertiary CNS/ MDT Routine monitoring by GP	Yes

Part 2.2

Statements of assurance from the board

The following section includes response to a nationally defined set of statements which will be common across all Quality Reports. These statements serve to offer assurance that our organisation is:

- performing to essential standards, such as
- securing Care Quality Commission registration
- measuring our clinical processes and performance, for example through participation in national audits involved in national projects and initiatives aimed at improving quality such as recruitment to clinical trials.

Health services

During 2019/20 Gloucestershire Hospitals NHS Foundation Trust provided and/or subcontracted 111 NHS Services.

Gloucestershire Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 111 of these relevant health services.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust can confirm compliance with this requirement for the 2019/20 financial year.

Information on participation in clinical audit

From 1 April 2019 to 31 March 2020, 44 national clinical audits and 4 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. Where national audits could not be undertaken then local data was collected and reviewed.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in during 2019/20 are as follows:

	Eligible	Participated	Status
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes	Yes	Complete
BAUS Urology Audits: Cystectomy	Yes	Yes	Underway
BAUS Urology Audits: Nephrectomy	Yes	Yes	Underway
BAUS Urology Audits: Percutaneous nephrolithotomy	Yes	Yes	Complete
BAUS Urology Audits: Radical prostatectomy	Yes	Yes	Underway
Care of Children in Emergency Departments	Yes	Yes	Complete
Case Mix Programme (CMP)	Yes	Yes	Ongoing
Elective Surgery (National PROMs Programme)	Yes	Yes	Ongoing
Endocrine and Thyroid National Audit	Yes	Yes	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	Yes	Complete
Inflammatory Bowel Disease (IBD) programme	Yes	No	n/a
Major Trauma Audit The Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing
Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection	Yes	Yes	Ongoing
Maternal, Newborn and Infant Review Programme Clinical Outcome	Yes	Yes	Ongoing
Mental Health: Care in Emergency Departments	Yes	Yes	Completed
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	Ongoing
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Underway

	Eligible	Participated	Status
National Audit of Dementia	Yes	Yes	Complete
National Audit of Seizure Management in Hospitals (NASH3)	Yes	Yes	NYR
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	Ongoing
National Bariatric Surgery Registry (NBSR)	Yes	Yes	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Ongoing
National Diabetes Audit – Adults	Yes	Yes	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Ongoing
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Underway
National Gastro-intestinal Cancer Programme	Yes	Yes	Ongoing
National Joint Registry (NJR)	Yes	Yes	Ongoing
National Lung Cancer Audit (NLCA)	Yes	Yes	NYR
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Ongoing
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	Yes	Ongoing
National Ophthalmology Audit (NOD)	Yes	Yes	Ongoing
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Ongoing
National Prostate Cancer Audit	Yes	Yes	Ongoing
National Smoking Cessation Audit	Yes	Yes	Underway
National Vascular Registry	Yes	Yes	Ongoing
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	DTF
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	Ongoing
Surgical Site Infection Surveillance Service	Yes	Yes	Ongoing
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	Underway
UK Cystic Fibrosis Registry	Yes	Yes	Ongoing
UK Parkinson's Audit	Yes	Partially	Underway
NCEPODs			
Long Term Ventilation	Yes	Yes	Completed
Acute Bowel Obstruction	Yes	Yes	Completed
In Hospital Management of Out of Hospital Cardiac Arrests	Yes	Yes	Completed
Dysphagia in Parkinson's Disease	Yes	Yes	Completed

- **Underway:** Data collection has started but the deadline has not yet passed, or collection has been suspended/ extended due to Covid 19
- **Ongoing:** relates to continuous data collection, please note some audits have suspended data collection due to Covid 19
- **NYR:** data collection has not yet started
- **DTF:** Details to Follow

The reports of 43 of national clinical audits were reviewed (or will be reviewed once available) by the provider in 2019/20 and Gloucestershire Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	The objectives of the audit were to identify current performance in EDs against clinical standards and show the results in comparison with performance nationally in order to facilitate quality improvement. The report was reviewed at a Clinical governance meeting in May 2020. Whilst many of the Trust's outcomes were significantly better than the National results in a few areas, it was felt there is room for improvement. Improvements include; the design and implementation of a cognitive impairment checklist, and the Trust is currently trying to facilitate amendments to discharge information on the ED database and electronic patient record to ensure it captures abbreviated mental test score as part of discharge information.
BAUS Urology Audits: Cystectomy	The Trust has participated in this audit and the information will be reviewed at a Clinical Governance meeting when the report is available.
BAUS Urology Audits: Nephrectomy	The Trust has participated in this audit and the information will be reviewed at a Clinical Governance meeting when the report is available.
BAUS Urology Audits: Percutaneous nephrolithotomy	The Trust has participated in this audit and the recently published report will be reviewed at a Clinical Governance and audit meeting in July.
BAUS Urology Audits: Radical prostatectomy	The Trust has participated in this audit and the information will be reviewed at a Clinical Governance meeting when the report is available.
Care of Children in Emergency Departments	The objectives of the audit were to identify current performance in EDs against clinical standards and show the results in comparison with performance nationally in order to facilitate quality improvement. The report was reviewed at a Clinical governance meeting in May 2020. The information has been used to consider some improvements, including the production and trial of a psychosocial assessment tool – HEADSS. An adjustment to IT systems has been requested to help capture when a senior RV has occurred. All children currently redirected to paediatrics since April 2020 as part of Covid response so this is currently on hold.
Case Mix Programme (CMP)	The Case Mix Programme (CMP) is an audit of patient outcomes from adult and general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland. The information from CMP is reviewed at individual unit M&M. Lessons are shared between units at cross county quarterly meetings. The reports provide information on mortality rates, length of stay, etc. and provide the Trust with an indication of our performance in relation to other ICUs. Where trends are identified then these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society. Whilst DCC at the GRH site is still an outlier in terms of delayed discharges due to lack of ward beds and out of hours discharges DCC has made real inroads working with the site team and things are improving this year.
Elective Surgery (National PROMs Programme)	PROMs measures a patient's health status via a short, self-completed questionnaires. PROMs may be collected before and after a procedure or at regular intervals for those with long-term conditions. This information gives an indication of the outcomes or quality of care delivered to patients. All hip and knee arthroplasty cases are submitted. The independent company contacts the patient directly to report their PROM scores – uptake is variable (37% for hips and 64% for knees in last quarter). The report was disseminated to colleagues on 5th Feb 2020 and is used as part of the appraisal process.
Endocrine and Thyroid National Audit	This audit is clinically reviewed at the ENT governance meetings. No further actions have been required this year.

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Falls and Fragility Fractures Audit programme (FFFAP)	The Falls and Fragility Fracture Audit Programme (FFFAP) is a suite of three national clinical audits, commissioned by the Healthcare Quality Improvement Partnership (HQIP). They are the National Audit of Inpatient Falls (NAIF), the National Hip Fracture Database (NHFD) and the Fracture Liaison Service Database (FLS-DB). These provide a quality improvement platform for trusts in England – aiming to help local clinical teams and health service managers understand why people fall in hospital, the care that should be provided for fragility fractures, and what can and should be done to prevent future fractures. All the FFFAPs are reviewed annually as soon as the reports are released online, at the appropriate clinical and governance meetings. Actions taken as a result of the NHFD report were : Nutrition assessment using nutritional assistants rolled out to include all fragility trauma patients. Change in theatre scheduling to ensure OG assessment pre-theatre. Change in trauma co-ordination to improve time to theatre. Actions taken as a result of the Inpatient Falls report : Collaborative formed to introduce Safety Huddles across specified wards. Introduction of safety briefings on chosen wards. Splitting of the Falls Care Bundle to Assessment and post fall assessment. The extension of the Little Things Matter Campaign (a series of posters and education highlighting actions to consider to reduce falls).
Major Trauma Audit: The Trauma Audit and Research Network (TARN)	TARN was developed by the Trauma Audit & Research Network to help patients who have been injured. It provides important information about the rates of survival for patients who have been injured and treated at different hospitals across England and Wales. It also provides information about the benefits of certain kinds of treatment. The TARN data is reviewed once a quarter at the major trauma meeting. The Trust previously struggled with its submission rates which it has improved and is now 100%. The TARN co-ordinator changed the order in which cases are dispatched to improve our 40-day submission deadline percentage rate from 0% to over 90%.
Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection	All cases are reported and reviewed at a board level on a monthly basis. The outcomes are also discussed at the Trust infection committee.
Maternal, Newborn and Infant Review Programme Clinical Outcome	All losses over 22 weeks are reviewed at the appropriate risk meeting then the results inputted on the PMRT. Whilst there have been no specific actions required, learning points are always disseminated throughout the service.
Mental Health: Care in Emergency Departments	The report was reviewed at a Clinical governance meeting in May 2020. The Trust was a positive outlier in the majority of the standards. The Trust did not perform as well for undertaking mental state examination which had recently, been removed from the trust mental health assessment matrix as this was not felt to influence patient management. This will be reviewed by the mental health and ED MDTs. Improvements in this area have included an Australasian triage tool introduced prior to commencing the project, continued work on modifying the model of care in the minors/ majors pathways regarding staffing levels and space, and a newly appointed ED Mental Health Lead to develop pathways.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	The National Asthma and COPD Audit Programme (NACAP) for England, Scotland and Wales aims to improve the quality of care, services and clinical outcomes for patients with asthma (adult, children and young people) and chronic obstructive pulmonary disease (COPD). The Trust has been an outlier in data acquisition and discharge bundles. In order to improve this, quarterly team meetings have been reinstated and strategies have been developed to meet the BPT target. A lot of work has been done in this area including: staff training on wards to complete discharge bundles, a quality improvement project on smoking cessation to improve pick up and referral, and an e-learning package has been created to assist with training. To help increase our data a pathway has been developed to identify patients on the respiratory wards suitable for audit.
National Audit of Breast Cancer in Older Patients (NABCOP)	The aim of NABCOP is to support NHS providers to improve the quality of hospital care for older patients with breast cancer, by publishing information about the care provided by all NHS hospitals that deliver breast cancer care in England and Wales and looking at the care received by patients with breast cancer and their outcomes. The National Audit of Breast Cancer in Older Patients (NABCOP) is reviewed at the appropriate departmental meetings. The trust operates within national outcomes, however it has identified an improvement relating to frailty assessments on patients over 70 years old – this is currently on hold due to Covid 19

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
National Audit of Care at the End of Life (NACEL)	The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute and community hospitals in England and Wales. The audit measures progress against the five priorities for care: One Chance To Get It Right, Leadership Alliance for Care of Dying People and NICE Quality Standards 144 and 13, and NICE guideline NG31. The audit also has links with NHS England & NHS Improvement plans for personalised end of life care and NHS England & NHS Improvement plans for the five ambitions. This audit has been postponed for this year and will carry forward to 2021 due to Covid 19.
National Audit of Dementia	The National Audit of Dementia (NAD) is a clinical audit programme commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England and the Welsh Government looking at quality of care received by people with dementia in general hospitals. Patients are reviewed from both sites and the information from the audit is reviewed at the Dementia Steering Group, within the department of Care of The Elderly and at GIFT (getting it right first time) review. Areas for improvement have been highlighted in screening, documentation and staff training. Quality improvements have been planned for delirium screening and patient centred care. These have been slightly delayed due to Covid 19.
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Epilepsy12 aims to help epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. The Trust is participating in the data collection which is still ongoing for this audit. A report has not been published this year and is expected at the end of the current data collection period and will be reviewed at the appropriate specialty governance meeting.
National Bariatric Surgery Registry (NBSR)	The National Bariatric Surgery Register is a comprehensive, prospective, nationwide analysis of outcomes from bariatric surgery in the United Kingdom and Ireland. It contains pooled national outcome data for bariatric and metabolic surgery in the United Kingdom. All cases performed in Gloucester are submitted to NBSR. These are then reported on the NBSR Website. The results are presented at the SQAG (Surgical Quality Assurance Group) Meeting and at the Upper GI Surgical Governance Meeting.
National Cardiac Arrest Audit (NCAA)	The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland. It is a joint initiative between the Resuscitation Council (UK) and ICNARC. The report is reviewed within the Resuscitation Department and then shared at the Deteriorating Patient and Resuscitation Committee meetings every quarter. The reports are also now available on our shared committee drive to allow all appropriate staff access to use and review. The Trust continues to perform within the national expectation across both CGH & GRH. The report is used to recognise any inappropriate CPR attempts and use simulation and training to improve these incidents. The data is also presented at all mandatory training for all staff. In addition to this we investigate potential non-arrests and the unexpected non-survivors that are highlighted by NCAA. A more detailed audit, that expands on the NCAA, has been started to look at admission details and escalation prior to arrest to highlight whether appropriate escalation happened and if any other factors could have prevented arrest from happening.
National Diabetes Audit – Adults	The National Diabetes Audit (NDA) is a major national clinical audit, which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. The NDA is delivered by NHS Digital, in partnership with Diabetes UK. It collects and analyses data and produces reports for a range of stakeholders to use to drive changes and improve the quality of services and health outcomes for people with diabetes. The latest national audit dataset for adult inpatients with diabetes show that the Trust is operating within national parameters, It has however highlighted some potential quality improvements that will be taken forward this year. The last national audit dataset published for National Pregnancy in Diabetes Audit shows that the Trust is performing within the national standards. Nationally women's access to pre-conception care is poor, this and the other results were discussed at Community Diabetes Training Day for Gloucestershire Oct 2019 to try and raise awareness in primary care. The Gloucestershire Health and Care NHS foundation Trust undertake the National Diabetes Foot Care Audit, and the Trust works with them to provide an integrated service.

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
National Early Inflammatory Arthritis Audit (NEIAA)	The NEIA audit aims to improve the quality of care for people living with inflammatory arthritis, collecting information on all new patients over the age of 16 in specialist rheumatology departments in England and Wales. Following the report, publication results were discussed with the whole Rheumatology team on 29th January, particularly in relation to difficulties with enrolment of patients. Analysis of the data showed an improvement within the data collection period with the recruitment of a consultant post to the team. With a more representative sample expected in future audits, this will provide a true baseline of results to which improvement projects can be implemented and supported as needed.
National Emergency Laparotomy Audit (NELA)	NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy, through the provision of high quality comparative data from all providers of emergency laparotomy. The NELA database is populated with every emergency laparotomy case. Quarterly joint surgical and anaesthetic QI meetings are undertaken to review morbidity and mortality and review compliance with other NELA standards of care. Our mortality continues to improve across both sites. Critical care admission for patients with >5% mortality is high, close to 100%. We have met the criteria for the Emergency Laparotomy best practice tariff in every quarter since its introduction (Consultant surgeon and anaesthetists and DCC admission for >5% mortality patients). This has attracted the enhanced tariff payments. We are the busiest trust in the country to have consistently met the target. An elderly care perioperative service is now up and running at GRH and boarding passports have been introduced to improve and standardise pre-operative workup. Elderly care reviews are increasing and are for any patient >65 years of age rather than the suggested >80 years so we are going above and beyond the requirements.
National Gastro-intestinal Cancer Programme	The overarching aim of the National Gastrointestinal Cancer Audit Programme (NGCAP) is to improve the quality of services and patient outcomes for patients newly diagnosed with bowel cancer and oesophago-gastric cancer or high-grade dysplasia of the oesophagus. The Trust submits data for the NOGCA. The reports are reviewed at the appropriate specialty and governance meetings when they are published.
National Joint Registry (NJR)	The Trust provides information to the National Joint Registry (NJR) which collects information on hip, knee, ankle, elbow and shoulder joint replacements operations and monitors the performance of implants, hospitals and surgeons. The annual report (16th NJR report) was reviewed at the hip and knee MDT and in addition to this the data has been discussed and used for individual surgical appraisal. The next report is due in September 2020 and will be reviewed at the appropriate specialty and governance meetings.
National Lung Cancer Audit (NLCA)	The National Lung Cancer Audit (NLCA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and works with a number of specialists to collect hospital and healthcare information and report on how well people with lung cancer are being diagnosed and treated in hospitals across England, Wales, (and more recently) Jersey and Guernsey. The outcomes are reviewed at the Lung AGM and appropriate specialty and governance meetings.
National Maternity and Perinatal Audit (NMPA)	The National Maternity and Perinatal Audit (NMPA) is a large scale audit of NHS maternity services across England, Scotland and Wales. The NMPA aims to support improvements in the care for women and babies by providing national figures and enabling comparison between maternity services. 2019 saw the publication of both the NMPAP Clinical report (data 2016/17) and the organisational report providing a snapshot of maternity and neonatal services during January 2019. Key messages and recommendations from these reports (and locally gathered data to provide up to date information) are discussed at appropriate specialty and governance meetings and shared with the wider service as needed. In 2019 the maternity service completed a structured improvement collaborative with support from the Gloucestershire Safety and Quality Improvement Academy, covering a wide range of projects including continuity of care and a multi-professional approach to improving postnatal care in the community.

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	The NNAP aims to helps neonatal units improve care for babies and their families by identifying areas for quality improvement in relation to the delivery and outcomes of care. The Trust continually takes part in this ongoing audit of all Neonatal Unit admissions. NNAP online provides updated annual data relating to all audit standards via it's publicly visible website. This information is reviewed at Paediatric governance and neonatal consultants meetings. For most standards the Trust has shown to be equivalent to, or higher than national rates: Antenatal steroids, antenatal magnesium sulphate, temperature on admission and consultation with parents. There are two areas where he Trust was found to be lower than the national rate: Babies being fed either exclusively with their mother's milk or with another form of feeding on discharge (GHT 48% compared to the national rate of 60%) and babies born at less than 30 weeks having a documented medical follow up at 2 years of age (GHT 57% compared with national rate of 70%). The Trust has enrolled in the PERIPrem project which has early breast milk as a key standard and continues to work on accreditation to the Unicef UK Baby Friendly Initiative. For medical follow up a gap in staffing was identified and recruitment of additional nursery nurses is underway to support the completion of developmental assessments.
National Ophthalmology Audit (NOD)	This year's report has not yet been published and is provisionally scheduled for publishing in September 2020. The previous year's report was published in August 2019 and this was reviewed at a national level by the Royal College of Ophthalmologists, and was available locally for individual clinician use for appraisal. The case complexity adjusted PCR rate was 0.75% which was lower than the national average of 0.80%. The case complexity adjusted visual acuity loss rate was 0.59% which was higher than the national average of 0.47.
National Paediatric Diabetes Audit (NPDA)	The results of the audit have been discussed at the appropriate departmental audit meeting. The Trust also participates in the Southwest Regional Diabetes Network and the outcomes were discussed in June 2020 meeting. Data from all units in the region was compared. The Trust's unit's outcomes have improved steadily over the last 5 years especially median HbA1c which was 58.8 in 2018/19.
National Prostate Cancer Audit	The National Prostate Cancer Audit (NPCA) is a national clinical audit assessing the process and outcome measures from all aspects of the care pathway for men newly diagnosed with prostate in England and Wales. The findings help to define new standards and help s NHS hospitals to improve the care they provide to patients with prostate cancer. The Trust submits data for NPCA and reviews the reports at the appropriate specialty and governance meetings when they are released. Manpower and changes in data IT systems have led to less than 100% of patients being entered onto the Audit. Where possible retrospective data is entered. There have been issues relating to capacity and demand in the andrology service. Plans were made to review this service fully in early 2020 which has been impacted on by the COVID 19 situation but Autumn 2020 should see this new assessment and treatment service established.
National Smoking Cessation Audit	The 2019 National Smoking cessation audit took place between 1st July and 31st October. Data collection focuses around inpatients who smoke and providing support to them through referral to an on-site stop smoking service and offering nicotine replacement therapy and organisation level engagement for enforcement of smoke free grounds. The results were reviewed in at the Quality Delivery group and the Respiratory Unit Meeting. The Trusts results were in line with the national results, however, performance worse than national in offering smoking cessation. In order to improve, a Smoking steering group has been established, a tobacco addiction pathway re-written, with a pilot of new pathway – ongoing QI PDSA (recently interrupted by Covid).
National Vascular Registry	The NVR data entry system is a secure online database where vascular specialists working in NHS hospitals in the UK can enter their data for vascular procedures they carry out. 100% of data is extracted from the NVR database. The reports are reviewed at the specialty meetings and there are no reported actions.

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Perioperative Quality Improvement Programme (PQIP)	PQIP measures complications, mortality and patient reported outcomes from major non-cardiac surgery. The ambition is to deliver real benefits to patients by supporting clinicians in using data for improvement. The project has been a great success with the Trust having achieved the recruitment target of 236 patients. There have been several QI projects and a consultant anaesthetist has identified several more, which will be discussed with the QI Specialty lead and Manager. An example of one of the QI projects is Perioperative Diabetes Management (which won 1st prize at the Welsh Perioperative Medicine conference), this looked at improving provision with individualised risk assessment prior to surgery project and data to inform on ERAS pathways. The next project is likely to look at addressing Anaemia; a meeting is already in place to discuss the options.
Sentinel Stroke National Audit programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme that measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence based standards, including the 2016 National Clinical Guideline for Stroke. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. The Trust is able to access the SSNAP data directly and it is used to provide regular data for a number of purposes and is reviewed on a regular basis by ED, radiology, Stroke nurses, consultants and the wider stroke team. It helps inform potential quality improvements within the stroke service.
Surgical Site Infection Surveillance Service	Information is reviewed at the appropriate governance meeting. A Surgical Site Infection (SSIs) Quality Improvement was undertaken that has been outlined in more detail below.
Society for Acute Medicine's Benchmarking Audit (SAMBA)	The SAMBA audit benchmarks Trusts on care received in an acute inpatient setting, looking at standards of care such as: an early warning score being measured upon arrival, being seen by a competent clinical decision maker with 4 hours, a management plan and regular monitoring being present. The Trust showed a need for improvement in the time taken for review in both ACU and ED in Cheltenham. Improvements have included an increased consultant presence in ED, juniors have been instructed to actively seek PTWR reviews in ED and currently the acute medical services are located in GRH.
UK Cystic Fibrosis Registry	The UK Cystic Fibrosis Registry is a secure centralised database, sponsored and managed by the Cystic Fibrosis Trust. It records health data on consenting people with cystic fibrosis (CF) in England, Wales, Scotland and Northern Ireland. CF care teams enter data at every specialist centre and clinic across the UK, with over 99% of people with CF consenting to their data being submitted. This information is used to create CF care guidelines, assist care teams providing care to individuals with CF, and guide quality improvement initiatives at care centers. The Trust submits data to the registry and reviews the report data at the appropriate specialty meetings when it is published. The registry is also used to track trends. Last year the Trust attend a regional meeting for paediatrics held in Bristol to analyse these further and pinpoint areas for improvement. BMI was selected as a potential area for improvement and as a result patients, who required it, were offered targeted support by the MDT: medics, dietitians, psychologist and physiotherapist.
UK Parkinson's Audit	The UK Parkinson's Audit is the recognised quality improvement tool for Parkinson's services. It allows measurement of practice against evidence-based standards and patient feedback in a continuous cycle of improvement. The Trust has not been able to collect data for all areas of this audit due to clinical manpower commitments for which they were recruiting at the time of the data collection. The second stage of this audit is ongoing and the deadline was extended due to Covid.

The reports of 225 local clinical audits were reviewed by the provider in 2019/20 and these are reviewed and actioned locally. This includes 36 'Silver' quality improvement projects graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2019/20. Some examples of actions associated with audits and completed QI projects are as follows:

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Neonatal	This project was co-designed with a group of dads. 'SHED – Support and Help for Every Dad', is an initiative to support dads' involvement in the Neonatal journey to promote immediate care-giving engagement. A number of dads now volunteer providing support to other dads going through the experience of a baby in the neonatal unit and this has been adopted in other organisations with interest in it from as far away as Australia.
Homelessness	The Homeless Reduction Act (HRA) 2017 places a legal duty on the trust to refer all those that are homeless or at risk of homelessness to a local authority. A QI project was set up to implement this legislation but to also improve the care our homeless patients receive in the ED. By working with community services and local authorities as well as developing documentation, homeless patients now receive appropriate support post discharge from ED. Work for this project helped secure funding to improve services at Cheltenham General Hospital in the form of a dedicated Housing Officer and also a trust Homeless Specialist Nurse
Staff Development	Through the appraisal process and other feedback mechanisms, the ward clerk management team identified that there were few developmental opportunities available to the ward clerks in the Trust. Using a co-design process with the ward clerks themselves, a QI project was set up to develop and implement a bespoke training programme to provide ward clerks with skills required for their role, but which would also provide them with transferrable skills should they wish to progress their careers within the Trust and beyond. Feedback indicated greater satisfaction with opportunities, feeling more valued, greater confidence to progress and new skills having been learnt.
Surgical Site Infections	Surgical Site Infection (SSIs) are the 3rd leading cause of healthcare associated infections. Keep Calm, Stay Warm was a QI project initiated by one of the Trust Chief Nurse Junior Fellows with the aim of helping to prevent SSIs through perioperative temperature management. Incidents of inadvertent perioperative hypothermia were found to have reduced form 33% to 14% over the duration of the project and the project was awarded the OneTogether Small Steps Award in recognition of helping to reduce the risk of Surgical Site Infections.
Theatres	The World Health Organisation (WHO) Surgical Safety Checklist, introduced in 2008, has been shown to improve patient safety, as well as improving teamwork and communication in theatres. However, this is dependent upon the style of implementation used, and the engagement of clinical teams. It was highlighted that there was no standardised way the checklist is performed in Gloucester and Cheltenham which led to the development of a QI project 'WHO Checklist: The Writing's on the Wall' The implementation of a wall mounted checklist was tested and found to improve compliance with completion of sections and engagement with the checklist process.
Staff Experience and retention	**GloStars:** Gloucestershire Hospitals Staff transition and support network for newly qualified professionals is an initiative introduced by two of our Chief Nurse Junior Fellows to provide a supportive network for newly qualified professionals. The quality improvement project was focussed around newly qualified nurses with the plan to expand to include all newly qualified professionals as they start their roles.
Renal Dietetics	Two members of our renal dietetic team were able to become supplementary prescribers in line with new legislation. They wanted to measure the impact of the introduction of dietetic supplementary prescribing in the renal dialysis population in the management of Chronic Kidney Disease-Mineral Bone Disorder (CKD-MBD). The service improvement identified an improvement even better than they had hoped for so they submitted an abstract to share their work at UK Kidney Week which was accepted and generated much discussion and interest with other professionals.
Improving patient flow by reducing the number of discharges where a TTO needs to be sent to pharmacy	Delays in patients leaving hospital can occur due to 'To Take Out' (TTO) medications not being available to them at the point of discharge. This Quality Improvement project sought to address this issue by reducing the number of TTOs that needed to be sent to Pharmacy to below 50% (as TTOs requiring pharmacy input require multiple extra steps to be processed which can lead to delays.) Difficulties were faced with some medications being controlled drugs, so unable to be prepared in advance of a TTO being written and sent to pharmacy. However, a successful business case for the introduction of a Medicine Optimisation ATOs (who visit the wards to help facilitate medication transfer and discharge readiness) has led to a reduction in TTOs being sent to pharmacy on two targeted wards to 36% and 48.3% respectively.

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Management of fever and/or sepsis in children under 3 months on Children's Inpatient Ward	Infants up to and including 3 months of age who appear unwell and have a fever of 38.0 degrees+ should be treated for presumed bacterial sepsis until proven otherwise. The audit standards assessed were compliance with blood, urine and cerebrospinal fluid (CSF) being taken and in such a way as to allow results to be obtained in a timely manner for further input into management plans. Both blood and CSF were found to have been obtained in 100% of cases, with urine samples being obtained in 94% of cases which reflects current behaviours to request nursing staff or parents to collect urine via the 'clean catch' method rather than catheterisation. 62% had all three samples within the laboratory by 36 hours of admission (the delay exclusively being the shortfall of urine collection). Ongoing recommendations include the completion of all samples to be collected swiftly and in one go (and utilise the catheterisation method of obtaining a urine sample) and microbiology to be alerted in advance of samples arriving. Ideally all samples should be processed 'in-house' to avoid delays in couriering and logging samples in Bristol.
Audit to assess the compliance of current operation note documentation	The Royal College of Surgeons (RCS) provides guidance on the documentation requirements of operation notes for both elective and emergency surgery to assist in the facilitation of post-operative management and to provide clear and detailed information should a medico-legal requirement arise. A re-audit of compliance was undertaken following an audit of standards the previous year, recommendations included education sessions for surgeons, aide memoires being readily visible and the introduction of a new electronic template. Re-audit showed an increase in the quality of operation notes and compliance with standards; 100% of notes were found to have the signature of the operating or assisting surgeon and a detailed post-operative plan was found in 95% of cases (an increase from 17% found in the initial audit). Periodical re-audits will continue to raise awareness and sustain the standard.
Improving documentation of Clinical Frailty Score in trauma patients >60 years	Frailty impacts 10% of adults over 65 years, increasing to 25-50% at 85 years and rises from then on. Frail patients are at risk of under triage, delayed diagnosis and sub-optimal care but identifying frailty can improve access to appropriate interventions. With a primary outcome measure of documentation of the clinical frailty score for trauma patients over 60 years, multiple interventions were tested to assess how they impacted on results. Although an SHO teaching session was found to improve knowledge of frailty, it had limited impact on documentation compliance. Documentation was adapted to provide a space for completion of this information which provided a positive 29% improvement. Posters to raise awareness provided an additional positive impact with documentation through increased awareness, but compliance rates of 90%+ were reached in January 2020 with an alteration of admission documentation which enforced frailty score entry.
Neonatal Unit feeding audit	Following an update to neonatal feeding guidelines an audit was undertaken to assess compliance with the new regimen. In addition to the changed feeding protocols the new guideline provides a clearer format with which to assess the needs of lower, medium and higher risk infants with clear steps to show how feeding volume is increased from the initial start of feeds, through the first 24-48+ hours. A prospective observational study of 20 newborns admitted to the neonatal unit was undertaken assessing compliance with a clearly stated risk assessment being present, feeding box completed, age at first feed and rate of feeding increase as per new guidance. Upon analysis, 100% of newborns had a risk level stated, 75% used the feeding box and of these 53% also had the feeding rate increase included. Results found that new guidelines were not always followed. It was suggested that prior to re-audit the following short and long term actions would be taken: update of documentation to provide a risk assessment box on ward round notes, adapt fluid chart to incorporate risk level, ensure the removal of any hard copy documentation referring to the old guideline and increase awareness of the new guideline.
Improving Medical Record Keeping on Orthopaedic Wards	A previous audit of record keeping on orthopaedic wards showed varying degrees of compliance of documentation standards including poor compliance with the presence of patient ID on every page and filing of pages in chronological order to allow easy access to plans of care. Temporary files were introduced in which current notes for each patient were kept in lever arch files until discharge whereby the ward clerk would file back into the full set of notes. Labelled dividers were placed inside each folder to facilitate ease of locating required documents. Re-audit results showed an improvement in ID documenting on every page as well as clear current plans. The movement of the Trust away from paper based documentation to electronic forms which allow the timestamping of entries will greatly improve documentation quality (legibility) and compliance with standards.
Appropriateness and timeliness of referrals to fracture clinic	The British Orthopaedic Association produced guidance for fracture clinic services in August 2013 (BOAST 7 Guideline). Two previous audits have taken place in 2017 and 2018, this audit reassessed compliance in 2019. Levels of inappropriate referrals have showed a decline since 2017 (20%), 2018 (17%), 2019 (13%) and a marked improvement in the proportion of patients being seen within 8 days when compared to previous years, despite the number of patients per clinic being found to have increased.

Participation in clinical research

The number of patients receiving relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 1834.

Commissioning for Quality and Innovation (CQUINS)

There are 7 CQUINS in total this year;

- 5 CCG commissioned schemes,
- 1 Specialised Commissioning and
- 1 commissioned by the Armed Forces arm of specialised commissioning.

The overall 19/20 CQUIN value is £4,849m:

- GCCG is a block contract (1.5% contract value) of £4,046m
- Specialised commissioning (0.75% contract value), NCA and PH contributions: £641,184k
- Armed Forces: 4,451k
- South Worcester and associates: £157k

Figure 47: Breakdown of potential income if all CQUIN requirements met to the highest levels

CQUIN	Description	Value (£) if requirements met
CCG1 AMR		
a) Lower UTI older people	Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.	420,332
b) Antibiotic prophylaxis in elective colorectal surgery	Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	420,332
CCG2 Staff Flu jab	Achieving an 80% uptake of flu vaccinations by frontline clinical staff.	840,663
CCG3 Screening and advice for alcohol & tobacco in inpatient setting		
a) Alcohol & Tobacco screening	Achieving 80% of inpatients admitted to an inpatient ward for at least one night that are screened for both smoking and alcohol use.	280,221
b) Tobacco – brief advice	Achieving 90% of identified smokers given brief advice.	280,221
c) Alcohol – brief advice	Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	280,221
CCG7 3 high impact interventions – falls prevention	Achieving 80% of older inpatients receiving 3 key falls prevention actions	840,663
CCG 11 Same Day Emergency Care		
a) Pulmonary Embolus (PE)	Achieving 75% of patients with confirmed PE being managed in a same day setting where clinically appropriate.	280,221
b) Tachycardia with AF	Achieving 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate.	280,221
c) Community Acquired Pneumonia	75% Patients with confirmed CAP should be managed in a same day setting where clinically appropriate.	280,221
PSS1 Medicines Optimisation		
Trigger 1: Chemotherapy Waste	Improve efficiency in IV chemo pathway – reducing waste	192,355
Trigger 3: Auditing prior approvals of NHSE commissioned drugs	Accurate prior approval (Bluteq) completion – reducing clinical variation	128,237
Trigger 4: Faster adoption best value medicines	Improving adoption rates of prioritised medicines at local level	192,355
Trigger 5: Anti-fungal stewardship	Reduce inappropriate use AF's and prevent resistance through development of AF stewardship teams	128,237
PSS-AF: Armed Forces Scheme	Continue to embed AF covenant	4,451
Total Value		4,848,950

End of year performance

As we were not required nationally to submit data for Q4 because of the Covid-19 Pandemic our final performance will be agreed with the CCG and will be based on Q3 performance where appropriate based on the national advice.

Performance and payment calculations

Payment calculation is usually based on accumulative value of achievement across the quarters. If the upper threshold is reached accumulatively at year end 100% of payment will be earned; where it drops below the lower threshold, 0% would be earned. Payment is graduated between the two thresholds.

Q3 performance:
PSS1 Medicines Optimisation

All indicators achieved 100% to Q3 – securing £480,888 with no losses. The concerted pharmacy team, and individual effort, to achieving this result should be recognised and acknowledged as a significant result.

- **Trigger 1:** Implementation of chemo waste Calculator tool
- **Trigger 3:** Audit of Bluteq prior approval forms (Q3: Pembrolizumab and Dimethyl Fumerate)
- **Trigger 4:** Adoption best value drugs in new and existing patients for identified Q3 drugs.
- **Trigger 5, Antifungal Stewardship:** Gap analysis completed. There have been resource concerns around auditing requirements, however the first audit is not required until Q4; Q1-Q3 focus is on implementation of an AF Stewardship team that will meet NHSE guidelines, and it is anticipated that this team will be in a better position to co-ordinate the required Q4 baseline audit.

CCG1a Lower Urinary Tract Infection (UTI) older people

40% compliance therefore did not achieve the minimum target of 60% (max 90%) – unlikely to attract any performance pay for 19/20. As for each of the schemes this year audits require a minimum of 100 patients sample which has continued to be extremely challenging. Clinical signs and symptoms need to be recorded in the patient notes and coded appropriately, hence the recommendations from NHSE is that audits should be retrospective – this has proved very time consuming and a prospective approach was planned for Q2/3 – however due to pressures on the wards for pharmacists this was not successful. Discussions have begun with EPR team to help data capture for 20/21 as UTI will continue in some form next year. A working team is also a requirement to include support for audits which will see this CQUIN under achieving 20/21 if that is not available.

CCGb Antibiotic prophylaxis in elective colorectal surgery

100 patient audit produced a performance total of 90% against a maximum target of 90% – therefore we were on target for maximum achievement 19/20.

CCG3 Screening and advice for alcohol & tobacco in inpatient setting

- **Alcohol & Tobacco screening:** Q3 84% compliant against a maximum target of 80% (minimum 40%) bringing cumulative performance Q1-Q3 to 82%. On target to achieve maximum for this element.
- **Tobacco – brief advice:** 78% compliant against a maximum target of 90% (minimum 50%) bringing cumulative performance Q1-Q3 to 75%. Currently on target to achieve 63% of this element.
- **Alcohol – brief advice:** 72% compliant against a maximum target of 90% (minimum 50%) bringing cumulative performance Q1-Q3 to 77%. Currently on target to achieve 67% of this element.

As part of the healthy living message and improvement plan a smoking quality improvement group led by Dr Charles Sharpe are now meeting; this is collaboration across surgical and medical services, including Healthy lifestyles and GCCG. Alcohol and tobacco questions have been approved for EPR and will improve data capture.

CCG7 3 high impact interventions – falls prevention (see section in quality account for update)

Q3 100 patient audit: 29% compliant for all 3 falls preventative actions against a minimum target of 25% (maximum 80%), the remainder failing to fulfil one or more of the actions:

CCG 11 Same Day Emergency Care

100 patient audits, or all patients meeting diagnosis, were completed for each of these elements, however not all who met the eligibility criteria for SDEC were fit to discharge – that made this a challenging CQUIN as this was not considered.

- **Pulmonary Embolus (PE):** Report not received by time reporting portal closed – working to make the appeal deadline date in May.
- **Tachycardia with AF:** 91% achieved against minimum target of 50% (maximum 75%)
- **Community Acquired Pneumonia:** 63% achieved against maximum target of 75% (maximum 75%).

The clinicians report that they feel the CAP indicator also presented challenges. The NICE guidance on which it was based specifically says: “Use clinical judgement in conjunction with the CURB65 score to guide management of CAP

The CQuIN criterion doesn’t include bloods or clinical judgement – although these are taken into consideration for SDEC.

It is possible to have a NEWS of 6 (and therefore be clinically septic) and not trigger any of the criteria so have a score of 0-1. It is possible there were some more patients that could have pulled through SDEC but at the same time most of them were unsuitable for SEC for any number of reasons. The team will continue to review.

	Min	Max	Q1	Q2	Q3
Med Ops					
Trigger 1			achieved	achieved	achieved
Trigger 3			achieved	achieved	achieved
Trigger 4			achieved	achieved	achieved
Trigger 5			achieved	achieved	achieved
AMR					
UTI	60%	90%	45	35	40
Colorectal	60%	90%	88	90	94
Flu	60%	80%	Q4 only		
Alcohol/Tobacco					
a) Screen for both	40%	80%	84.2	78.2	83.9
b) Tobacco brief advice	50%	90%	77.1	70.7	78.2
c) Alcohol brief advice	50%	90%	89.7	69.2	72.1
Falls	25%	80%	27	28	29
SEC					
a) PE	50%	75%	76	69	Late report
b) Tachycardia with AF	50%	75%	67	73	91
c) CAP	50%	75%	27	38	63

Care Quality Commission (CQC)

Gloucestershire Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Good". Gloucestershire Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2018/19.

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

Secondary uses services data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data: which included the patient's valid NHS number was:

- 99.3% for admitted patient care
- 100% for outpatient care and
- 100% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- 99.4% for admitted patient care;
- 99.8% for outpatient care; and
- 99.8% for accident and emergency care.

Information Governance Statement

Information governance incidents are reviewed and investigated throughout the year and reported internally through the Committees. Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the General Data Protection Regulation (GDPR) and guidance from the Information Commissioner's Office (ICO), are reported to the ICO through the DSP Toolkit where they may also be monitored by NHS England.

Fourteen incidents have been reported to the ICO during the 2019/20 reporting period. This compares to three reported in the previous period. This largely reflects the fact that reporting criteria under the GDPR have a lower threshold than under the previous Data Protection Act.

Figure 48: Summary of incidents reported to the ICO under Article 33 GDPR

Month of Incident	Nature of Incident	Number Affected	How Patients informed	Lessons Learnt
June 2019	A letter addressed to the natural mother of a child was sent and included the address of the foster parents.	3	Social worker	Review of practice for cc letters for children in care. Improved visibility of children in care status on trust clinical information and administration systems. Ensure there are appropriate checking and verification measures in place
July 2019	Package containing copy patient records being sent to patient by post broken in transit	1	Correspondence following patient enquiry	Improvement made to packaging used to send copies of records in the post
August 2019	Spreadsheet containing staff information saved in a shared drive was moved / copied in error to a shared drive with insufficient access control	75	Face to face (for those of the 75 where sensitive data involved)	Improved project governance for new data processing initiatives. Restricted access to shared drives. Reduction in amount of data held. Sensitive data to be password protected
August 2019	A letter, intended to inform a patient of the outcome of tests, included in a collection of documents sent to another patient.	1	Letter from service	Element of human error. Ensure there are appropriate checking and verification measures in place
September 2019	A copy of a ward nursing handover sheet was accidentally included in paperwork given to a patient to take home on discharge.	14	Not informed	Element of human error. Ensure there are appropriate checking and verification measures in place
October 2019	Several emails relating to other patients were included in a Pregnancy Pack given to a patient. Emails related to safeguarding issues.	5	Not informed	Review of management of safeguarding information prepared for safeguarding reviews.
October 2019	Paediatric Safeguarding Notification forms being emailed to internal and external recipients accidentally copied to a member of public – wrong email address selected.	7	Not informed	Review of email safeguards in place where external recipients are involved and outside of organisation warning present
November 2019	Care Plans were printed to be sent to patients. Plans for patients' A and B were accidentally picked up together and posted to patient A in the same envelope.	1	Letter from service	Human error rather than systemic failure. Example to be used in IG training
November 2019	Member of staff inappropriate access to patient record	2	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Member of staff inappropriate access to patient record (2)	1	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Member of staff inappropriate access to patient record (3)	1	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Report relating to a nine-year-old child inadvertently disclosed to the ex-wife of the child's father who was not the child's mother and had no parental rights.	2	Correspondence following patient enquiry / complaint	Improved visibility of parental responsibility required within trust clinical information and administration systems. Ensure there are appropriate checking and verification measures in place

Month of Incident	Nature of Incident	Number Affected	How Patients informed	Lessons Learnt
February 2020	Member of staff inappropriate access to patient record (4)	2	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Medical report sent to patient's employer without consent	1	Correspondence following patient enquiry	Human error rather than systemic failure. Consent thought to have been obtained.

The majority of the incidents have been now been closed by the ICO with the ICO expressing satisfaction with the steps taken by the Trust to mitigate the effects and minimise the risk of recurrence. With respect to the number of incidents of inappropriate access by staff there has been a communications exercise to remind staff of the requirements of the Code of Confidentiality.

A large number of the near miss reported incidents (189) relate to lost SmartCards which are disabled when reported as missing.

Figure 51: Summary of confidentiality incidents internally reported 2019/20

Reportable breaches	(detailed above) 14
Number of confirmed Non-reportable breaches	153
Number of no breach / Near miss incidents	266
Total number of confidentiality incidents internally reported	433

The effectiveness and capacity of these systems has been routinely monitored by our Trust's Information Governance and Health Records Committee and will continue to be monitored by the Digital Care Delivery Group under new governance arrangements. A performance Summary is presented to our and Finance and Digital Committee and/or Trust Board annually.

Clinical coding

Gloucestershire Hospitals NHS Foundation Trust was not subject to the "Payment by Results clinical coding audit" during 2019/20.

Data Quality: relevance of data quality and action to improve data quality

Good quality information underpins the effective delivery of safe and effective patient care. Reliable data of high quality informs service design and improvement efforts. High quality information enables safe, effective patient care delivered to a high standard.

High quality information is:

1. Complete
2. Accurate
3. Relevant
4. Up to date (timely)
5. Free from duplication (for example, where two or more difference records exist for the same patient).

Gloucestershire Hospitals NHS Foundation Trust will be taking the following actions to improve data quality

- Identification, review and resolution of potential duplication of patient records
- Monitoring of day case activity and regular attenders
- Gathering of user feedback
- All existing reports have been reviewed and revised
- Routine Data Quality reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'Insight'
- The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.
- Gloucestershire Hospitals NHS Foundation Trust regularly send data submissions to SUS and via these submissions we receive Data Quality reports back from SUS. Based on SUS Data Quality reports we action all red and amber items highlighted in report to improve Data Quality.
- In data published for the period April 2019 to March 2020, the percentage of records which included a valid patient NHS number was:
  - 99.8% for admitted patient care (national average: 99.4%)
  - 100% for outpatient care (national average: 99.7%)
  - 99.1% for accident and emergency care (national average: 97.7%)
- The percentage of published data which included the patient's valid GP practice code was:
  - 99.9% for admitted patient care (national average: 99.7%)
  - 99.8% for outpatient care (national average: 99.6%)
  - 99.9% for accident and emergency care (national average: 97.9%)
- A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly
- These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as:
  - Outpatients including attendances,
  - Outcomes, invalid procedures
  - Inpatients including missing data such as
  - NHS numbers, theatre episodes
  - Critical care including missing data, invalid
  - Healthcare Resource Groups
  - A&E including missing NHS numbers,
  - Invalid GP practice codes
  - Waiting list including duplicate entries, same day admission

On a daily basis, any missing/incorrect figures are highlighted to staff and added or rectified. Our Trust Data Quality Policy is available on the Trust's Intranet Policy pages.

Audit trails are used to identify areas of data quality concern within the Trust, which means that these areas can be targeted to identify issues. These could be system or user related. Training is offered and process mapping undertaken to improve any data quality issues.

Most of the Trust systems have an identified system manager with data quality as a specified duty for this role. System managers are required under the Clinical and Non-Clinical Systems Management Policy to identify data quality issues, produce data quality reports, escalate data quality issues and monitor that data quality reports are acted upon.

Data Quality is now part of the yearly mandatory training package for staff – a signed statement is needed that tells staff that Data Quality is everyone's responsible to ensure good quality and clinically safe data.

Learning from deaths

Data being updated.

Doctors in Training rota gaps

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receives, and patient feedback about the care provided. As part of our Quality Account 2019/20 we are providing a statement on our Trust Doctors in Training Rota Gaps, which we are required to report on annually through the following legislation schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

Monitoring, Delivery and Assurance

The Guardian of Safe Working presents a quarterly board report directly to Trust Board, providing an update and assurance on the monitoring of exception reports and medical rota gaps.

Improvements (2019/20)
Through analysis of our data and knowing what our issues are in 2019/20 we took the following steps to make improvements

1. Looking at data to support hard to fill areas where there are pressures on certain rotas due to national supply and reviewing the demand requirements within departments to ensure that there is a transparency about safe staffing levels.

2. Setting up regular meetings with the Medicine Division Rota leads to discuss known issues and discussing ways of reducing gaps.

3. Guardian of Safe Working proactively involved with rotas to ensure these maintain safe working hours along with good training/education opportunities, encouraging future applicants.

Next Steps (2020/21)
In 2020/21, we intend to build on our 5-year People and Organisational Development Strategy, to provide a robust picture of rotas and ensure that early intervention for service provision is agreed to mitigate gaps within the rota. This will be in collaboration with departments, senior clinicians and junior doctors to agree on improved rotas which will support workforce plans, triangulating this information with other workforce, activity and quality indicators and with consideration of known labour market supply issues. In addition to this our Guardian of Safe Working will seek to improve the information dashboard relating to rota gaps, enabling a more proactive response and improving collaborative working with our clinical Divisions.

Part 2.3

Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC), now known as NHS Digital.

NHS Improvement has produced guidance for the Quality Account outlining which performance indicators should be published in the annual document. You can see our performance against these mandated indicators in the next Figure.

Figure 50: Reporting against core indicators

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
a) The value and banding of the Summary Hospital level Indicator SHMI for trust for the reporting period	2015/16	1.13	1	1.178	0.68	2019/20 data period: Dec18 – Nov19 (latest published data as at 11/05/20)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17	1.12	1	1.23	0.73		
	2017/18	1.09	1	1.11	0.89		
	2018/19	1.0462	1.0012	1.2058	0.7069		
	2019/20	1.0128	1.0036	1.1957	0.6909		
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	2015/16	20.90%	28.50%	54.60%	0.60%	2019/20 data period: Dec18 – Nov19 (latest published data as at 11/05/20)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group & End of Life Steering Group (delivery) and Q&P Committee (assurance).
	2016/17	21.00%	31.10%	58.60%	11.20%		
	2017/18	32.10%	32.80%	59%	12.60%		
	2018/19	35%	35.84%	60%	12%		
	2019/20	33%	36.81%	59%	11%		
Number of patient safety incidents / number which resulted in severe harm or death	2015/16	11,517 / 40	9,465 / 39	23,990 / 60	3,510 / 26	Pre 2019/20: data covers the last 6 months in the financial year. 2019/20 data period: Apr19 – Sep19 (latest published data as at 11/05/20).	The actions to be taken have already been described within this report and are monitored by the improvement group Safety and Experience Review Group (delivery) and Q&P Committee (assurance).
	2016/17	6,932 / 22	4955 / 19	23,990 / 60	3,510 / 26		
	2017/18	7,523 / 35	5,449 / 19	19,897 / 51	1,311 / 0		
	2018/19	6,780 / 12	5,841 / 19	22,048 / 72	1,278 / 12		
	2019/20	7,216 / 15	6,276 / 19	21,685 / 95	1,392 / 20		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Rate per 1000 bed days of patient safety incidents resulting / rate per 1000 bed days resulting in severe harm or death	2015/16	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	Pre 2019/20: data covers the last 6 months in the financial year. 2019/20 data period: Apr19 – Sep19 (latest published data as at 11/05/20).	
	2016/17	41.82/0.13	39.89/0.15	71.81 / 0,6	21.15/0.06		
	2017/18	45.00 / 0.21	42.55 / 0.15	124.0 / 0.05	24.19 / 0.00		
	2018/19	41.32 / 0.07	46.06 / 0.15	95.94 / 0.32	16.90 / 0.16		
	2019/20	44.88 / 0.09	49.78 / 0.16	103.84 / 0.01	26.29 / 0.31		
Rate of C diff (per 100,000 bed days) among patients aged over two	2015/16	11.4	15	62.6	0	As at 11/05/20	The actions to be taken are within an improvement plan and are monitored by an improvement committee The Infection prevention and Control Committee (Delivery) and Q&P Committee (assurance).
	2016/17	12.5	13.2	82.7	0		
	2017/18	17.4	13.1	90.4	0		
	2018/19	16.9	11.7	79.7	0		
	2019/20	not available	not available	not available	not available		
Percentage of patients risk assessed for VTE	2015/16	93.30%	96.10%	100.00%	88.60%	2019/20 data period: Apr19 – Dec19 (as at 14/05/2020)	The actions to be taken are that we have a Task and Finish Group set up to improve this indicator been described within this report and are monitored by the improvement group. The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17	93.50%	95.60%	100.00%	78.70%		
	2017/18	90.00%	95.30%	100.00%	77.00%		
	2018/19	93.71%	96.70%	100%	74.30%		
	2019/20	93.79%	99.03%	100%	71.72%		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Rate per 1000 bed days of patient safety incidents resulting / rate per 1000 bed days resulting in severe harm or death	2011/12*	9.88%	10.26%	14.94%	6.40%	As at 14/05/20	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
Readmissions within 28 days: age 16 or over	2011/12*	10.52%	11.45%	13.80%	9.34%	As at 14/05/20	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	As at 14/05/20	
	2016/17	67.7	69.6	86.2	58.9		
	2017/18	65.8	68.6	85.0	60.5		
	2018/19	65.1	67.2	85.0	58.9		
	2019/20	not available	not available	not available	not available		
Staff Friends & Family Test Q12d (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2015/16	69.0%	65.0%	85.4%	46.0%	2019/20 data period: Survey in Oct19-Dec19 (as at 14/05/20	The actions to be taken are monitored by the improvement group Staff and Experience Improvement Group (delivery) and People and OD Committee (assurance).
	2016/17	64. 0%	70.0%	84.80%	48.9%		
	2017/18	61%	70%	93%	42%		
	2018/19	65%	70%	87%	41%		
	2019/20	64%	70%	88%	41%		

PROMs

Four patient reported outcome measures (PROMS) were originally collected

1. groin hernia surgery
2. varicose vein surgery
3. hip replacement surgery and
4. knee replacement surgery during the reporting period.

This reduced to two items, which are detailed below.

	EQ-5D		EQ VAS	
Procedure	**Trust %**	**England %**	**Trust %**	**England %**
Hip	96.30%	91.40%	76.60%	70.58%
Knee	90.32%	84.32%	62.50%	60.69%

PART 3

Other information

The following section presents more information relating to the quality of the services we provide.

In the figure below there are a number of performance indicators which we have chosen to publish which are all reported to our Quality & Performance Committee and to the Trust Board. The majority of these have been reported in previous Quality Account documents. These measures have been chosen because we believe the data from which they are sourced is reliable and they represent the key indicators of safety, clinical effectiveness and patient experience within our organisation.

Indicator	2017/ 2018	2018/ 2019	2019/ 2020	National target (if applicable)	Notes/ Other information
Maximum 6-week wait for diagnostic procedures	0.28%	0.45%	3.16%	<1%	Mar 20 snapshot
Clostridium difficile year on year reduction	56	56	97	2019/20: 114	Total Apr 19 – Mar 20
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	4	6	2	0	Total Apr 19 – Mar 20
MSSA	100	80	18	<=8	Total Apr 19 – Mar 20
Never events	6	2	6	0	Total Apr 19 – Mar 20
Risk assessment for patients with VTE	87.03%	93.20%	93.19%	>95%	2017/18 = Jul to Mar based on submissions (did not have data Q1) Apr18-Mar19
Crude mortality rate	1.24%	1.09%	1.19%	No target	Total Apr 19 – Mar 20
Dementia 1a: Case finding	0.80%	1.90%	0.80%	>=90%	Total Apr 19 – Mar 20
Dementia 1b: Clinical assessment	65.00%	27.90%	29.40%	>=90%	Total Apr 19 – Mar 20
Dementia 1c: Referral for management	11.00%	2.80%	0%	>=90%	Total Apr 19 – Mar 20
% patients spending 4 hours or less in ED	86.70%	89.60%	81.58%	>=95%	Total Apr 19 – Mar 20
Number of ambulance handovers delayed over 30 minutes *(<=1hr)	506	666	1218	Annual Target TBC (<=40 per month STP)	Total Apr 19 – Mar 20

Indicator	2017/ 2018	2018/ 2019	2019/ 2020	National target (if applicable)	Notes/ Other information
Number of ambulance handovers delayed over 60 minutes	15	14	35	0	Total Apr 19 – Mar 20
Emergency readmissions within 30 days: elective and emergency	6.9%	6.9%	7.0%	<8.25%	Total Apr 19 – Mar 20
% stroke patients spending 90% of time on stroke ward	88.2%	90.8%	87.70%	>=80%	2019/20: Apr – Feb
% of women seen by midwife by 12 weeks	89.50%	89.80%	88.90%	>90%	Total Apr 19 – Mar 20
Number of written complaints	1031	898		No target	Apr 18 – Mar 19
Rate of written complaints per 1000 inpatient spells	6.26*	5.65		No target	Apr 18 – Mar 19
Cancer – urgent referrals seen in under 2 weeks from GP	82.30%	90.10%	92.50%	>=93%	Total Apr 19 – Mar 20 (unvalidated)
2 week wait breast symptomatic referrals	90.40%	95.90%	97.50%	>=93%	Total Apr 19 – Mar 20 (unvalidated)
Cancer – 31 day diagnosis to treatment (first treatments)	96.30%	94.60%	93.40%	>=96%	Total Apr 19 – Mar 20 (unvalidated)
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	94.80%	95.30%	93.60%	>=94%	Total Apr 19 – Mar 20 (unvalidated)
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.80%	99.90%	99.40%	>=98%	Total Apr 19 – Mar 20 (unvalidated)
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.10%	99.30%	94.90%	>=94%	Total Apr 19 – Mar 20 (unvalidated)
Cancer 62-day referral to treatment (urgent GP referral)	75%	74.80%	73.10%	>=85%	Total Apr 19 – Mar 20 (unvalidated)
Cancer 62-day referral to treatment (screenings)	92.20%	96.50%	95.40%	>=90%	Total Apr 19 – Mar 20 (unvalidated)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	Not reported in 2017/18	79.75%	79.79%	92%	Mar 20 snapshot
Delayed Transfer of Care rate	2.39%	3.15%	2.96%	<=3.5%	Mar 20 snapshot
Number of delayed discharges at month end	34	43	15	<=38	Mar 20 snapshot

ANNEX 1

Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Statement from NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire CCG Comments in Response to Gloucestershire Hospitals NHS Foundation Trust Quality Report 2019/20

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2019-20. The past year has continued to present major challenges across both Health and Social care in Gloucestershire and none more so than in recent months as we work through the Covid-19 pandemic. We are very pleased that GHNHSFT have worked jointly with partner organisations, including the CCG and colleagues within the local authority during 2019/20 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers.

Given the current context and the unusual times ahead the CCG wishes to start by thanking the Trust for all the hard work and outstanding efforts made by staff to ensure high quality treatment and care delivery during the pandemic alongside great innovation and flexibility. Frontline staff have continued to risk their own health by treating those infected by COVID-19 while the majority of the country remains in lockdown, the courage and kindness shown must not be underestimated and the CCG intend to continue working with partners to monitor the effects of the COVID pandemic on NHS staff.

Before the COVID-19 pandemic the Trust were further progressing and building on their 'Journey to Outstanding' following their previous CQC inspection in October 2018 in which they were awarded 'Good'.

The CCG have good visibility of the ongoing action planning and the progress that is being made against the deliverables and look forward to working with the Trust further with their dedication to improve. The CCG is also pleased to see that the focus of the new strategic vision is very much around kindness and compassion and acknowledge the Board's work with Professor West.

The 2019/20 Quality Account is a comprehensive document which identifies how the Trust performed against their priorities for improvement in 2019/20 and outlines the improvement in the quality of the services they deliver. The report is open and transparent and demonstrates their commitment to continuous quality improvement. The CCG endorses the quality priorities that have been selected for 2020/21, whilst acknowledging the very difficult challenges and pressures that GHNHSFT have to address in the coming year. The CCG are particularly pleased to see as part of the quality priorities for 2020/201work to include improving patient experience on discharge processes and to improve outpatient experience. Alongside the quality priority to improve mental health care for patients coming into hospital as per the NHS Long Term Plan. The CCG is also pleased to see the Trust address of their safety culture as a priority for the year ahead and looks forward to reviewing the work of the focus groups.

The CCG are aware of a number of Serious Incidents that GHNHSFT have reported in the last year and the Never Event reports as they occur. The CCG continue to work with the Trust in relation to the management of these incidents/events in order to ensure that all learning and improvement actions

are embedded within clinical environments and wider system learning is shared. The Trust's Safety & Experience Review Group, with representation and challenge from the CCG, continues to retain detailed oversight of all serious incidents, complaints and never events. There is a clear and robust system in place for ongoing monitoring of all action plans and recommendations.

As part of this work on serious incidents, the CCG is also pleased to see the improvement plans that aim to reduce the number of pressure ulcers developing in patients receiving care at GHNHSFT and also the ongoing work to prevent falls in hospital. The CCG continues to work closely with the Trust to provide support where required and monitor improvements and was also pleased to partake in the quality summit. This, alongside joint working on the deteriorating patient and improving the care for patients with diabetes, helps to provide assurance and system wide learning linking with other health providers.

The CCG acknowledges the content of the Trusts Quality Account and will continue to work with the Trust to deliver acute services that provide best value whilst having a clear focus on providing high quality, safe and effective care for the people of Gloucestershire. Gloucestershire CCG confirms that to the best of our knowledge we consider that the 2019/20 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT. During 2020/21 the CCG will work with GHNHSFT, all stakeholders including the people of Gloucestershire, to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the acute hospital services provided to the residents of Gloucestershire and beyond.

Dr Marion Andrews-Evans
Executive Nurse and Quality Director

Statement from Healthwatch Gloucestershire (HWG)

Healthwatch Gloucestershire's Response to Gloucestershire Hospitals NHS Foundation Trust's Quality Account 2019/2020

Healthwatch Gloucestershire welcomes the opportunity to comment on Gloucestershire Hospitals NHS Foundation Trust's quality account for 2019/20. Healthwatch Gloucestershire exists to promote the voice of patients and the wider public with respect to health and social care services.

We value having representation on the Council of Governors and look forward to making more use of the opportunities this offers. We appreciate the openness and transparency of the Trust's relationship with its Governors. The information shared so freely during the coronavirus pandemic has been frank and therefore reassuring, even when the news was not good. We will remain a critical friend, seeking to offer constructive feedback.

We are pleased to note the launch of the Patient Experience Improvement Faculty and the philosophy of care that this represents. We hope that this can continue to remain a priority throughout the challenging times that lie ahead through the coronavirus pandemic. The Real Time Survey showed that just 9-10% of people were asked to give their views on the quality of their care and we look forward to there being a marked improvement on this figure as the Quality Improvement programme takes effect.

In the current climate, innovative approaches are called for. Whilst we agree that testing new ways of working and finding 'silver linings' to carry forward is positive, we hope that changes emerging from the treatment of patients during Covid-19 are based on patient experiences as well as clinical and operational criteria.

During the year, we worked closely alongside our NHS partners as they embarked on Fit for the Future, an ambitious and far-reaching engagement project to review urgent and hospital care in Gloucestershire. Our aim was to make sure the needs, views and experiences of local people were placed at the heart of decision making about changes to services in the county. In 2019-20 people told us that moving from inpatient to outpatient services is an area of concern and we note that hospital discharge has also been identified by the Trust as an area for improvement. Healthwatch Gloucestershire had planned for this to be a focussed piece of work for the coming year and, whilst our in depth work may be delayed due to Covid-19, we look forward to being able to making progress as restrictions allow.

Over the coming months we will be seeking out the experiences of patients and their loved ones of hospital care during the coronavirus pandemic and look forward to sharing this with Gloucestershire Hospitals NHS Foundation Trust to ensure real improvements in patient experience. Measures of experience outside of the Friends and Family Test are invaluable and Healthwatch Gloucestershire will be pleased to work positively with the Trust on this as they continue their focus on Quality Improvement.

Nikki Richardson
Chair of Healthwatch Gloucestershire Board

Helen Webb
Manager of Healthwatch Gloucestershire

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health Overview and Scrutiny Committee I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Quality Account 2019/20.

These are challenging times with the impact of COVID-19 impacting on services in the short and long term. The Committee recognises the work that has taken place in response and wishes to convey it's thanks to the Trust as a whole.

Scrutiny has been preparing to consider and add value to the Fit for the Future programme having had to pause its work over the previous four months. Members understand the temporary service changes that have had to be put in place and will welcome further conversations as to how the planned approach has changed in light of the recent outbreak. As the Quality report says, it is important to embrace the innovations that have surfaced and move forward.

One of the areas outlined within the report, which will be a focus of the Committee's work plan, is to improve cancer patient experience. Members note that one of the challenges of the Cancer Patient Survey was the timeliness of data. Members also understand that nationally Trusts are struggling to meet the 62 day standard performance for Cancer patients following an urgent GP referral. The Committee welcomes the wide range of improvement activity planned for 2020/21 and will be closely following this going forward.

Members noted the focus on reducing Delayed Transfers of Care as this has a huge impact on patient outcomes and experience. The target of keeping delays under 3.5% has not been achieved in recent months with December 2019 and February 2020 particularly challenging. The Committee will want to see improvements in this areas moving forward and understand more about the improvement plan in place.

Members recognise the important of 'Getting It Right First Time' to improve the quality of care within the NHS. The Committee notes the key progress but it was surprising to see that the majority of specialities were unaware of litigation claims against them. It would seem like a key part of the improvement process that they are made aware and members welcome the development of a litigation report being prepared by the Trust.

The Committee would also like to emphasis the important of improvement work related to consultants reviewing patients within 14 hours of admissions.

I would just like to also thank Deborah Lee and Peter Lachecki for their engagement with the committee, and their willingness to answer the many questions asked by committee members.

Cllr Brian Robinson

Health Overview & Scrutiny Overview and Committee

Independent Auditor's Limited Assurance Report to the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust on the Quality Report

Not required for the 2019/20-year due pandemic Covid-19

ANNEX 2

Statement of directors' responsibilities for the quality report

Statement of directors' responsibilities for the Quality Account

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

In preparing the quality report, directors have taken steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19
- 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 2019 to March 2020
  - papers relating to quality reported to the board over the period April 2019 to March 2020
  - feedback from commissioners 23.06.20
  - feedback from governors 17.06.20

Our Governors have contributed to identifying the priorities for next year 2020/21 and have also provided us with feedback on this year's Quality Account.

- feedback from local Healthwatch organisations 11.06.20
- feedback from overview and scrutiny committee 29.06.20
- the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated T.B.C. https://www.gloshospitals.nhs.uk/contact-us/feedback-and-complaints-pals/
- the 2018 national patient survey published by CQC 20/06/2019 https://www.cqc.org.uk/provider/RTE/survey/3
- the 2018 national staff survey published November 2019 https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2019/
- the Head of Internal Audit's annual opinion of the trust's control environment – not applicable this year
- CQC inspection report dated 07/01/2019 https://www.cqc.org.uk/provider/RTE

This 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.

The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

Chairman

Chief Executive

Quality Account

2019/20