NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality Account 2023–2024

the Best Care for Everyone
care / listen / excel

Our Quality Account 2023/24

Our Quality Account is our annual report about the quality of our services provided by us, Gloucestershire Hospitals NHS Foundation Trust. Our Quality Accounts aims to increase our public accountability and drive our quality improvements. Our Quality Account looks back on how well we have done in the past year at achieving our quality 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.

Table of Contents

Part 1

Statement on quality from the Chief Executive Officer of Gloucestershire Hospitals NHS Foundation Trust

Welcome to our 2023-2024 Quality Account, which demonstrates our commitment to providing the best possible care to our patients and their families. This report reviews the quality of care we have provided over the past 12 months and shares our priorities for the year ahead for improving the safety, outcomes and experience of our staff and patients.

Our achievements are all thanks to the commitment, adaptability and professionalism shown by our staff across the Trust. Over the past year, our teams made significant progress delivering our key quality priorities for our patients as we have continued our recovery from the Covid-19 pandemic, in the face of strong headwinds from increased demand, industrial action, and financial pressures. Despite the many challenges, we have achieved a huge amount.

The year just gone 2023/24

Month	Key event
April 2023	- The year started with news that Deborah Lee would be standing down from her role as Chief Executive of the Trust after seven years in post and would like to thank Deborah for her service to the Trust and people of Gloucestershire. - The **Care Quality Commission (CQC)** were on site and revisited our Surgery and Maternity Services. - We are starting the year with patients in **non-designated bed spaces** and so we held a Quality Summit, with clinical colleagues, to develop a plan for reducing and, ultimately, eliminating the need to care for patients in corridors on our wards and care for patients in areas not intended for this purpose, including day surgery and Emergency Department cohort areas. - Our journey commenced on the national, NHS England (NHSE) sponsored, "**Worries and Concerns"** quality improvement collaborative. This programme of work was designed to ensure that patient and family concerns are central to the management of acute illness and deterioration. We are going to be testing and implementing methods for patients, families and carers to escalate their concerns about deterioration and to input their views about their illness into the health record.
May 2023	– The Trust has strengthened its approach to accountability, challenge and staff support through the appointment of a dedicated lead for **Freedom to Speak Up** (FTSU). There are a number of teams across the Trust who have 'Guardians' so plans are now in place to ensure clarity between the roles they all play. – NHS Resolution publish the year 5 **Maternity Incentive Scheme** (MIS) guidance. This is a financial incentive program designed to enhance maternity safety within our service. It rewards Trusts that can

Month	Key event
	demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families and newborns.
June 2023	- Teams have worked incredibly hard to minimise the loss of elective activity associated with **industrial action**. However, thanks to the efforts of our administrative teams, 90% of these patients have been re-booked. - The **Armed Forces Covenant** was re-signed by the Chief Executive and work commenced to capture Armed Forces Serving personnel and families onto our patients' digital record. - Launch of '**PALS champions'** an initiative to support our ward clerk team to be able to provide advice to our patients, carers and visitors.
July 2023	- On Wednesday 5 July 2023, the **NHS celebrated 75 years of service** and our Trust played its part, along with system partners, in marking this significant milestone. A wide range of activities were planned throughout the week as we came together with our community to mark the occasion. - We continue delivering our **cultural improvement plan** with great work being done with good engagement with a significant number of colleagues who have joined a dedicated Taskforce. - National **Urgent and Emergency Care (UEC22) Patient Experience** survey results published, overall experience 'about the same' as other Trusts. - National **Cancer Patient Experience** (CPES22) survey results published, achieved 'above expected' in 9 questions.
August 2023	- Our **Maternity service** continues on the improvement phase of Maternity Safety Support Programme (MSSP). System and Regional input being provided to support increasing pace of change. The MSSP team are providing support to undertake thematic analysis of cases relating to massive obstetric haemorrhage. - **Industrial Action** has been ever present throughout the year, and there has been a total of 17 separate periods of action by different health staff since December 2022, affecting on our hospitals, our staff and our patients. As part of our planning, we had to temporarily close Cheltenham's ED for extended periods and pause some planned care and outpatient appointments, although we worked hard to minimise disruption for patients receiving cancer care, and for those who have been on the waiting list a long time. We hope that positive progress will be successful this year in resolving the issues nationally. - In Cheltenham, two new theatres and the new Chedworth Surgical Unit opened providing dedicated day surgery facilities. The state-of-the-art facilities will be used for urology, Gastrointestinal (GI) and orthopaedic surgery bringing the total number of theatres on the Cheltenham site to 14 and together this will help us treat up to 2,500 more day-surgery patients per year.

Month	Key event
September 2023	- The **Care Quality Commission (CQC)** were on site and visited our Children and Young People's Services for an unannounced focused inspection. - The "**Slipper Trial**" on Woodmancote Ward started and this initiative reduced falls from an average of 11 falls per month to 6 during period of trial (19/09/23 – 19/11/23). - **National Inpatient (IP22) Survey** results published, overall experience 'about the same' as other Trusts. Areas requiring improvement continue to be around discharge.
October 2023	- Through our **Health Inequalities** Improvement Programme "Tackling Tobacco Dependency", our percentage (%) compliance of recorded smoking status on admission has been sustained at greater than 80% and this has been supported by changes to the digital systems. This enabled better oversight of patients so that interventions can be targeted.
November 2023	- **CQC** published inspection reports with improved position for surgery and Trust remaining with a "requires improvement" rating. Maternity were rated "inadequate" and were served with a continued section 29a warning notice. This was to ensure safeguarding training level 3 was provided for all staff and incidents to be investigated in a timely way so learning can be shared quickly to reduce the risk of it happening again. This is a repeat of part of the warning notice issued following the inspection in April 2022. - This month we were delighted to see an early evaluation of **stroke services** following their centralisation at Cheltenham General. Since then the team has improved access to imaging within an hour (gold standard care) from 54% to 74% (52 minutes median time to 11 minutes) and 71% of patients were admitted to a specialist stroke unit within four hours of a stroke being confirmed compared to just 32% previously (383 minutes median to 15 minutes). We know from the evidence that achieving these care goals significantly reduces both mortality and morbidity from stroke and we are now **rated 'B' overall in the Sentinel Stroke National Audit Programme** from a previous rating of 'E' - Our Learning from Deaths Report was presented at Trust Board and the **Standardised Hospital Mortality Index** (SHMI) data was starting to improve, although there appeared to be greater potential for harm at weekends with work underway to understand the differences to improve flow, visibility and access at weekends. There was also a need to ensure that data captured reflected those patients with dementia, as failure to do so made it appear patients were in better health then they actually were and leads to a potential overstatement of mortality measures. Three new projects had been initiated to improve communications related to **end-of-life care**.

Month	Key event
	- Received more than 10,000 responses to the **Friends and Family Test** in one month thanks to further expansion of the survey into areas not previously covered
December 2023	- The **Care Quality Commission (CQC)** were on site and visited our Emergency Department at Gloucester Royal Hospital for a focused unannounced inspection. - The new **Emergency Department** (ED) at Gloucestershire Royal Hospital is now fully operational, which includes a new Minors and the new Children's department opens in January. This significantly larger footprint will enable us to support patients when they are acutely unwell.
January 2024	- In January 2024, Kevin McNamara joined the Trust as our **new CEO,** having previously led Great Western Hospitals NHS Foundation Trust and with over 20 years in the NHS in a number of senior roles. - 29 January 2024 **BBC Panorama** documentary was broadcast. The documentary explored the challenges nationally in **maternity**, with a specific focus on our Trust's maternity services. It includes the tragic deaths of two babies and a mother and interviews midwives and families. We released a statement which you can read and since April 2020 we have invested an additional £1.8 million to increase Maternity staffing, including obstetricians, consultants, administration support and the number of Midwives working in the department has increased from 242.99 (2020) to 263.77 (December 2023). - In January 2024 the **Preventing Deconditioning Project**, funded by £15,000 from the Gloucestershire Integrated Care Board (ICB) commenced in the emergency department to facilitate all eligible patients to sit out of bed/trolley. The project will roll out through February with nursing and AHP leadership support in AMU, Courtyard, Frailty Assessment Unit, Cardiology, to become Trust wide. - Our **Patient Safety Incident Review Framework (PSIRF) Plan and Policy** were approved on 24th January by Trust Board, and these were then ratified by the Gloucestershire Integrated Board on 15 February. We will be transitioning into new ways of working from 1st March 2024.
February 2024	- We have submitted to our declaration to NHS Resolution that we are fully **compliant with all 10 Maternity Incentive Scheme (Year 5) safety actions**, In January we presented evidence for each safety standard to the Trust Board. - The head of the NHS has announced the rollout of 'Martha's Rule' in hospitals across England from April, enabling patients and families to seek an urgent review if their condition deteriorates and we will be continuing with our "Worries and Concerns" project and implementing the 3 Martha's Rule standards.
March 2024	- The Trust received a visit in March 2024 from HRH The Princess Royal, who met staff and mothers, babies and families at the maternity unit at Stroud Hospital. The royal visit was organised by Stroud

Month	Key event
	Hospitals League of Friends who have been a dedicated supporter of Stroud Maternity for decades, funding refurbishment projects and equipment. - CQC published an inspection report for our Stroud Maternity Unit and rated the service as requires improvement. - On 2 March 2024, we received a letter giving us an overview and guidance for the NHS Resolution Maternity Incentive Scheme for year 6 which will be fully published in April 2024. - Our CQC national maternity survey results were published and we have about the same scores (when compared to other maternity services) for "labour and birth", "staff caring for you" and for "care in hospital after the birth". We will respond to the results and will continue our patient experience improvement work. - On 7 March 2024 our local our local Staff Survey results were published and we had a slight percentage increase in questions related to **speaking up "**we each have a voice that counts: Raising concerns". - Our Patient Safety Incident Review Framework (PSIRF) Plan and Policy go live as we transition into a new way of working. - Introduction of '**Your chance to say thank you'** pilot enabling patients and staff a quick method to say 'thank you' to a member of staff or department. This is a collaborative project between the PALS and ward clerk management team

To improve patient outcomes and experience we must continue to maintain our collective focus on the overall quality and safety of our services, based on the national approach set out in A shared commitment to quality and The NHS Patient Safety Strategy. This includes applying the Patient Safety Incident Response Framework (PSIRF) in the development and maintenance of patient safety incident response policies and plans.

The Year Ahead

The outlook for 2024/25 is equally challenging and we will continue to make important progress on things that matter to our Gloucestershire community, our staff and our patients. We will need to keep a relentless focus on improvement, fewer delays and unnecessary processes so that we can provide the best care for our patients.

This year we will consult again on developing our **new Quality Strategy** for 2025-2029, this will outline our ambition to improve the care we provide. It will set out our aims to deliver the Best Care for our patients, improve the experience of our staff and volunteers, improve the health of our population, and ensure value for money through improvement and efficiency. As part of that journey we will complete the NHS IMPACT self-assessment and use this to create a shared, measurable plan for embedding improvement, systematically using improvement as the approach to deliver key priorities.

To improve patient outcome and experience we must continue to focus on the overall quality and safety of our services. In line with the NHS Operating Plan 2024/25 we will continue to implement the Patient Safety Incident Response Framework and our key **Safety Priorities**

will be our Quality Priorities for 2024/25. In addition to the safety priorities we will continue with our journey and focus on deterioration and with this we will be scoping implementing Martha's Rule.

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 a patient.

Finally, 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.

Kevin McNamara
Chief Executive Officer

Parts 2 and 3

Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following 2 sections are divided into parts:

- Part 2
    - Part 2.1
        - 2.1.1 What our priorities for 2024/25 are
        - 2.1.2 How well we have done in 2023/24
    - 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

Part 2.1

2.1.1 Our priorities for 2024/25

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 provide. 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 Quality Strategy outlines the clear approach to ensuring we have robust systems and processes in place to gather and analyse quality and patient experience data, and involve patients, colleagues and communities in a cycle of continuous improvement. The Quality Strategy was approved by the Quality and Performance Committee in October 2019.

The strategy outlines our approach to delivering quality across the Trust and this is through the Insight, Involvement and Improvement model:

- Improve our understanding of quality by drawing insight from multiple sources (**Insight**).
- People have the skills and opportunities to improve quality through the whole system (**Involvement**).
- Improvement programmes enable effective and sustainable change in the most important areas (**Improvement**).

Patient Safety Incident Response Plan (PSIRP)
For next year, we have chosen to focus on our Patient Safety Incident Response Plan (PSIRP) as this sets out how Gloucestershire Hospitals NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Data Sources
Data sources were identified by the Patient Safety Incident Response Framework (PSIRF) working group based on those which would provide insight into our patient safety incident profile. Using these sources, data representing the preceding 12 months (June 2022 – May 2023) was reviewed, as the preceding years were impacted by the COVID-19 pandemic and were therefore potentially not representative of the ongoing safety profile of the organisation. It is intended that a small-scale data review will occur again 18 months after publication to cover the data period June 2022 - May 2024, to validate the selection of safety priorities with a larger data set and a full data review occurring, every four years. At this time, the PSIRP will be updated as necessary, to ensure that it continually reflects the organisation as it changes.

- The data sources used to identify our initial safety priorities include:

- Patient safety incidents,
- Risks and their controls,
- Claims
- Complaints
- Staff survey
- Inquests
- Freedom to Speak Up themes
- Patient Advisory & Liaison (PALs) themes
- Friends and Family Test (FFT) themes

Stakeholder Engagement

An initial list of potential safety priorities was identified by comparing the themes contained within these data sets and identifying areas of commonality. Whilst consideration was given to the frequently occurring outcomes, the focus was largely on the underlying issues and factors that appeared to contribute to different safety incidents and other forms of unwanted outcomes. This list was initially reviewed by the PSIRF working group, which consisted of members of the patient safety, risk and quality teams from across the Trust. This initial review identified a list of potential safety priorities, which were then shared with staff Trust wide through a Quarterly Pulse Survey. Through this survey, staff members were able to comment on the proposed priorities by answering the following question:

Figure 1: Quarterly Pulse Survey Question

As part of the development of our Patient Safety Incident Response Plan, a review of our data has highlighted the following themes from safety incidents, risks and patient feedback. Which of these do you believe should be included as Trust Safety Priorities for the coming year? (Choose up to 3)

▪ Staffing

▪ Culture (i.e., Our organisational behaviours, values and normal practices)

▪ How we introduce and use digital systems in our clinical and administration processes

▪ Environment design and facilities

▪ Falls

▪ Pressure Ulcers

What else would you include that is not listed above and why?

Using the feedback from the survey, supplemented by an additional review of emerging risks the safety priorities listed below were agreed.

Due to ongoing improvement work within the maternity department, this supplemental review

included further consideration of any trends which highlighted the necessity for maternity specific safety priorities, which were not already encompassed by the identified Trust-wide safety priorities. This additional review concluded that whilst the majority of the Trust-wide safety priorities were equally relevant to maternity, an additional safety priority related to the recognition and escalation of deterioration within pregnancy, should be considered. This was subsequently added to the priorities listed below.

Our patient safety incident response plan: local focus

Patient Safety Incident type or issue	Description	Planned response and anticipated improvement route
Staffing	Risks and incidents where inadequate numbers of staff or skill mix have been identified.	Trends identified and incidents reviewed and used to inform the workforce sustainability work stream of the people and organisational development strategy.
Culture	Risks or incidents where team / department or organisational culture is impacting on behaviours, standards or safe delivery of services/ care.	Trends identified and incidents reviewed and used to inform the staff experience work stream of the people and organisational development strategy.
Digital Systems	Risks and incidents related to the introduction and use of digital clinical systems.	Trends identified and incidents reviewed by the clinical systems safety group. Emerging risks/ issues identified for Quality Summits and inform ongoing improvement efforts
Flow and discharge	Risks and incidents related to impeded patient flow from assessment to discharge, including delays to discharge, excluding clinical complications.	Trends identified and incidents reviewed and used to inform the discharge improvement programme and the urgent and emergency care work stream. Emerging risks/ issues identified for Quality Summits and inform ongoing improvement efforts
Communication	Risks and incidents that relate to communication between staff and	Trend analysis used to inform quality improvement efforts

Patient Safety Incident type or issue	Description	Planned response and anticipated improvement route
	patients and their families	
Patient Falls	Patient fall	Incidents reviewed and trends identified Moderate/ severe harms and deaths plus those with other learning opportunities reviewed at falls learning hub. Learning, trends and annual audit used to inform improvement programme. Annual quality summit.
Pressure Ulcers	Hospital acquired pressure ulcers	Incidents reviewed and trends identified. Moderate/ severe harms and deaths plus those with other learning opportunities reviewed at pressure ulcer learning hub. Learning & trends used to inform improvement programme. Annual quality summit.
Delay to recognition and/or escalation of deterioration during pregnancy and/or delivery	Risks and incidents where delays in recognition and/or escalation of deterioration during pregnancy and/or delivery have or could have affected the safe care and outcome for mother or baby.	Trends identified and incidents reviewed by the maternity governance team; Individual incidents that meet national (mandated) criteria for PSII to be referred to MNSI and Patient Safety Review Panel. Emerging risks/ issues that do not meet criteria for referral to MNSI or Patient Safety Review Panel to be identified for Quality Summits and inform ongoing improvement efforts.

As a result of our consultation processes, 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 (Governors are members of 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.

Health Inequalities

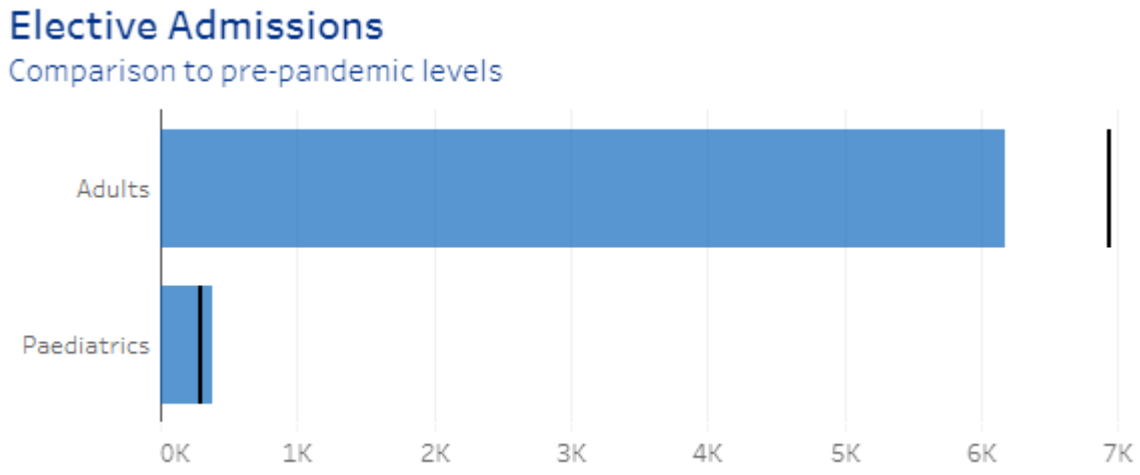
Health inequalities are systematic, unfair and avoidable differences in health across the population, and between different groups within society. They arise because of differences in the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can affect both our physical and mental health and wellbeing. Health inequalities can stem from barriers individuals experience when accessing healthcare services, or poor experiences of healthcare that deter individuals from future engagement. These scenarios can contribute to delayed healthcare access and poorer outcomes as a result.

Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs. NHS England's Healthcare Inequalities Improvement Programme's vision is for the NHS to deliver "exceptional quality healthcare for all, ensuring equitable access, excellent experience and optimal outcomes". Good quality, robust data enables the NHS to understand more about the populations we serve. It enables NHS bodies to identify groups that are at risk of poor access to healthcare, poor experiences of healthcare services, or outcomes from it, and deliver targeted action to reduce healthcare inequalities.

Elective Recovery

- Over the last 12 months, **children's elective services at the trust are treating a similar number of patients compared to pre-pandemic levels** (financial year 2019/20). In April of this year, 382 children had some form of elective procedure or surgery carried out compared to 283 in April 2019
- However, **delivering elective adult services at pre-pandemic levels has been much more challenging**, with the trust consistently performing fewer procedures last year compared to 2019/20
- However, **all demographics within Gloucestershire have been affected equally**. There is no difference due to age, gender, ethnicity or deprivation. All available evidence points to patients being treated in order of clinical urgency. This would suggest the **downturn in activity is due to capacity constraints, rather than any particularly group taking priority**, either consciously or unconsciously.

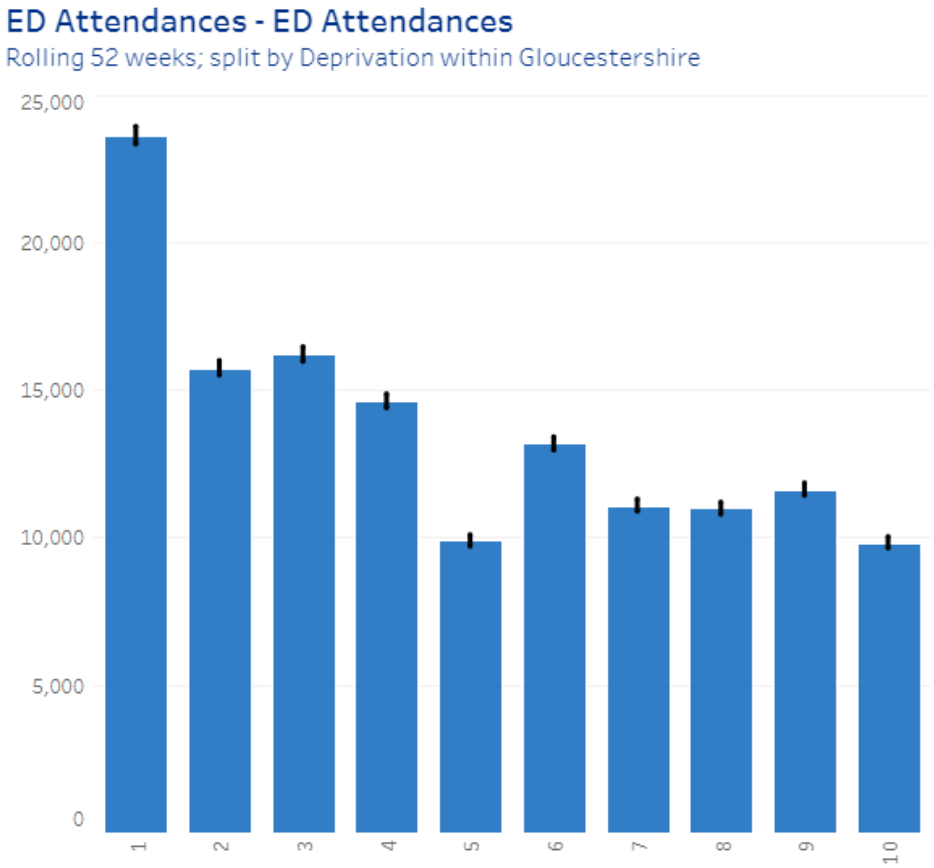
Figure 1. Elective admissions in April 2024 compared to pre-pandemic levels



Emergency Care

- Across all sectors of our hospital, **demand for services correlates with deprivation** i.e., people living in the most deprived parts of the county are much more likely to require hospital care.
- This is most pronounced for our emergency services; people living in the top 10% most deprived areas are **1.5x more likely to attend A&E** and **1.3x more likely to be have an emergency admission**, compared to people living the next 10%.
- This is true for both adults and children.

Figure 2. Number of attendances to A&E in the last 12 months, split by deprivation (1 = most deprived, 10 = least deprived)



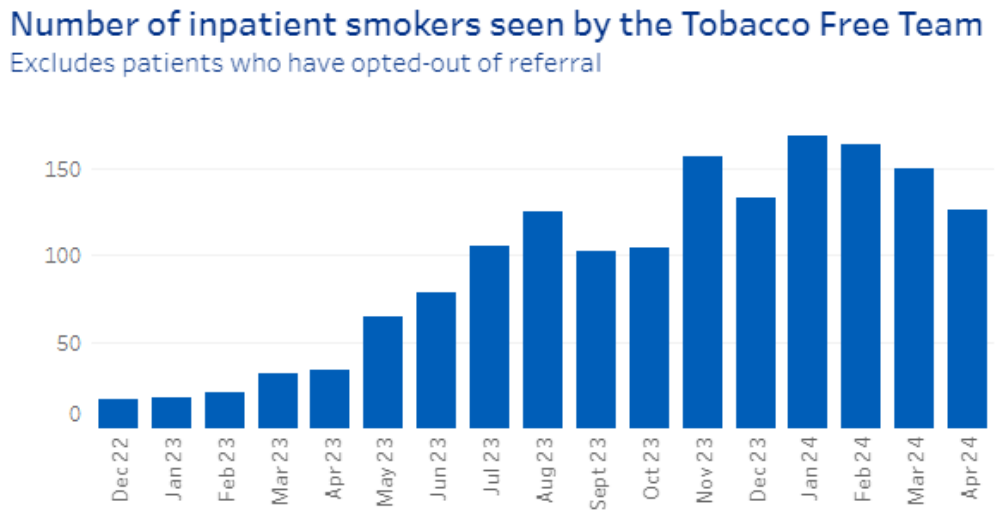
Smoking Cessation

- Smoking cessation sits across all the domains of the Core20Plus5 adult framework.
- Since December 2022, the trust has employed tobacco treatment advisors to offer support to patients on wards on an opt-out referral, to support them to give up smoking by providing them with evidence based bedside interventions and Nicotine Replacement Therapy. We also follow up, and referral to community service for onward support.
- As of June 2023, we offer this service across our Gloucester and Cheltenham sites, and **60% of all smokers who were inpatients on our wards were offered support from one of our advisors.**
- The service is also available to all trust staff who would like support in stopping smoking.
- We have also vastly improved how we record a patient's smoking status when they visit one of our wards, through a combination of better use of technology and offering

training to staff. Over the last 6 months, **99% of patients were asked about their smoking status on admission.**

- Provide **Very Brief Advice (VBA) training** to staff to improve their knowledge and confidence around smoking.

Figure 3. Number of smokers offered support to stop smoking in hospital, per month



Children's Oral Health

- Over the last 12 months, 74 tooth extractions were carried out due to tooth decay in children aged 10 and under
- We found **no differences due to age, gender or ethnicity**
- However, we found that **children living in the most deprived part of the county are much likely to require a tooth extraction due to tooth decay** e.g., places like Cinderford, Coleford, and Newnham in the Forest of Dean, Matson in Gloucester, as well as parts of Stonehouse in Stroud.

Deprivation

- The English indices of multiple deprivation measure relative deprivation in small areas of England called lower-layer super output areas (LSOA). The index of multiple deprivation (IMD) is the most widely used
- These measures can be used to compare regions to one another to determine whether they are more or less deprived than one another, relative to the rest of England
- Locally we also look at comparing how deprived an area is to the rest of Gloucestershire

Why do we use deprivation relative to Gloucestershire?

- While comparisons of deprivation to England as a whole are useful, it is also useful to consider deprivation relative to other parts of Gloucestershire. For example, an area may not be considered particularly deprived when compared to other parts of England, but may still have worse outcomes and less access to services compared to other parts of the county. Therefore, if when we are evaluating whether there are

inequalities present in our community, we need to consider this alongside a local picture as well as a national one.

- Deprivation is made of 7 domains:
    - **Income** – measures the proportion of the population experiencing deprivation relating to low income
    - **Employment** – proportion of working age people involuntarily excluded from the labour market
    - **Education** – measures the lack of attainment and skills in the local population
    - **Health** – measures the risk of premature death and the impairment on quality of life due to poor physical or mental health
    - **Crime** – measures the risk of personal and material victimisation
    - **Barriers to Housing & Services** – measures the physical and financial accessibility of housing and local service
    - **Living Environment** – measures the quality of both 'indoor' and 'outdoor' local environment

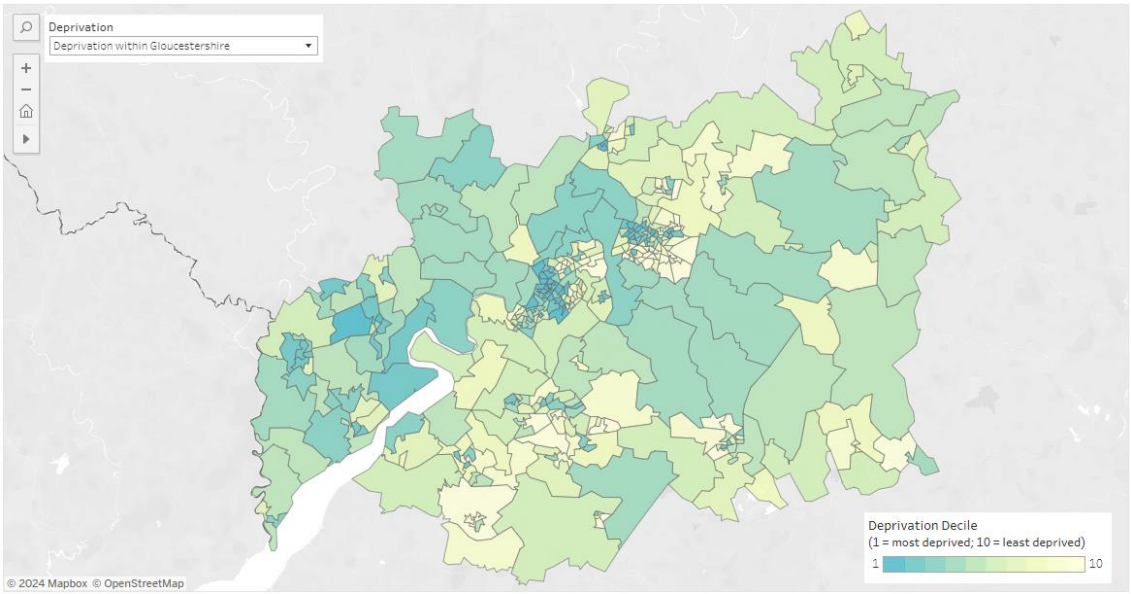


Figure 4. Deprivation compared to the rest of Gloucestershire (1 = most deprived; 10 = least deprived)

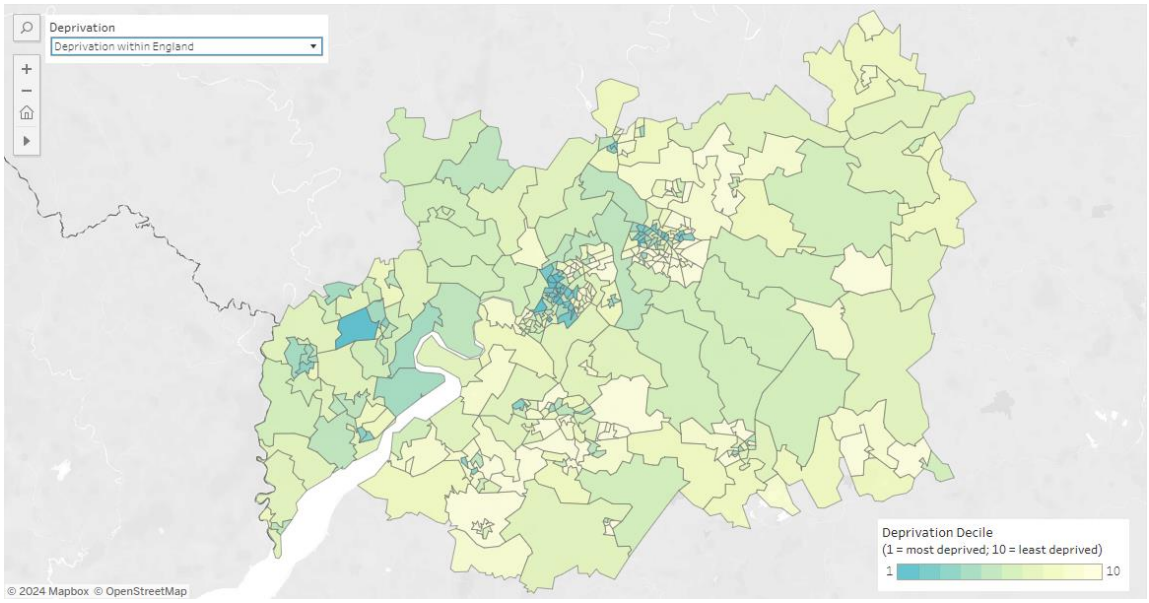


Figure 5. Deprivation compared to the rest of England (1 = most deprived; 10 = least deprived)

Areas of improvement for 2024/25:

A key priority for the trust in the upcoming year is to develop a Health inequalities strategy/plan. This will act as a framework for delivery of health inequalities activity within the trust.

Data Quality

- Ethnicity is one area where our data capture is poor in regards to data quality. As a Trust, we are **expected to record ethnicity for 95% of patients**, but we are below this for inpatients, outpatients and waiting lists. **Only 90% of patients on our waiting lists have their ethnicity recorded**. While we have not encountered any observable differences due to ethnicity, this may be to certain groups being missed in our data capture. We can't assume we are providing an equitable service if we are not recording ethnicity consistently. Therefore, an ambition to improve data quality in the upcoming year should be prioritised.
- Further understanding of those patients that are waiting on the waiting list for a long period of time.
- Data capture for protected characteristics in all indicators could be improved.
- Work with patient experience team to further understand the experiences of patients accessing hospital services.
- Work with services to further understand patient demographics specific to their area and identify areas of improvement.
- Ensure services are aware of the translation and interpretation service.
- Consideration to the **accessibility of information**, services and support, and digital inclusion for patients; by applying the Core20Plus5 framework, digital inclusion framework, inclusion health framework.
- EHIA can support and inform actions to support and reduce healthcare inequalities, therefore implement a proactive approach to ensure that any policies, programmes, proposals or initiatives meet the necessary Equality Act duties.

- In order to improve the access, experience and outcomes of our patients improve partnership working with VCSE, local government and anyone else involved in the care of our patients.
- Workforce- consider health inequalities within the staff population and provide improvement suggestions for staff wellbeing.

1.1 A summary position for our priorities for improving quality 2023/24

No.	Priority for 2023/24	Why we have chosen this priority	Beginning and then final position
1.	To improve maternity safety/ experience	The priority for 2023/24 will be focused on delivering the 10 safety standards within the NHS Resolution **Maternity Incentive Scheme (MIS)**.	At the beginning of the year new safety standards were published and by February 2024 we have submitted a position of achieving 10/10.
2.	To improve emergency department (ED) care safety/ experience	One of our programmes of work we have chosen to report on will be delivering the Commissioning for Quality and Innovation indicator (CQUIN 05) "**Identification and response to frailty in emergency departments".**	Our aim was to achieve 30% by the end of the year. Our starting position at quarter 1 was 29% and we finished the year with a slightly decreased position of 27%. Operational pressures impacting on the ability to complete assessments.
3.	To improve adult inpatient safety/ experience	Our adult inpatient Friends and Family feedback tells us that patients do not like to be cared for **in non-designated bed spaces**, including boarding, and therefore our focus will be on monitoring and then reducing/eliminating our use of escalation beds.	We started the year with an average of 20 patients a day in non-designated bed spaces and finished the year with a decrease to 8. Our plan is to reduce this to zero but operational pressures continue to impact on the flow of patients through the hospital.
4.	To improve experience of discharge	In order to release beds for waiting patients we will have an improvement programme focused on our **discharge lounge** (this is a change from simple discharges).	We started the year with an average of 15 patients per month attending the Discharge Lounge and by March 2024 this has **increased** to 19. We will continue to improve the number of patients using this facility.
5.	To enhance and improve our safety culture	To enhance and improve our safety culture we will be implementing the **National Patient Safety and Incident Response Framework (PSIRF)** which will bring a	Our 2023 Staff Survey scores, for the raising concerns questions, have **increased** by an average of 1%.

No.	Priority for 2023/24	Why we have chosen this priority	Beginning and then final position
		change to our safety investigation work and we will be **focusing on staff being able to raise their concerns (Staff Survey questions 20a, 20b, 25e, 25f.**	
6.	To improve our prevention of harm (pressure ulcers and falls)	The priority for 2023/24 will be to improve our risk assessment, prevention and management of harm in relation to **pressure ulcers and falls.** This will include the delivery of the CQUIN (CQUIN12) assessment and documentation of pressure ulcer risk assessments.	At the beginning of the year our compliance rates were 62% (aim 85%) and by the end of the year our position was 64.25%. There was a 2% improvement and this work will continue as this is a safety priority next year.
7.	To improve our care for patients whose condition deteriorates	We are one of 7 Trusts who have been chosen by NHS England to implement improvement work in the area of including patients/carers and their families in identifying deterioration – our "**Worries and Concerns Programme**" of improvement work. Alongside this programme, we have reviewed the CQUIN07 recording of and response to NEWS2 scores for unplanned critical care admissions.	Our aim was that we would be achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration. We started the year with 32% compliance and ended the year with improved scores of 52% - this was an improvement of 20%.
8.	To improve mental health care for our patients coming to our acute hospital	We will be continuing the implementation of the Trust's Mental Health Strategy – **Whole Person Care Strategy**.	We have improved our systems for requests for enhanced care professionals reducing spend for temporary (agency) Registered Mental Health Nurses.
9.	To improve our care for patients with diabetes	Our focus will be on carrying out improvement work in response to the national **diabetes** audit findings.	We have focused our improvement efforts on improvement identified by national audits and GIRFT data.
10.	To reduce health inequalities	We will continue to deliver the Core20Plus5 health inequalities programme	We began the year with % compliance rates of recorded smoking status

No.	Priority for 2023/24	Why we have chosen this priority	Beginning and then final position
		focused on **tackling tobacco dependency** for colleagues, inpatients and in maternity.	on admission at 75% and by April we have increased this to 86%.
11.	Surgical experience	Our focus will be delivering on the Commissioning for Quality and Innovation Indicator (CQUIN 02) **supporting patients to drink, eat and mobilise (DrEaMing) after surgery.**	We started the year with overall compliance rates of 90% and at the end of the year we had made an improvement and scores were at 95%.
12.	Equality, diversity and inclusion – equality priorities	The Patient Experience Team will be enabling the delivery of **2 equality priorities** by improving our translation and interpretation services and focusing on the accessibility of our services.	As part of the Equality Delivery System Gloucestershire Integrated Care Board in conjunction with Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Health and Care NHS Foundation Trust along with system partners have rated Gloucestershire for domain one of the EDS as 2 – achieving activity. This is a maintained position from previous year.
13.	Commissioning for Quality and Innovation (CQUINs)	We will be focused on delivering our 5 CQUINs – **CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery** (TARGET - 80% of patients within 24hrs) – **CQUIN04:** Prompt switching of intravenous to oral antibiotic (TARGET 40% of fewer) – **CQUIN05: Identification and response to frailty in emergency departments**	See CQUIN results for each programme within the report.

No.	Priority for 2023/24	Why we have chosen this priority	Beginning and then final position
		(TARGET 30% receiving clinical frailty assessment) – **CQUIN07: Recording of and response to NEWS2 score for unplanned critical care** (TARGET 30% having timely response Early Warning Score (EWS) 5-6 60-minute response and EWS 7+ response time 30 min) – **CQUIN12: Assessment and documentation of pressure ulcer risk assessments (**Target: 70% to 85%).	
14.	Caring for people at the end of their lives	We will support the improvement of our compliance with national guidance on care at the end of life (One Chance to Get It Right, NICE guidelines and the Quality Standards for end of life care).	At the start of the year we used the feather icon (signifying end of life) 31 times and at the end of the year increased this to 42.

1. Quality priority - To improve maternity safety/ experience

To improve maternity safety/ experience	The priority for 2023/24 will be focused on delivering the 10 safety standards within the NHS Resolution **Maternity Incentive Scheme (MIS)** for year five.

Background

The priority for 2023/24 was focused on delivering the 10 safety standards within the NHS Resolution **Maternity Incentive Scheme (MIS) for year five**. The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Specifically, Safety action 7 has a focus on patient experience and requires the service to listen to women, parents and families using maternity and neonatal service and co-produce services with users. We have worked collaboratively with Gloucestershire Maternity and Neonatal Voices (GMNVP) to develop our priorities to improve the experiences of our maternity service. These are now reviewed and monitored at our Maternity and Neonatal Experience Group.

How we have performed 2022/23

The Maternity Service were able to report that they were compliant with ten out of ten standards and submitted this return to NHS Resolution in February 2024.

Table: Summary of Safety Action Compliance (link)

Safety Action	Description	Compliance
Safety Action 1	Are you using the National Perinatal Mortality Review Tool to 8 review perinatal deaths to the required standard?	Compliant
Safety Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Compliant
Safety Action 3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the	Compliant

Safety Action	Description	Compliance
	recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?	
Safety Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliant
Safety Action 5	Can you demonstrate an effective system of midwifery 37 workforce planning to the required standard?	Compliant
Safety Action 6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Compliant
Safety Action 7	Can you demonstrate you listen to women, parents and families using maternity and neonatal services and coproduce services with users?	Compliant
Safety Action 8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Compliant
Safety Action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Compliant
Safety Action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Compliant
Overall		**10/10 Compliant**

The Maternity Service awaits confirmation of their position by NHSR and this should be received in April 2024.

Plans for improvement 2024/25

The plan for 2024/2025 will be to implement year 6 of the Maternity Incentive Scheme but this will not be reported in the account as we will focus on the Patient Safety Priority - **Delay to recognition and/or escalation of deterioration during pregnancy and/or delivery**.

2. Quality priority - To improve emergency department (ED) care safety/ experience

To improve emergency department (ED) care safety/ experience	One of our programmes of work we have chosen to report on will be delivering the Commissioning for Quality and Innovation indicator (CQUIN 05) "**Identification and response to frailty in emergency departments".**

Background

Although important before, it is now even more of a priority for hospital teams to develop and adapt their services for vulnerable adults, such as older people living with frailty. This requires early and appropriate assessment to identify those who need hospital admission and those whose needs may best be met by Same Day Emergency Care Services (SDEC).

Frailty is an important marker of adverse outcomes for older people accessing emergency care. Identifying the most at risk older people in Emergency Departments (EDs) may help guide clinical practice, and service improvement in emergency care. If frailty identification is to be used to direct patients towards an appropriate clinical response, it is logical for the process to start at the beginning of the patient's urgent care episode. For example, delays in identifying and managing delirium (a hyper-acute manifestation of frailty) are associated with increased patient harm. Earlier identification and management of frailty syndromes, such as delirium, has the potential to improve outcomes.

In 2023/24, we took part in the Commissioning for Quality and Innovation (CQUIN) with the ambition of achieving 30% of patients of our patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.

Table: CQUIN goals

CQUIN05: Identification and response to frailty in emergency departments	
Applicability: Acute CQUIN goal: 10% to 30% Supporting ref: SDEC guide to frailty – Link	There are well-evidenced links between frailty and adverse health outcomes including deconditioning, malnutrition and irreversible cognitive decline which may all lead to increased health and care requirements. Early identification of frailty can mitigate some of these risks. Under the NHS Long Term Plan, every acute hospital with a Type 1 Emergency Department (ED) was asked to provide acute frailty services for at least 70 hours a week. Patients with grades of frailty (clinical frailty score (CFS) 6 or above) should be assessed for frailty associated syndromes via a comprehensive geriatric assessment and/or be referred to the acute frailty service.

How we have performed 2023/24

There is a growing awareness that the identification of frailty in the urgent care context is important, allowing a population at high risk of harm and resource use to be flagged for focussed interventions.

Frail older people usually present with a range of issues, not just medical, and require a thorough, multidisciplinary management plan. Isolated medical interventions cannot alone optimise outcomes for these people – a more holistic, multidimensional care model is required. Comprehensive geriatric assessment (CGA) is a structure for the thorough assessment and management of a person's medical, psychological, functional, social and environmental circumstances and needs. It improves patient and service outcomes, and increases the likelihood that patients survive and are back home 3 to 12 months after discharge.

Description

We took part in in the CQUIN with the ambition of achieving 30% of patients of our patients aged 65 and over attending the emergency department (ED) or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.

Table: CQUIN results

Quarter (Q)	Denominator	Numerator	Results	Narrative
Q1 report	99	28/99	29%	Where screened, 8 patients were found to have a frailty score of 6+. 7 of these had a CGA initiated, and 1/6 were appropriately referred to the acute frailty service. GSQIA Silver course underway focussing primarily on ensuring patients 65yrs+ have a frailty assessment score documented.
Q2 report	80	9/80	11.3%	15% (12) had a frailty score documented Of these patients, who had a score, three had a score of 6+. None of the three had a Comprehensive Geriatric Assessment (CGA) or referral to Acute Frailty Service (AFS) completed (remaining 9 appropriately scored and not referred).

Quarter (Q)	Denominator	Numerator	Results	Narrative
Q3 report	97	23/97	24%	Overall compliance 24% (23/97) 27% (26) had a frailty score documented, and of these x8 had a score of 6+. 5 of these (62.5%) had a CGA completed. 2/8 were not applicable for referral to acute frailty, so 4/6 were referred.
Q4 report				Overall compliance 26% (26/100) 27% (27) of patients had a frailty score documented, and of these x11 had a score of 6+. 100% (11) of these had a CGA completed and x 7 (64%) were referred to the acute frailty service

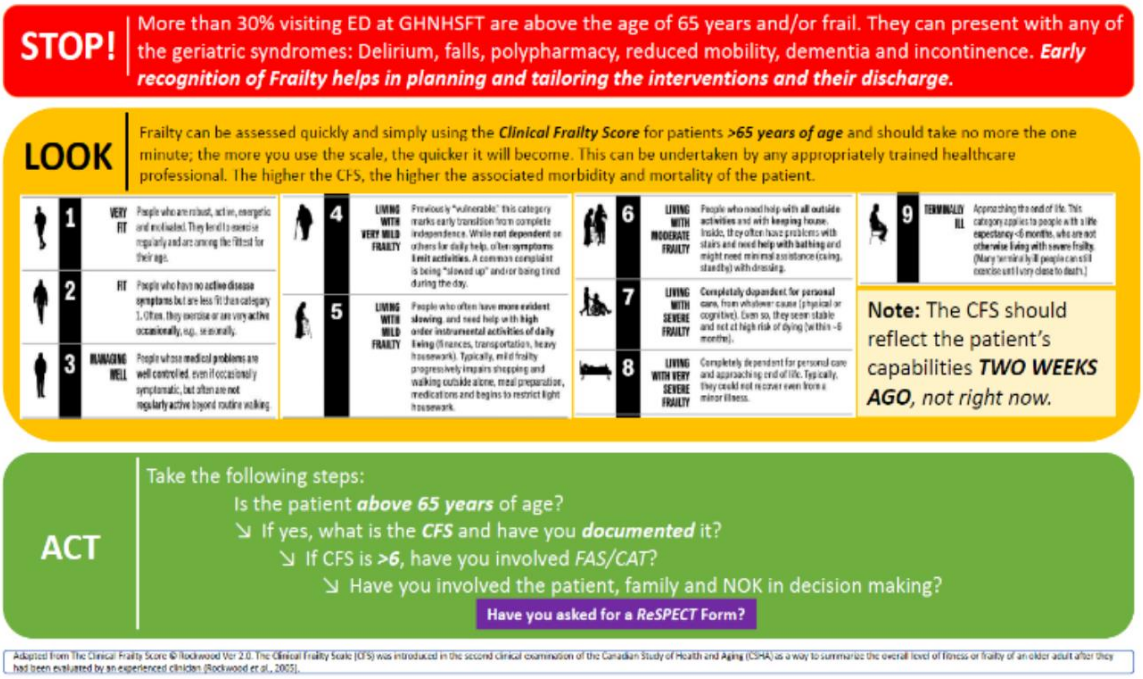
Commentary on the data

- Frailty is an important marker of adverse outcomes for older people accessing emergency care.
- The advantages of identifying frailty in the ED include prompting a more holistic clinical assessment, influencing clinical decision-making, guide disposition decisions and service design.

Following discussions with key stakeholders. **p**lan, **d**o, **s**tudy, **a**ct (PDSA) cycles are focussing on targeted education of staff through teaching sessions and the creation of a visual prompt (see below NB – draft copy, awaiting further changes to align with ED messaging), and changes to the electronic documentation of frailty score at triage. Currently frailty score is a non-mandatory field resulting in poor compliance with completion. The hope is it can be made a 'significant field' with the additional evidence of initiation of a comprehensive geriatric assessment (CGA) where appropriate and/or referral to the acute frailty service, however this requires further discussion to ensure there are no difficulties created where patients attend via other routes.

One of the improvement initiatives was to create a poster which flags to our colleagues when to consider completing the frailty assessment.

Chart: Improvement initiative used to improve recognition and completion of scores



Plans for improvement 2024/25

Identifying that a patient is living with frailty is as important as identifying illness severity. Both contribute to immediate and longer-term patient experience and outcomes. There will be a frailty work stream with the 'clinical vision of flow' work and there has been some scoping for 2 Silver QI projects looking at frailty scoring, including in and out-patients. We will continue this work in 2024/25 and we will be reporting on this in the Quality Account.

3. Quality priority - To improve adult inpatient safety/ experience

To improve adult inpatient safety/ experience	Our adult inpatient Friends and Family feedback tells us that patients do not like to be cared for **in non-designated bed spaces**, including boarding, and therefore our focus will be on monitoring and then reducing/eliminating our use of escalation beds.

Background

Boarding is the term used when placing a patient in an undesignated bed space usually in a corridor on a ward. In October 2022, the Trust implemented boarding to reduce ambulance handover delays. This had been trialled at North Bristol NHS Trust in August 2022 and the change involved moving patients from the Emergency Department (ED) to hospital ward corridors irrespective of bed availability. NHS England encouraged Trusts to implement this model. The Royal College of Emergency Medicine recommended boarding in response to a full Emergency Department. Our adult inpatient Friends and Family feedback told us that patients did not like to be cared for **in non-designated bed spaces**, including boarding, and so our focus has been on reducing/eliminating our use of these non-designated bed spaces.

How we have performed 2023/24

Patients are best served by being taken to their speciality ward into a designated bed space. Moving patients to corridors inside already full wards enables us to take new emergencies patients and this must be done with care, caution and with safety in mind. Crowding in the emergency department is associated with increased mortality and poor patient and staff experience. Delayed off-loading of patients from emergency ambulances has a consequent issue of reduced ability to attend further emergency calls. Emergency departments can become crowded for many reasons, but a lack of inpatient bed capacity and the resulting “exit block” from the department is one of the key factors. Our ED tends to start fill up from mid-morning, but often inpatient beds often become available late in the afternoon or early evening. This was one of the reasons for us to create our discharge lounge as this was to enable wards to take ED patients earlier and patients who were to be discharged had their care in the lounge area.

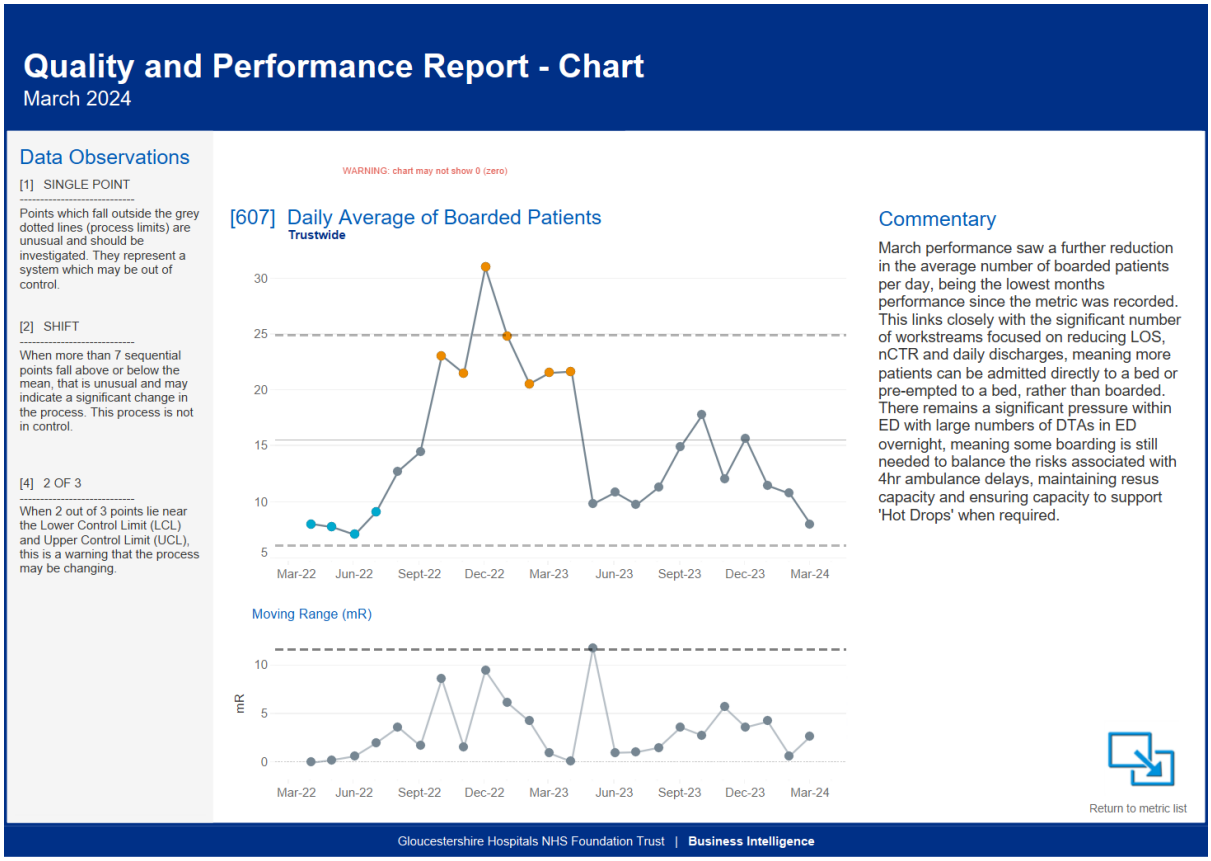
Our ED is often “boarding” patients who need to be admitted and this in turn is congesting the department and maximising staff demand, impeding the care of newly arriving emergency patients. To mitigate this situation, using the Trust Escalation Policy, specified wards take admissions to undesignated bed spaces in their corridors. The patients need to meet certain criteria in order to be boarded and one benefit is that they have the right specialised staff caring for them. The action of boarding in corridors does then lead to further issues as we might have decompressed ED in the short term but the long-term issue is that the wards have more patients to care for and can pay less attention to focusing on enabling discharges to happen.

Through our detailed analysis of our data it shows us that boarding has not had the impact on flow it was assumed that it would although there are occasions when it has positively

impacted on the risk profile of ED and/or the community when in extremis. This is probably due to the impact it has on the ability to ‘pre-empt’. Effectively filling our hospitals and reducing, rather than increasing flow. There are occasions when the organisation works outside of policy which increases the risk of regulatory enforcements. There may be a place for boarding in our escalation process, but the current triggers are not appropriate, this will be rectified as current escalations and triggers are reviewed.

In March 2024, our data performance saw a further reduction in the daily average number of boarded patients per day. The figures for March recorded that there were the lowest number of patients, 8, since the metric was recorded. This reduction also aligns with the number of comments we received in our friends and family test data relating to experiences of boarding. This improvement links closely with the significant number of work streams focused on reducing length of stay, reducing the number of patients with no criteria to reside and increasing the number of daily discharges. These improvement programmes mean that more patients can be admitted directly to a bed, rather than being boarded in an undesignated bed space. Unfortunately, there remains significant pressure within the Emergency Department, with large numbers of patients with a decision to admit waiting for a bed in the Emergency Department overnight, meaning that some patients will need to be boarded to balance the risks associated with greater than 4-hour ambulance delays, maintaining resuscitation bay capacity and ensuring there is capacity to support emergency ‘hot drops’ when required.

Chart: Quality and Performance Report – Chart - Daily Average of Boarded Patients



Plans for improvement 2024/25

Our analysis has demonstrated that moving patients to already full wards does not ultimately improve flow through the hospital. Our focus must be on enabling our patients to discharged to their homes in a timely way and to utilise our beds effectively. This metric will continue to have oversight from the Board as will be reported within the Quality and Performance Report and the improvement focus will be moved to enabling timely and **effective discharges as we will focus on the Patient Safety Priority – flow and discharges.**

4. Quality priority - To improve experience of discharge

To improve experience of discharge	In order to release beds for waiting patients we will have an improvement programme focused on "**simple" discharges**. N.B., We have amended this priority to the use of discharge lounge as simple discharge programme was delayed in implementation and starts 2024/25

Background

Our Discharge Lounge

To improve the patient experience of flow through the hospital and discharge home or to another care setting, a new £1.5m discharge lounge opened in February 2023, accommodating 29 patients, with room for 5 beds and 4 reclining chairs. Use of the discharge lounge frees up hospital beds as early as possible, helping to reduce the length of time that patients wait in the emergency department or are required to wait for a bed on the wards.

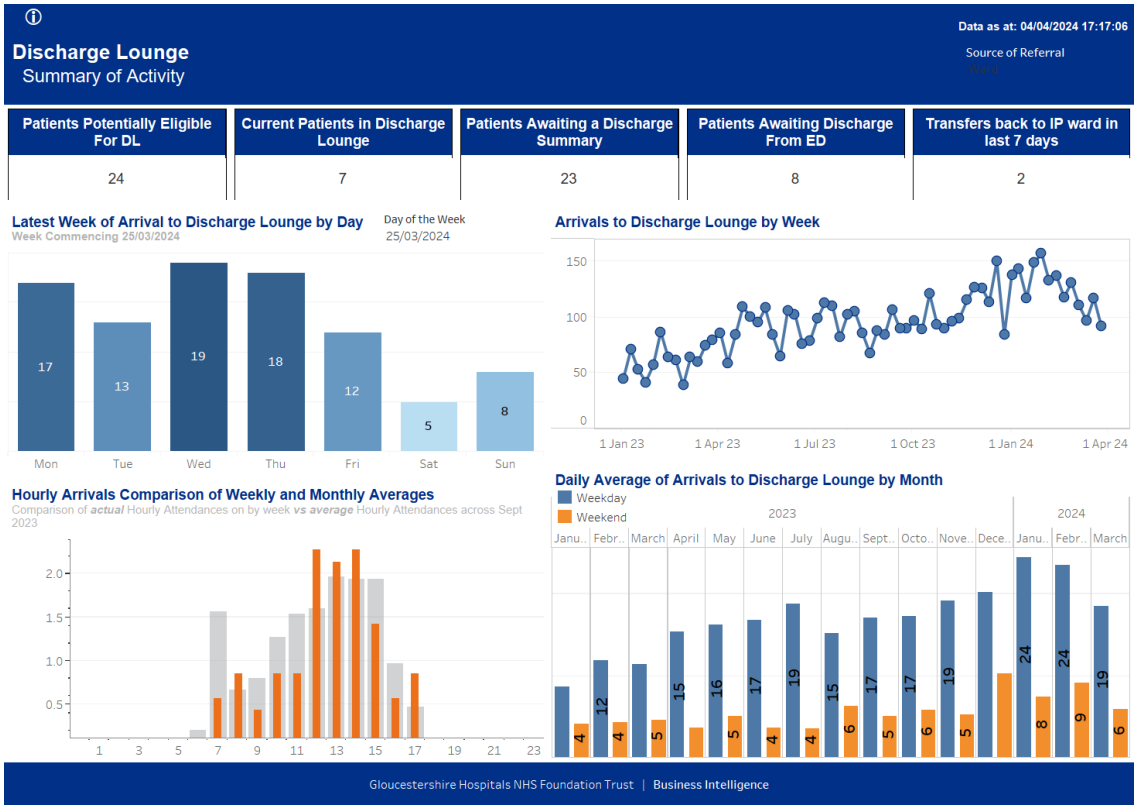
How we have performed 2023/24

A series of quality improvement initiatives have seen improved use of the discharge lounge from both the ward and emergency departments, to improve flow through the hospital. This means patients can be accommodated on the appropriate specialty ward and ambulance handover delays are minimised for patients awaiting admission to the emergency department.

The discharge lounge is open from 7:00am-7.30pm, and has aimed to accommodate at least 10 patients by 10:00am. Patients are able to access food and beverages, their medicines and a range of books, magazines or television channels while they await their transport. Situated at the rear of the hospital the discharge lounge offers easy and accessible access for transport collection.

The ward use of the discharge lounge has steadily increased throughout 2023-4, from a weekly average of 45 patients being discharged through the lounge in March 2023 to a high of 157 patients being discharged through the lounge in the peak of winter, in January 2024. The discharge lounge chart below also demonstrates an increase of patients per day, including over the weekend, as we aim to increase the number of patients who can be discharged over the weekend.

Chart: Discharge Lounge Data 31 March 2024



Continuous monitoring and reporting of the use of the discharge lounge on out Business Intelligence Hub permits continuous improvement in identifying times or days that use of the discharge lounge could enhance overall patient experience.
The medical division has established discharge co-ordinator roles to help ward staff facilitate complex discharges.

Emergency Department has enhanced its use of the discharge lounge throughout 2023/2024 from a daily average of 1-2 patients to a daily average of 4 patients. The weekly average of emergency department patients using the discharge lounge rose from 6 patients in June 2023 up to 30 patients in the peak of winter in February 2024. Each emergency department patient discharged through the lounge frees up a bed or chair for a waiting patient or ambulance to offload. We have added some specific questions to the friends and family test and early data shows that 80% of patients using the lounge felt their experience was very good or good.

Plans for improvement 2024/25

- We will continue to maximise the use of the Discharge lounge by the wards and emergency department by analysing and reporting the metrics to look for opportunities to grow.
- We will listen to feedback from patients on their experiences of the discharge lounge in order to improve, through continued use of specific questions on the friend and family test
- We will continue to monitor and improve our patients awaiting a discharge summary when this causes delays to discharge

- We will continue to monitor our potential patients eligible for the discharge lounge to understand and alleviate any blockages to smooth flow for patients.
- The improvement focus **will focus on the Patient Safety Priority – flow and discharges.**

5. Quality priority - To enhance and improve our safety culture

To enhance and improve our safety culture	To enhance and improve our safety culture we will be implementing the **National Patient Safety and Incident Response Framework (PSIRF)** which will bring a change to our safety investigation work and we will be **focusing on staff being able to raise their concerns (Staff Survey questions Q20a, Q20b, Q25e, Q25f).**

Staff Survey https://cms.nhsstaffsurveys.com/app/reports/2023/RTE-benchmark-2023.pdf

Background

Improving our safety culture remains a priority in line with the implementation of the National Patient Safety Strategy and Patient Safety Incident Response Framework (PSIRF). On the 16 August 2022, the PSIRF was published. PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents (unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patient) for the purpose of learning and improving patient safety.

The PSIRF replaces the Serious Incident Framework (2015) and makes no distinction between 'Patient Safety Incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement

The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS and is a key part of the NHS patient safety strategy.

PSIRF is not an investigation framework that prescribes what to investigate, instead it supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute healthcare providers.

Organisations are expected to transition to PSIRF within 12 months, completing by Spring 2024.

How we have performed 2023/24

Introduction of the Patient Safety Incident Response Framework (PSIRF)
The Trust transitioned from the Serious Incident (SI) framework to the PSIRF on the 01 March 2024. An implementation plan has been produced and has been shared with the wider patient safety team at a team briefing held on the 4 March 2024. A task and finish group is being established to coordinate the process development and testing that is required to support the transition.

PSIRF has introduced new training obligations, which vary by role. Individuals are currently being directed to undertake training which is of limited availability, but free of charge, through the Health Services Safety Investigations Body (HSSIB) or attend the online learning that was procured by the Integrated Care Board (ICB). Whilst other avenues are being pursued to fulfil this training obligation, there may be a requirement to arrange the necessary training through an external training provider at a cost.

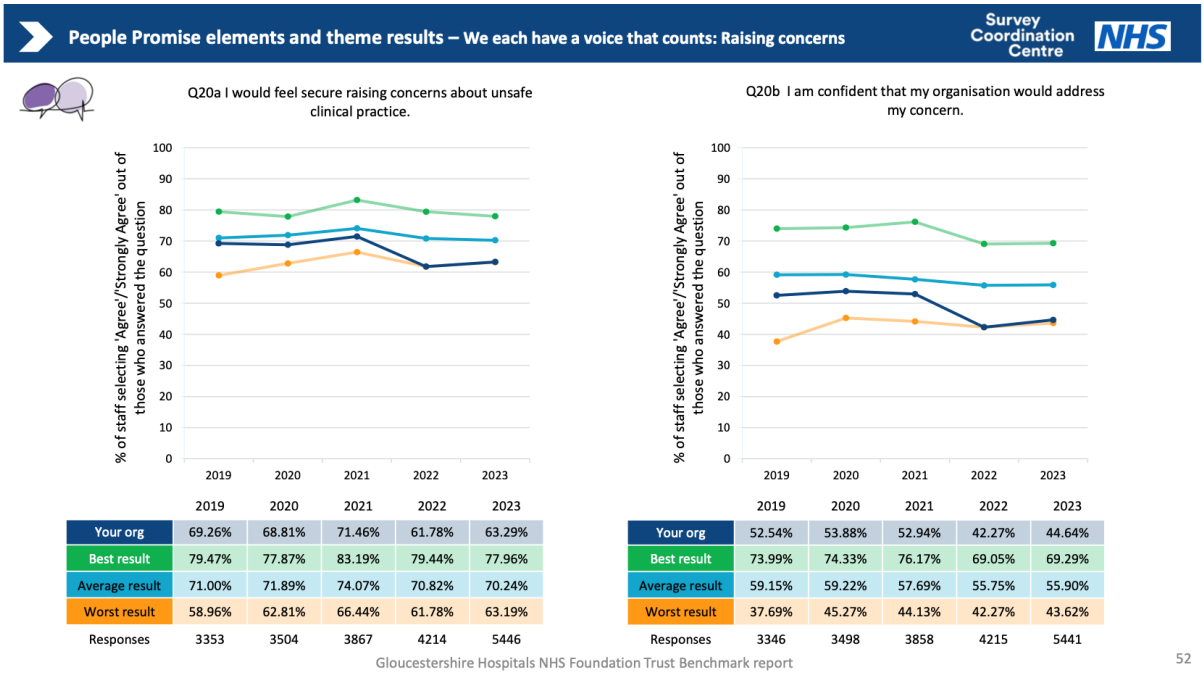
National Patient Safety Training
Level 1 national patient safety training was launched on the 20 February 2024 and is now available to all staff through the Electronic Staff Record (ESR). 22% of staff completed the training in the first two weeks.

Introduction of the Learn from Patient Safety Events (LFPSE) and Datix Cloud (DCIQ) Incident Reporting
Implementation may be impacted due to a previous shortage of end user testing and the requirement from the Information Governance team to complete a further data protection impact assessment (DPIA). The target implementation date of the module at the start of April 2024 is currently at risk, due to these two issues, which we continue to try and progress.

Safety culture and raising concerns
In our Quality Strategy, we stated that we would use our Staff Survey questions to monitor the safety culture within the Trust. This year the raising concerns culture metrics have improved across all 4 questions by an average of 1% (see charts for **Staff Survey questions Q20a, Q20b, Q25e, Q25f).**

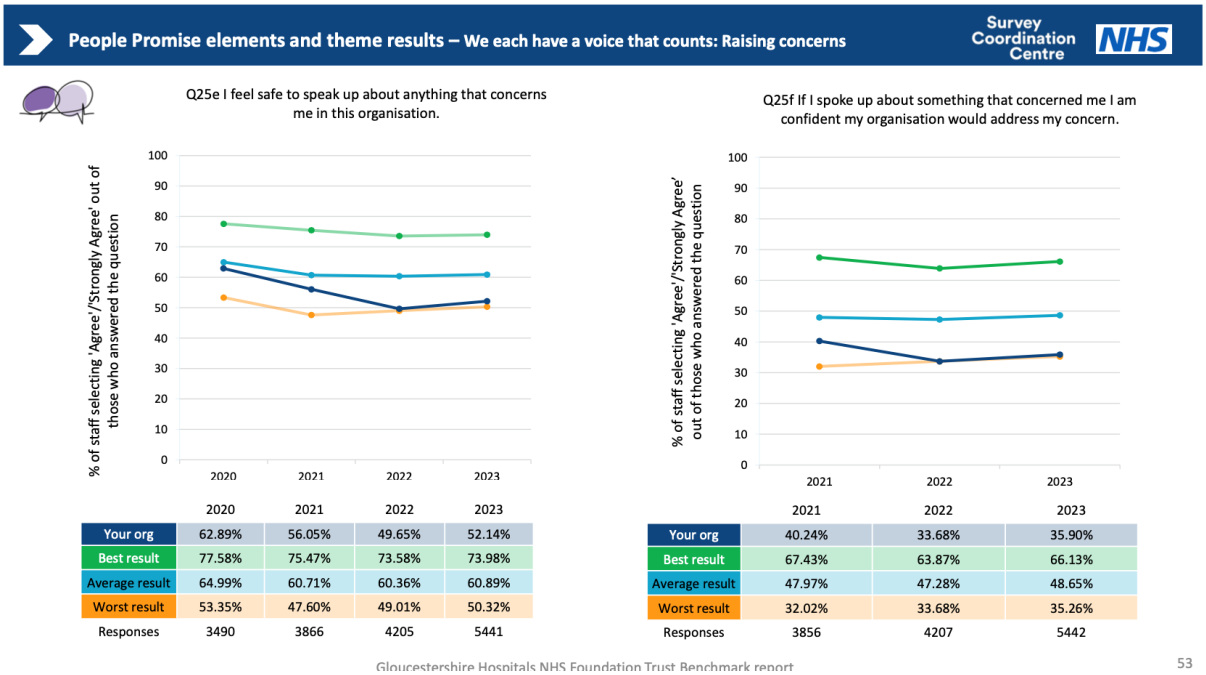
Questions
I would feel secure raising concerns about clinical practice
I am confident my organisation would address the concerns
I feel safe to speak up about anything that concerns me in this organisation
If I spoke up about something that concerned me I am confident that my organisation would address my concerns.

Graphs: Gloucestershire Hospitals NHS Foundation Trust NHS Staff Survey Benchmark Report 2023 (link)



	2019	2020	2021	2022	2023
Your org	69.26%	68.81%	71.46%	61.78%	63.29%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	3353	3504	3867	4214	5446

	2019	2020	2021	2022	2023
Your org	52.54%	53.88%	52.94%	42.27%	44.64%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	3346	3498	3858	4215	5441



	2020	2021	2022	2023
Your org	62.89%	56.05%	49.65%	52.14%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	3490	3866	4205	5441

	2021	2022	2023
Your org	40.24%	33.68%	35.90%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	3856	4207	5442

Plans for improvement 2024/25

The Safety Priorities laid out in this Quality Account will become our priorities for 2024/25 and we will continue to monitor this via our executive led Quality Delivery Group.

6. Quality priority - To improve our prevention of harm (a) pressure ulcers and b) falls)

To improve our prevention of harm (pressure ulcers and falls)	The priority for 2023/24 will be to improve our risk assessment, prevention and management of harm in relation to a) **pressure ulcers and b) falls.** This will include the delivery of the CQUIN (CQUIN 12) assessment and documentation of pressure ulcer risk assessments.

Pressure ulcer prevention

Background

a) Pressure ulcer prevention

In 2023/24, we took part in the Commissioning for Quality and Innovation (CQUIN 12) the assessment and documentation of pressure ulcer risk. NICE clinical guideline CG179 sets out best practice for assessing the risk of pressure ulcer development and acting upon any risks identified. It is fully aligned with the recently re-published National Pressure Injury Advisory Panel (NPIAP).

The aim of this improvement programme was to reduce the risks to our patients (1945 pressure ulcers and 3963 boarding of patients) and that is if the pressure ulcer risk assessment tool is not completed and patients deemed at risk of developing pressure ulcers do not have an adequate pressure ulcer prevention plan, patients will be at risk of developing pressure damage. All patients must have a pressure ulcer risk assessment (Waterlow) completed within 6 hours of admission and if they are at risk a plan for prevention must also be completed within 24 hours of that admission. There are obstacles within the SSKIN (**s**urface, **s**kin inspection, **k**eep moving, **i**ncontinence, **n**utrition and hydration (SSKIN)) bundle don't allow appropriate information to be documented. There are risks when patients are boarded that skin inspection cannot be facilitated.

How we have performed 2023/4

For CQUIN12, assessment and documentation of pressure ulcer risk, our aim was to be achieving 85% of patients having a pressure ulcer risk assessment (PURAT) by the end of March 2024.

Overall there was good compliance with the completion of the risk assessment tool within the specified time frame (6 hrs) however if patients are at risk of pressure damage then often compliance with completing the full risk assessment plan within 24 hours of admission is poor and this impacted on our overall compliance.

For quarter 4 our current data from business intelligence (BI) was an overall compliance of 64%.

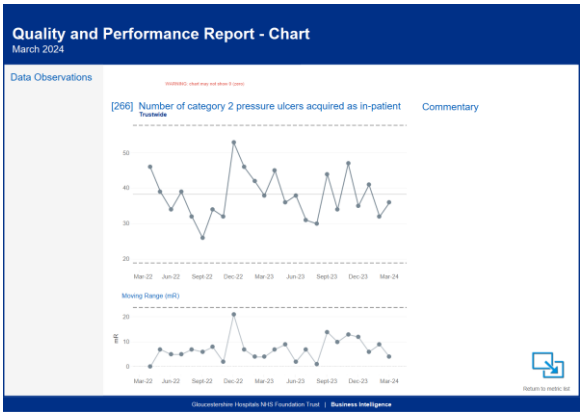
Table: Percentage of completed risk assessment by quarter

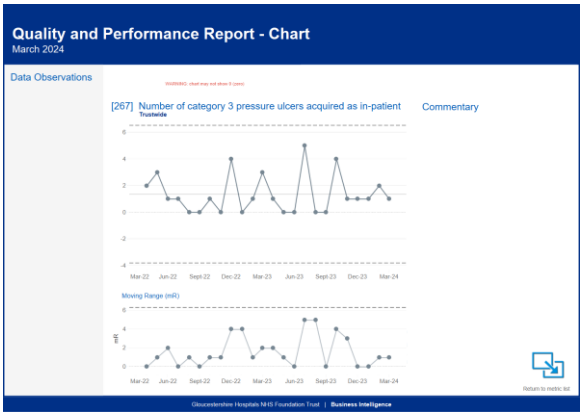
CQUIN measurement	Q1	Q2	Q3	Q4
Compliance with completion of: pressure ulcer risk assessment and actions	62%	61.66% 4801/7786 pts	60.35% 4670/7737	64.25%

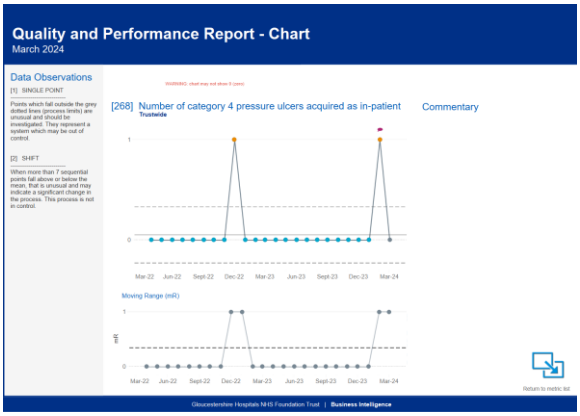
Over this year, we have:

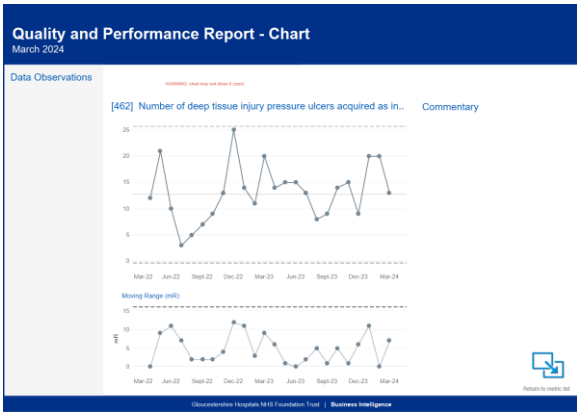
- Improved our recording of data via the dashboard.
- A Silver Quality Improvement (QI) project underway which is focused on understanding the barriers to completion of PURAT.
- Developed our electronic patient record (EPR) to facilitate high quality pressure ulcer prevention care plans.
- Developed a programme of pressure ulcer prevention (PUP) simulation to facilitate high quality education to staff in the prevention of pressure injuries.
- Re introduced the Pressure Ulcer Steering Group (bi monthly meetings).
- Raised awareness of our programme of work on the “International Stop the Pressure” day in November 2023 and by holding conversations about Pressure Ulcer Preventions (PUP).

Chart: Pressure ulcer outcome data









Plans for improvement 2024/25

We will:

- Continue to analyse our data to understand our issues and to make improvements to preventing pressure ulcers

- Analyse our data from the Silver QI project (this was a questionnaire developed and sent to staff in order to understand current knowledge and key challenges at ward level).

- Implement further EPR changes, key changes were completed in January 2024 including extra opportunities for staff to document their pressure ulcer prevention care.

- Continue to implement PUP simulation, pilot undertaken now implemented and dates integrated into tissue viability (TV) training and the evaluation will be ongoing.

- Collaborate with Gloucestershire Health and Care Trust (GHC) and the Gloucestershire Integrated Care Board (ICB) to share information and ideas in our pressure ulcer prevention PUP.

- The improvement focus will be **on the Patient Safety Priority – pressure ulcer prevention.**

Falls prevention

Background

b) Falls prevention

In 2023/24, we took forward the recommendations made by the NHSE Team when they visited the Trust and the National Audit of Inpatient Falls (NAIF) recommendations. Our overall aim of our improvement programme was to reduce inpatient falls and falls with harm.

How we have performed 2023/4

This year we have focused on supporting our training program and falls link education days for falls prevention. We have improved and made changes to the current electronic Patient Record (EPR) documentation. Finally, we have supported changes with the Patient Safety Incident Review Framework (PSIRF) for investigating falls with harm.

Achievements

- Patients who repeatedly fall continue to be reviewed with prevention strategies developed by the specialist team with the ward teams (212 people in total).

- We have improved our falls prevention training which is now a whole day a month and 248 staff members have attended this year.

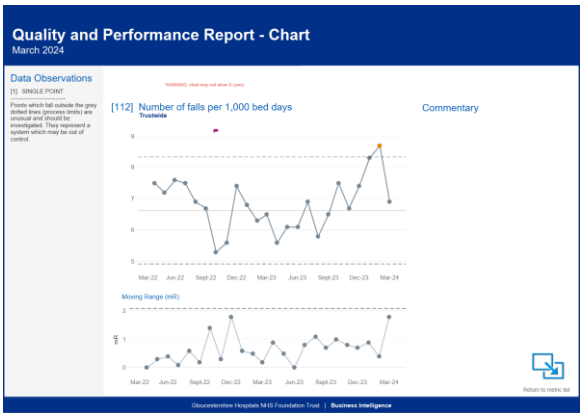
- We have provided “Falls Link Education” days (there was a total of 4 session this year).SEP These days have been very well received. Each day looks at an aspect of falls and we hold collaborative conversations to listen to each other’s ideas to make prevention improvement. The subjects we have covered this year have been “Vision and falls”, “Dementia and falls”, “Medications and falls and “The Fear of Falling”.

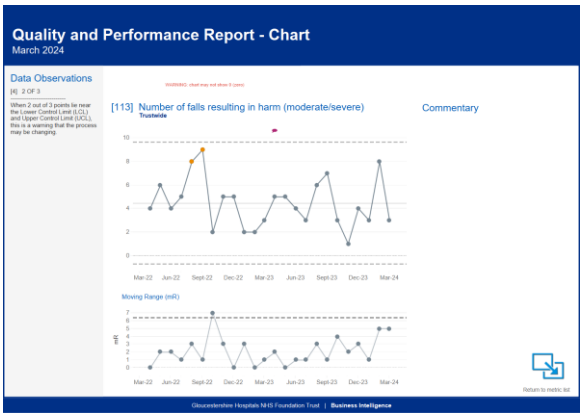
- The Falls Steering Group was reinstated and will continue quarterly in 2024.

- The specialist team have provided education on our Preceptorship Programme (224 staff have received education).

- The “Slipper Trial” on Woodmancote Ward reduced falls from an average of 11 falls per month to 6 during period of trial (19/09/23 – 19/11/23).

Chart: Falls outcome data





Plans for improvement 2024/25

We will:

- Learn from our project on Woodmancote Ward and procure slippers for other areas.

- Complete a silver QI project to improve the calculation of lying/standing blood pressure BP to ensure that a condition called orthostatic hypotension is recognised and managed accordingly. The Falls Team are currently working with Ward 4b, 7b and the Stroke Unit.

- Commence investigating falls under the new Patient Safety Incident Framework (PSIRF) from 1 March 2024. The process is well underway in how we investigate falls under PSIRF. We will also capture the learning from non-injurious falls.

- Continue to improve wording of electronic patient record documentation and also for bedrails to improve accuracy of assessment.

- Improve the documentation of the medical/nursing assessment post fall to replace ‘blue sticker’ in paper notes. The new nursing and medical post falls form will be added to our electronic patient record. The nursing assessment is a new addition, meaning that the whole post falls audit initial assessment and plan are all in one place.

- The improvement focus will be **on the Patient Safety Priority – falls prevention.**

7. Quality priority - To improve our care for patients whose condition deteriorates

To improve our care for patients whose condition deteriorates	We are one of 7 Trusts who have been chosen by NHS England to implement improvement work in the area of including patients/carers and their families in identifying deterioration – our "**Worries and Concerns Programme**" of improvement work.

Background

The Worries and Concerns programme of work to detect and facilitate escalation of patient concerns about clinical deterioration began in Jan 2023, through sponsorship from NHS England as one of 7 NHS Trusts to be supported. This pre-dated the work on Martha's Rule, which honours Martha Mills, who lost her life to undetected clinical deterioration after her parents repeatedly tried to escalate their concerns over Martha's clinical deterioration.

The Worries and Concerns Project has been consumed into Martha's Rule, which is now a requirement from NHS England that all acute NHS Trusts should have:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition. This is Martha's Rule.
3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

CQUIN07: Recording of and appropriate response to NEWS2 score for unplanned critical care admissions

As part of this programme we have reviewed the CQUIN data - CQUIN07: recording of and appropriate response to NEWS2 score for unplanned critical care admissions. The NEWS2 protocol is the RCP and NHS-endorsed best practice for spotting the signs of deterioration and ensuring a timely response, the importance of which has been emphasised during the pandemic. This CQUIN measure incentivises adherence to evidence-based steps in the identification, recording and timely response to deterioration, which will reduce the rate of preventable deaths and ICU admissions in England. The goal was to achieve 10-30%.

Progress made in 2023/2024

We are making a cultural change to see patients as partners in their care. We are encouraging staff to ask patients how they are feeling about their illness/wellness trajectory every time staff undertake clinical observations. Research in the paediatric space suggests the more we ask patients their opinion about their illness/wellness perspective, the more confident they will feel about raising concerns.

Aim 1 of the project is to provide a 24-hour rapid response service for clinical deterioration on receipt of a patient or carer concern. Patient and carer escalation of concerns had been happening on an informal basis for those patients particularly at risk, for example step-down from critical care, patients with learning difficulty and those with fractured ribs. In preparation to widen participation to all acute adult in-patients the staff, patient and family information was tested and adapted in two acute clinical areas. The staff escalation process remained unchanged. The patient escalation was through a mobile telephone number to call or text. Capturing the learning of the pilot sites, the project was rolled out to all acute adult inpatient areas with a series of launch days. The paediatric department are piloting the normal systems of escalation through their clinical matrons during the day, Monday to Friday, which is successful could be piloted in neonates and maternity.

AIM 2 of the project is where patients and carers can record their concerns in the clinical notes and this has been established in the acute adult areas by an addition to the NEWS chart after the NEWS score calculation. Stakeholder engagement and education has commenced on this new action and sustainment activities have been rolled out through our Basic Life Support training, News policy and clinical skills training for our healthcare assistants, Nursing associates and Registered Nurses. Business intelligence metrics have been set up to record the nurse and patient concern elements of the NEWS chart being recorded to identify areas of good practice and areas that need support.

Ongoing work with the Business Intelligence team have facilitated a ward/department compliance with routine and enhanced observations which are reaching on average an 80% compliance rate. Further work is in development to measure the metrics of a NEWS2 score within an hour of arrival or handover on a ward, and whether the observations are completed in a timely manner depending on the NEWS2 score. The number of patients scoring NEWS 2 of 5 or more are identified, facilitating easy identification of clinical episodes where an audit of escalation measures can be made.

We have re-drafted the NEWS2 Policy around the expectations of NEWS2 recording and escalation actions expected on the NEWS2 score. This will form part of the deteriorating patient policy with policies on Paediatric early warning scores and Maternity Early Warning Scores. Recognising that the scores, plus clinician concern, plus patient concern is the best indication of potential acute clinical deterioration.

We have published a Blog on our journey so far with the BMJ on-line here: Empowering patients and families to escalate worries and concerns. - Evidence-Based Nursing blog (bmj.com)

To assist other Trusts aspiring to follow our journey. We have briefed the Governors and had launch days in both Gloucester and Cheltenham where we have explained the project to patients and staff during our ward walks for e\ach site. The picture below is the launch day in Gloucester supported by the Acute Care Response Team and Governors.

CQUIN 07: results

Our aim was that we would be achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes. Our ambition was to have 30% compliance with all actions documents and we started the year well with 32% compliance. We have ended the year with 54% compliance.

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions	32%	42%	*13%	**54%**

*NB – small sample this quarter. Data collection is very time consuming and 17 cases were found to be not applicable to the audit. Multiple items are required to be present per case for it to be deemed compliant.

Improvements for 2024/2025

- Publication of the NEWS2 Policy to incorporate the Worries and Concerns Project
- Publication of the Deteriorating Patient Policy to include actions for acute adult, child, neonates and maternity
- Nomination for the Health Service Journal Patient Safety Awards under the Deteriorating Patient Category
- Application to NHS England for further support to develop the Worries and Concerns Project in Paediatrics and Neonates

- Publication of our lessons learnt so far in support of other Trusts wishing to implement a similar patient record and escalation of clinical concerns process.

8. Quality priority - To improve mental health care for our patients coming to our acute hospital

To improve mental health care for our patients coming to our acute hospital	We will be continuing the implementation of the Trust's Mental Health Strategy – **Whole Person Care Strategy**.

Background

Analysis of the reported violence and aggression incidents in the Trust, of which there are over 1000 per year, identified boredom and the lack of structure and meaningful activity as a contributing factor. Nursing teams were focussed on supporting patients with their activities of daily living and essential clinical care and therapy teams were focussed on rehabilitation. There was a gap in provision of policy advice and guidance on how to manage patients who may become confused, distressed, aggressive or at risk of self-harm. A multi-disciplinary cross-Trust collaboration revised the enhanced care policy to provide a robust risk assessment and intervention guide for adult and paediatric patients. The enhanced care policy forms part of the Trust's Whole Person Care Strategy To improve mental health care for patients coming into our hospital.

How we have performed 2023/24

The enhanced care policy was approved in September 2023 and was launched with a series of half-day workshops provided by the safeguarding team. The robust risk assessments have been well-received by staff as they risk assess and grade the clinical issues, falls risk, aggressive behaviour and risk of absconding and or self-harm, and thus the level of enhanced care required to mitigate the risk. The enhanced care is graded from ward care, to intermittent extra care, to within sight or continuous one to one. Observations have indicated staff have been empowered to apply the minimum level of enhanced care required to mitigate the risk, with growing confidence in using the tool. Patients have enjoyed more freedom when those who require to be in sight of a nurse to be cared for in a bay together, to give the freedom of movement within the bay area.

Interventions suggested as the risk of confusion, absconding or aggression increases includes patient engagement activities, inviting family and friend visits, bed or sensor alarms and medication reviews. The majority of patient interventions in enhanced care can be managed by our healthcare support worker teams. Where there is the highest risk of harm or absconding or there are statutory reasons to detain or treat a patient under the Mental Health Act, then a Registered Mental Health Nurse will provide the enhanced care.

An action card, published with the revised enhanced care policy provide direction and guidance for enhanced care provision, to include a structured plan for the day, clinical observations, and links to the 'This is Me' document, health passport, high intensity user plan or play therapy activities leads to a much-improved patient experience.

The clarification of the risk assessment matrix and recommendations for enhanced care activities have enabled the minimum restrictions to be placed on patients, with more healthcare support workers managing the enhanced care, rather than defaulting to request a

Registered Mental Health Nurse. A consequence of this improved patient experience has been a cost saving of @ £400,000 per month in nursing bank and agency shifts.

An external provider has continued to provide safe-hold and enhanced care training for all staff.

A review of nursing time allocated to each ward area has been undertaken with the NHS Safer Nursing Care Tool, to ensure baseline care needs are met, and ward leaders have been trained to escalate increased care needs requiring additional nursing support through the Safe Care platform.

Plans for improvement 2024/25

- A pilot project for 12 months will see a Band 7 Enhanced Care Lead appointed to facilitate a substantive enhanced care team of Registered Mental Healthcare Nurses and Healthcare Support Workers, to prevent reliance on nursing bank and agency staff.
- A security consultant will be appointed to review the safe-hold, restraint and enhanced care training and make recommendations for future training.
- The training contract will be tendered to facilitate the appropriate training competencies.
- A trial of activity co-ordinators will be conducted by the occupational therapy teams to provide meaningful and structured activities for patients at risk of mental deterioration.

9. Quality priority - To improve our care for people with diabetes

	To improve our care for patients with diabetes	Our focus will be on carrying out improvement work in response to the national **diabetes** audit findings (children and adults).

Background

To improve the safety, care and experience for the patient with diabetes, accurate insulin administrations are paramount to maintain healthy blood sugar levels. The aim for 2023/2024 was to look at clinical incidents relating to diabetic inpatients and adopt the learning into practice.

How have we performed in 2023/2024?

Getting it Right First Time (GIRFT)

The latest Getting It Right First Time (GIRFT) report feedback for Trust highlights that the Trust's multi-disciplinary foot care service (MDFS) is considered to be good. The Trust is performing better on access to and training on diabetes technologies. There is ongoing planning for continued improvement on this. The inpatient outreach service provision is below expected standards and the service was currently not able to provide 7-day week cover due to resourcing issues (inability to recruit).

National Diabetes Inpatient Safety Audit (NDISA)

The Trust introduced insulin prescribing on the electronic patient record (EPR), as of early December 2023, and as a result there are less insulin related clinical incidents occurring. The national audit recommendations in2023/24 were all at ICB and Commissioner level and primary care, these include ongoing planning for technologies and type 2 diabetes.

For the past 3 years, there have been approximately 100 insulin incidents reported onto the Trust Datix system. The main reason for incidents is missed insulin doses, at approximately 80% of all incidents. There were a small number of wrong prescription doses, time or insulin types, patients using insulin pens with expired drugs in or more than one insulin paper chart in use.

Throughout 2023/2024 we have focussed on moving the regular insulin prescription chart onto the electronic prescribing system on the patient's electronic records. This work is now complete and all routine prescriptions and administrations of insulin for adult inpatients are recorded electronically. Our Business Intelligence Team can now design reports to build a baseline measure for missed doses of insulin. We wanted to provide staff with the opportunity to learn and master the electronic prescribing and administering of routine insulins, prior to undertaking any additional quality improvement work. Also, for any quality improvement work to focus on the electronic prescribing system for future capability, not the insulin paper charts.

It is important to note the Trust guidelines, prescription and management for patients who are seriously unwell with diabetic ketoacidosis or may require a variable dose rate of insulin infusions are still managed on paper prescriptions. In the fullness of time, we hope all insulin

administration will be recorded electronically, but this is being carefully managed by the electronic prescribing team, because incorrect insulin administration can easily result in harm.

Plans for 2024/2025

- We will start to learn from the feedback from electronic prescribing and administration.
- We will actively measure missed doses of insulin, which we expect to decrease
- We will start to make plans for further movement of insulin prescription onto electronic patient records.

10. Quality priority - To reduce health inequalities

To reduce health inequalities	We will continue to deliver the Core20Plus5 health inequalities programme focused on **tackling tobacco dependency** for colleagues, inpatients and in maternity.

Background

The NHS Long Term Plan set out clear commitments for NHS action to improve prevention by tackling avoidable illness, as the demand for NHS services continues to grow. Supporting patients, service users and staff to overcome their tobacco dependence will not only provide improvements in their health, but reduce health inequalities and also decrease demand on services by reducing the number of smoking related admissions and readmissions. The Global Burden of Disease (GBD) ranks tobacco as the top modifiable risk factor that drives deaths and disability, with 96,058 avoidable deaths associated with its use in England in 2019 (GBD, 2019).

Tobacco dependency affects almost all patient pathways – both surgical and medical – from pregnancy and neonates through to children and adults. Latest figures record

- 13.9% of adults,
- 9% of 11-15 year olds, and
- 9.6% of pregnant women (at the point of delivery) in England **still smoke tobacco**

(ONS, 2020; NHSD, 2020; NHSD, 2021).

Smoking tobacco is linked to just over 500,000 hospital admissions each year, with smokers being 36% more likely to be admitted to hospital than non-smokers. Smoking tobacco is linked to over 100 different conditions, including at least 15 different types of cancer, 9 mental health conditions and numerous respiratory, cardiovascular and other disorders (RCP, 2018). Tobacco dependence treatment is effective and improves the health and wellbeing of the person smoking and their family, as well as saving them money.

Smoking is also the single greatest modifiable risk factor for poor outcomes in pregnancy, with nearly 1 in 10 women still smoking when their baby is born. The harms associated with smoking relate, not only to the mother, but also to the unborn child, where we see a doubling of the likelihood of stillbirth and tripling of the likelihood of sudden infant death. We also see smoking rates concentrated among pregnant women from poorer backgrounds, with women from the poorest 10% of the population six times more likely to smoke than those from the most affluent 10%. Continuing to implement the NHS England Saving Babies Lives Care Bundle version 2 (SBLCBv2) is designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of still births by bringing together 4 elements of care with reducing smoking in pregnancy being one of the four.

How we have performed 2023/24

Adult Inpatient Programme Update

It is well established that effectively treating tobacco dependent smokers attending hospitals requires provision of very brief advice, the offer of evidence-based pharmacotherapies and interventions, and referral to specialist tobacco dependency service.

Supporting patients, service users and staff to overcome their tobacco dependence will not only provide improvements in their health, but reduce health inequalities and also decrease demand on services by reducing the number of smoking related admissions and readmissions. The recommended acute inpatient pathway is underpinned by published evidence on the Ottawa Model for Smoking Cessation and based on work undertaken in Greater Manchester as part of the CURE model. We are pleased to offer this to adult inpatients admitted to our Hospitals.

Every patient admitted to Gloucestershire Hospitals NHS Foundation Trust (GHT) who smoke is offered NHS funded tobacco treatment, all inpatients are:

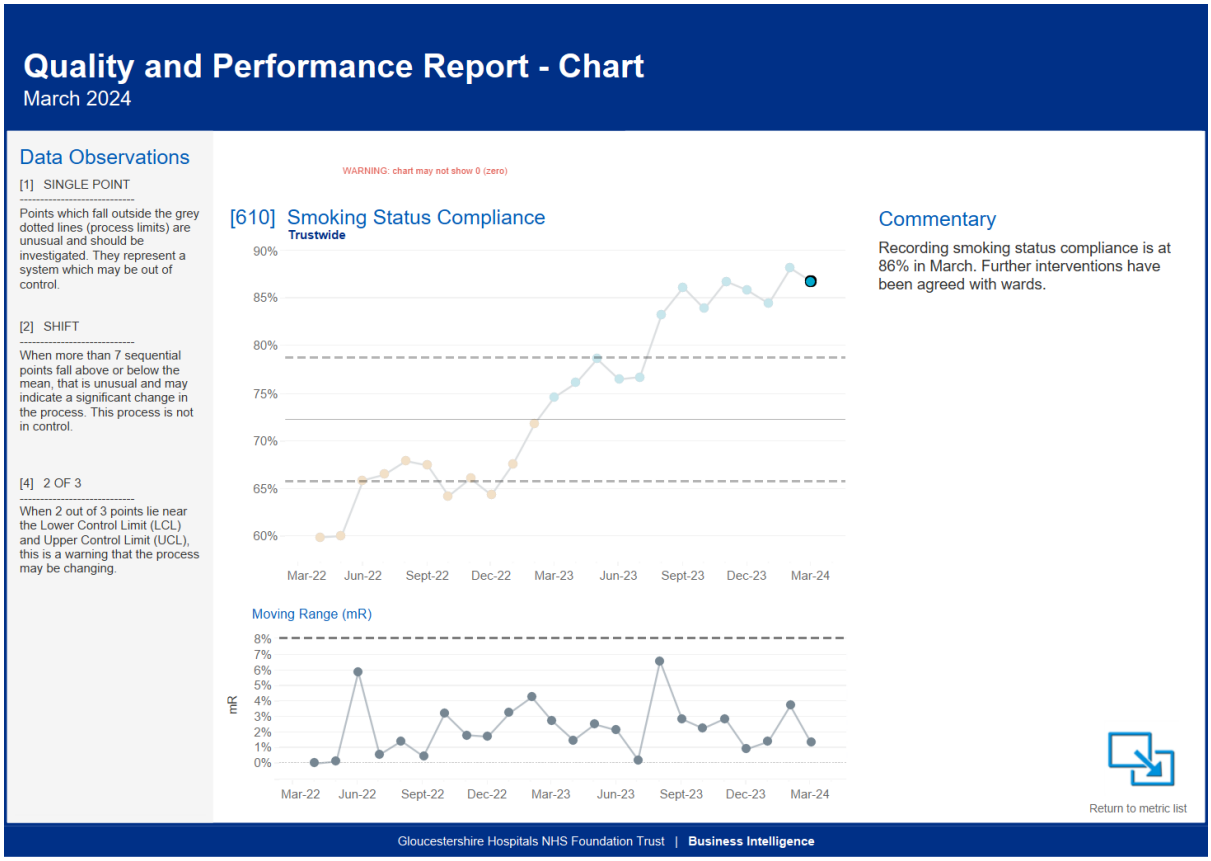
1. Screened for smoking status
2. Be on an opt-out referral pathway to a tobacco treatment advisor
3. Provided with personalised behavioural support and Nicotine Replacement Therapy (NRT)
4. Provided with a discharge package including continued smoking support by the community team.

We have been routinely collecting adult smoking status data since November 2022 and have created an internal Tableau dashboard that identifies all smokers and their location within the hospital (Adults - % compliance on recorded smoking status (Smoking Status | GHNHSFT BI Hub (glos.nhs.uk)).

Table: % compliance on recorded smoking status (adults)

Adult services	% compliance on recorded smoking status average
Trust compliance at end of year	82%

Graph: % compliance on recorded smoking status (adults) on admission documentation



Following a QI approach the Tobacco Free Team rolled out ward by ward on the inpatient wards, providing Very Brief Advice (VBA) training for staff to build staff confidence, subsequently the compliance of recording smoking status increased. This was further enhanced by making smoking status a significant field on EPR. A Trust wide communications campaign helped to embed this further. Although the Trust wide compliance is at 82% it is important to note some wards are achieving 100% compliance every month.

In the next table, we have summarised our key achievements over the last year and our plans for improving our service in 2024/25 will also start to take place.

Table: Key achievements over for the Adult Inpatient Programme over 2023/24 and Plans for improvement 2024/25

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
Leadership and Co-Ordination/ Project team	• Head of Health Inequalities and Healthy Hospitals • Health Improvement Manager • 2 x Tobacco Treatment Advisors • Clinical Lead • Deputy Director of Quality	• Recruit Tobacco free champions/ ambassadors on wards

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
	• Senior BI analyst • Pharmacist • Communications lead	
Data Collection and Monitoring	• The Electronic Patient Record (EPR) amended to support the relevant recording of smoking status as a **significant** field • NHS England data submission requirements have been updated. • BI have created and improved our daily Tableau smoking data dashboard and national metrics are included.	• Synthesise data to identify areas of improvement • Using the QI methodology embark on a silver QI project to identify improvements and efficiencies in the pathway.
Governance and reporting	• An internal programme Board has been set up and are meeting monthly. • Leads attend the Integrated Care Board (ICB) Tackling Tobacco Dependency Steering group meeting. • NHS England assurance meetings monthly • Updated NG209 • Programme reports into QDG • NHSE monthly tobacco treatment submissions	• Complete Service review evaluation • Sustainability of service when the funding from ICB finishes • Identify support for staff
Training and Development	• Advisors have attended specialised training programme. • Very Brief Advice training has been provided for all inpatient wards, this is being regularly topped up by the team to ensure coverage of new staff. • Developing bespoke training for tobacco-free champions/ambassadors.	• Increase the uptake of Very Brief Advice training on wards • Offer VBA training online for staff working evenings • Scope out support required for Paediatrics • Identify support required for outpatients

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
	• Tobacco free team participated in bespoke Quality Improvement (QI) support from British Thoracic Society for 6 months. • Team completed GSQIA Silver QI project to increase the compliance of smoking status recording across the Trust.	
Identification and Referral Pathways	• Follow up calls upon discharge • Patients are referred to community provider upon discharge for onward care.	• Establish relationships with new community provider to support patients when discharged from hospital. • Identify further referral pathways as appropriate for patients e.g. Mental health
Treating tobacco Interventions	• Evidence based interventions offered across both sites • Pharmacotherapy – Nicotine Replacement Therapy (NRT) is available on all inpatient wards. • New anti-smoking drug Cytisiene has been approved on Trust formulary. • Patients will be supplied with NRT upon discharge	• Pharmacotherapy- increase number of patients that are being offered NRT on arrival • Trial prescribing Cystisiene on respiratory unit
Communication and Engagement	• There have been Trust wide communications about the programme. • Smoke free policies have been updated. • The TTD Team are attending regular ward rounds and board rounds with identified wards.	• Continue to support national campaigns: • No Smoking Day • Mental Health Awareness week • World No Tobacco Day • Love your Lungs week • Stoptober • Lung cancer awareness month

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
	• New signage and posters have been created for teams to download • Team have carried out Trolley dash in both sites • Team paraphernalia produced • No smoking day stall in Atrium	• New Year Quit Attempts

Maternity Programme Update 2023/24:

We have been continuing to support pregnant smokers to quit by implementing the NICE clinical effectiveness guidance (NICE guideline NG 209 Tobacco: preventing uptake, promoting quitting and treating dependence) and the NHS England Saving Babies' Lives Care Bundle (version 3). The care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice and the first element is around reducing smoking in pregnancy as this element provides a framework to reducing smoking in pregnancy by following NICE guidance.

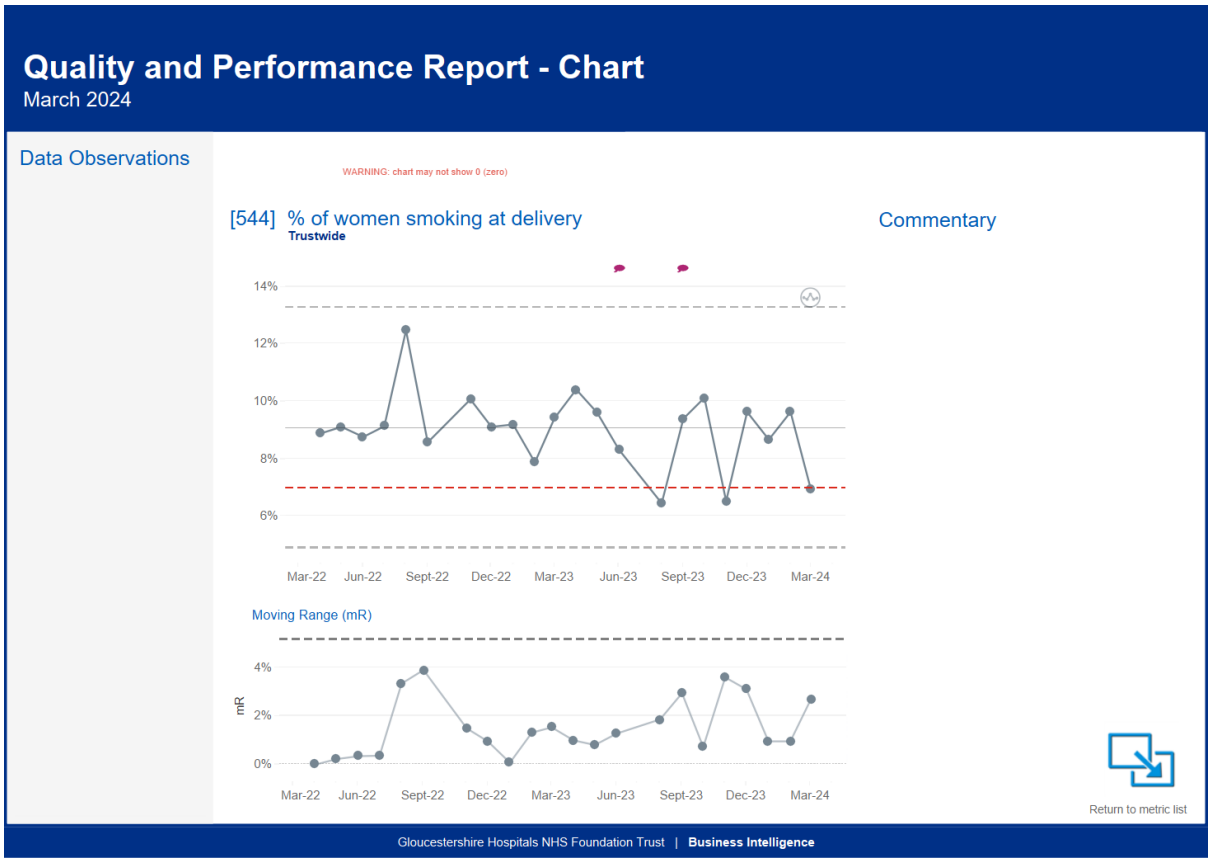
Reducing smoking in pregnancy will be achieved by offering carbon monoxide (CO) testing for all women at every antenatal contact throughout pregnancy, to identify smokers or those exposed to tobacco smoke and offer them a referral for support from a trained stop smoking advisor.

The interventions we have put in place are:

- CO testing should be offered to all pregnant women at every antenatal contact appointment, with the outcome recorded on the electronic maternity information system.
- Referral for those with elevated levels (4ppm or above) for support from a trained stop smoking specialist, based on an opt-out system. Referral pathway must include feedback and follow up processes.
- Referral to an in-house maternity treating tobacco dependency (TTD) team as recommended in SBLCB v3 available for residents of Gloucester City as part of a quality improvement programme initiative.
- All relevant maternity staff should receive training on the use of the CO monitor and having a brief and have meaningful conversations utilising very brief advice (VBA) techniques with the pregnant person.
- A range of treatments and support options are being procured to enhance the engagement with the in-house maternity TTD quit programme including GHT outpatient direct supply of nicotine replacement products (NRT), National 'swop to stop' interventions including e cigarettes and vaping alternatives and participation in the National financial incentive scheme.

The table below highlights are data for the 2022/23 year and now for 2023/24

Table: % of women smoking at delivery



	2022/23	2023/24
Indicator	**Data**	**Data**
Number of women smoking at booking	**594**	**434**
% women smoking at booking	**11.0**	**8.1 %** ***This cohort is not the same cohort as the data set for % women smoking at delivery***
Number of women smoking at delivery	**514**	**406**
% women smoking at delivery	***9.5***	***8.9 %*** ***This cohort is not the same cohort as the data set for % women smoking at booking***
Number of women smoking at booking	**654**	**N/A**

	2022/23	2023/24
Indicator	**Data**	**Data**
% women smoking at booking	***10.0%***	***N/A*** ***This data set is incomplete due to suspension in recording during the transition from Trakcare to Badgernet***
CO Monitoring at booking %	***93.2***	***85.1 %***
Number of women booking where CO reading >4ppm	**288**	**345**
% of women booking where CO reading >4ppm	***4.4%***	***6.4 %***
Number declining CO Monitoring at booking	**703**	**9**
Number of current smokers accepting referral to Smoking Cessation	**482**	**302**
% of current smokers who accepted referral to Smoking Cessation	***74.0***	***69.6 %***
% of current smokers who declined referral to Smoking Cessation	***23.5***	***20.3 %***
% of current smokers who were asked to be referred to Smoking Cessation	***97.5***	***89.9 %***
Healthy Lifestyles Smoking Referrals	**639**	**339**
HLS Referrals Declined, No response or blank	**314**	**156**

Table: Key achievements for the Maternity Programme over for 2023/24 and Plans for improvement 2024/25

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
Leadership and Co-Ordination	• Band 8a Lead Midwife Tackling Tobacco Dependency (TTD) • Appointed Maternity Support Workers (MSW) to be Smoke-free Advisors.	• A Band 8a Lead Midwife Tackling Tobacco Dependency (TTD) leads on a Quality Service Improvement and Redesign (QSIR) Programme developing an in-house maternity TTD team • 2 WTE Maternity Support Workers (MSW) have been recruited and given specialist training as TTD Advisors to support pregnant

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
		people and their partners on smoking cessation programmes in Gloucester City. • A Band 7 Specialist Midwife for TTD and a Band 6 QI project support Midwife lead the TTD team. • The National Lead & Lead for Greater Manchester Smoke-free programme provides monthly coaching on the project implementation strategy.
Planning and Commissioning	• TTD pathway in maternity services will be included in the Integrated Care Board (ICB) Maternity Services specification. • Areas with highest Smoking at Time of Delivery (SATOD) rates have been identified and linked to areas of highest deprivation in Gloucester and Forest of Dean (FoD). • Incentives and vaping are being explored with ICB TTD Steering group.	• TTD pathway in maternity services are included in the Integrated Care Board (ICB) Maternity Services specification. • Areas with highest Smoking at Time of Delivery (SATOD) rates have been identified and linked to areas of highest deprivation in Gloucester and Forest of Dean (FoD). The in-house maternity TTD are piloting the service in Gloucester City with an ambition to roll out to the area of the second highest rates of deprivation in the FoD after 1 year. • The National Financial Incentives Scheme and Swop to Stop vaping interventions are being pursued through the QI project and LMNS TTD team.
Data Collection and Monitoring	• Data was monitored by the service on a on monthly dashboard against a planned trajectory for improvement. • An audit was completed and action plan developed to review compliance for CO monitoring at 36 weeks.	• A digitalised maternity information system, Badgernet, has been introduced across the maternity service, launched in June 2023. The in-house TTD team coordinate all referrals and appointments through Badgernet. • In addition, an NHS supported software package from DCRS digital services is being procured to support the TTD caseload management for the in-house

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
		team and contribute to the production of high quality data to support the project evaluation. • Data has been mapped against the external provider for community TTD support, Healthy Lifestyles, and a data collection tool devised to support co production of TTD data that aligns across the 2 TTD services. • Data continues to be monitored by the service on a on monthly maternity assurance dashboard against a planned trajectory for improvement. • An audit of all SBL v3 element 1 recommendations has been carried out in response to the Maternity Incentive Scheme requirements and an action plan developed to improve carbon monoxide screening, staff training in skills for giving very brief advice (VBA) to increase the number of opt out referrals made.
Training and Development	• Training and development provided for Consultant Lead and for Lead Midwife. • Training has been identified for the MSW Smoke-free Advisors. • Very Brief Advice (VBA) training and e-learning training was put in place.	• Training and development provided for the Specialist and Project Support Midwife to enable them to provide service user support on quit programmes in addition to project and team leadership skills. • Training has been provided for the MSW TTD Advisors. • Smoke Free Pregnancy and Very Brief Advice (VBA) mandatory face to face training and an e-learning module training has been developed for all members of the MDT in maternity care.
Identification and Referral Pathways	• The maternity service is working with Healthy Life Styles (HLSs) to review current pathway and HLS's Health	• The TTD in pregnancy Trust policy has been updated and 4 new pathways created for CO screening, antenatal and postnatal

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
	Advisors now attending the Antenatal Clinic at Gloucester Royal Hospital (GRH).	referrals for TTD support and referral for raised CO screening results in non-smokers. These have been ratified. • Standard operating procedures (SOP) for the TTD Advisors role and NRT outpatient supply have been created and ratified.
Stop Smoking Interventions	• Research into the evidence for vaping, as an alternative to Nicotine Replacement Therapy (NRT), is being currently reviewed.	• Antenatal smokers and their significant other person are offered face to face behavioural support and a range of NRT products provided through a voucher pad system. • An outpatient supply of NRT products is being organised within the Antenatal Clinic at GHFT to enable direct supply of products and early intervention • The National Financial Incentives Scheme and Swop to Stop vaping interventions are being pursued through the QI project and LMNS TTD team.
Communication and Engagement	• Midwives survey on knowledge of TTD pathway results presented to Local Maternity and Neonatal System (LMNS).	• The Lead Midwife for TTD has engaged in an MVNP live event on social media, updated Trust and Maternity webpages and produced educational cards with a QR code for service users and staff. • Preparations are underway for National No Smoking Day in March 2024 and activities include production of a lived experience video of a current quit programme participant. • Discussions are in progress regarding carrying out further behavioural insights focus group work with social researchers to gain an understanding of strategies required to optimise engagement with a diverse community in the most

Programme Area	Key Achievements from last reporting period	Plans for Improvement 2024/25
		disadvantaged areas of Gloucestershire.

11. Quality priority - Surgical experience

	Surgical experience	Our focus will be delivering on the Commissioning for Quality and Innovation Indicator (CQUIN 02) **supporting patients to drink, eat and mobilise (DrEaMing) after surgery.**

Background

Getting it Right First Time (GIRFT) has supported a Commissioning for Quality and Innovation (CQUIN) indicator measuring whether patients are supported to drink, eat and start being mobile after surgery. This original CQUIN for 2022/23 has now been updated and published for 2023/24.

Ensuring that patients drink, eat and mobilise ('DrEaM') as soon as possible after surgery is an element of the NHS's enhanced recovery programme that helps to prevent post-operative blood clots and respiratory complications and that should result in an average 37.5% reduction in length of stay for patients who "DrEaM" in the first 24 hours after surgery. This indicator was updated for 2023/24 to include a more comprehensive range of procedures and to ensure that the thresholds continue to be stretching, but achievable.

This year we have been encouraged to ensure that 80% of all in patients undergoing major surgery are supported to DrEaM within 24 hours of surgery.

DrEaMing is supported by the Perioperative Quality Improvement Programme, as well as the relevant Royal Colleges, and was highlighted in the GIRFT national report for anaesthesia and perioperative medicine. The new indicator applies to surgery delivered from 1st April 2023.

How we have performed 2023/24

We are developing a culture of enhanced recovery in our departments and enhanced recovery targets have been embedded in our protocols. Empowering the multidisciplinary team to deliver care in line with the enhanced recovery ethos. The national goal for the CQUIN was 70% to 80% and we have performed above that figure at 95% in quarter 3.

Table: CQUIN results for each quarter

Measure	Q1	Q2	Q3	Q4
Overall compliance	90%	96%	95%	95%
The patient was supported to drink	99/99	97/97	98/98	92/92
The patient was supported to eat	86/87	88/88	90/90	81/89
The patient was supported to mobilise	88/98	93/98	92/97	91/95

Plans for improvement 2024/25

We are waiting to hear nationally if CQUINS will continue. The plan for the improvement work is that it will become part of our processes and will not be reported in our Quality Account next year as we will report on the Safety Priorities.

12. Quality priority - Equality, diversity and inclusion – equality priorities

	Equality, diversity and inclusion – equality priorities	The Patient Experience Team will be enabling the delivery of **2 equality priorities** by improving our translation and interpretation services and focusing on the accessibility of our maternity and cancer services.

Background

The Equality Delivery System (EDS) was first launched for the NHS in 2011 and is a system that helps NHS organisations improve the services they provide for their local communities. The main purpose of the EDS is to review and improve our performance for people with characteristics protected by the Equality Act 2010.
The nine Protected Characteristics are:

- Age
- Disability
- Gender reassignment
- *Marriage and civil partnership
- Pregnancy and maternity (and paternity)
- Race
- Religion or belief
- Sex
- Sexual orientation

How we have performed 2023/24

This year we have continued to work across Gloucestershire to revisit our EDS progress from 2022/23 for Cancer Services and Translation & Interpretation Services and we have also included Maternity Services.

EDS is an improvement tool to review and improve our approach in addressing inequalities in health access, experience, impact and outcomes. It is driven by data, evidence, engagement and insight.

For the EDS, for each service area, we were required to test four outcomes:
• 1A: Patients (service users) have required levels of access to the service
• 1B: Individual patients (service user's) health needs are met
• 1C: When patients (service users) use the service, they are free from harm
• 1D: Patients (service users) report positive experiences of the service

We have collated information to support this assessment from NHS Gloucestershire ICB, Gloucestershire Health & Care NHSFT and Gloucestershire Hospitals NHSFT. The evidence gathered includes statistical data, policies, strategies, working protocols and procedures, service specifications and health inequalities action plans. The evidence has been discussed with the ICB Working with People and Communities Advisory Group and Maternity and

Neonatal Voices Partnership representatives, who gave valuable insight into our self-assessment and made recommendations regarding ratings for each of the four outcomes.

Each outcome was scored based on the evidence provided. Once each outcome has a score, they are added together to gain domain ratings. Using the middle score out of the three services from Domain 1, domain scores are then added together to provide the overall score, or the EDS organisation rating. Ratings in accordance to scores are below.

The scoring system allows us to identify gaps and areas requiring action.

Table: EDS scoring

Undeveloped activity – **organisations score 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score 2** for each outcome	Those who score **between 22 and 30,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score 3** for most outcomes	Those who score **31 and above,** adding all outcome scores in all domains, are rated **Excelling**

Table: Gloucestershire scores for domain 1

Our assessment rating

There is a range of scores across the different services, but when combined they equate to the following:

Outcome 1A – Achieving activity = Score 2
Outcome 1B – Achieving activity = Score 2
Outcome 1C – Achieving activity = Score 2
Outcome 1D – Achieving activity = Score 2

Overall Rating for Domain 1: Commissioned or Provided services is Achieving Activity (score 8 out of possible 12)

Narrative

Outcome 1A: Patients (service users) have required levels of access to the service

Cancer services:

- There is good provision of cancer services across primary care, acute and community services.
- A place-based population health approach is being taken through Integrated Locality Partnership and Primary Care Networks.
- Our Integrated Care Strategy focuses on understanding our communities and achieving equity through a range of targeted improvement for those living in our most deprived areas of the county.

- There is ongoing work to improve data coverage and links across all health data sets, to improve the data completeness. Analysis by some protected characteristics remains challenging due to the incompleteness of data.
- The Gloucestershire ICS Cancer Programme oversees much of the work to increase early diagnosis rates and ensure identification of, and reduction in, inequalities

Translation and Interpretation (T&I) Services:
- Each NHS organisation in One Gloucestershire commissions Translation & Interpretation (T&I) Services, which are available to patients' attending appointments in Primary Care, Acute and Community Services.
- We are in the final phase of re-procuring one T&I service for spoken languages across One Gloucestershire partners.
- This will enable:
    - Continuity of interpreter (where preferred)
    - Improved access to services • Collection of robust feedback from people in our communities
    - Improved staff training
- Our work with Gloucestershire Deaf Association has provided a better understanding of the number of British Sign Language users accessing health care in the county.
- We are working with voluntary sector partners to raise awareness of the Accessible Information Standard (2016) and develop mechanisms to ensure compliance across our system.

Maternity Services:
- The Local Maternity and Neonatal System (LMNS) Board has regular oversight of and monitors the national local maternity services dashboard. This brings together information from different data sources to track, benchmark and improve the quality of maternity services in Gloucestershire. Maternity services, including Delivery Suite, Birthing Units, Community Midwives and Perinatal Mental Health Services are delivered in a number of locations in Gloucestershire.
- Our data shows that 21.3% of maternity bookings are for women from ethnic minority communities. This is higher than the ethnic minority population in Gloucestershire, which according to the 2021 Census is 17.7%, for women of child-bearing age. 23.9% of all bookings are from women who live in the most deprived areas (IMD Deciles 1&2) of Gloucestershire. 14.7% of these women are booked with the Continuity of Carer team/pathway.

Outcome 1B: Individual patients (service user's) health needs are met
Cancer Services:
System-wide work to deliver the Cancer Operational Planning guidance 2023/24 has contributed to local action, including:
- Faster diagnosis and operational improvement; e.g. Targeted focus on inequalities in prostate cancer aimed at increasing engagement in men over 45 from a black ethnic background, with family history of prostate cancer.
- Early Diagnosis: NHS Cancer Screening - Working to identify the population groups with low screening uptake locally e.g. Actively developing opportunities to improve screening uptake in women from South Asian communities and in areas of deprivation.

- Improving access to screening for people with Learning Disabilities and Autism by having a dedicated cancer screening support nurse. Primary Care Direct Enhanced Service and Quality Improvement Projects respond to local needs and challenges.

Translation and Interpretation (T&I) Services:

- Access to the T&I services available across One Gloucestershire services 24/7, 365 days.
- Policies and procedures in place to ensure staff are able to access T&I support.
- Reasonable adjustments made e.g. longer appointments, mobility, support for hearing and sight impairments.
- New service specification for spoken language will: - support requests for continuity of interpreter across organisations - enable service improvement (re T&I) based on feedback from patients
- Accessible Information Standard: Working in partnership with VCS organisations to support awareness raising of communication needs for people with a disability, sensory or cognitive impairment.

Maternity Services:

The Local Maternity and Neonatal System (LMNS) has developed an Equity and Equality action plan, in collaboration with the Maternity and Neonatal Voices Partnership (MNVP). This 5-year plan sets out initiatives which include:

- 2 Midwifery Continuity of Carer (MCoC) teams have been established to provide support in areas of high deprivation and ethnic minority communities.
- A Perinatal Emotional Health and Wellbeing pilot funded by the ICB and delivered by The Nelson Trust supports women with low/moderate perinatal mental health needs, and can support with issues around accommodation, drug and alcohol misuse and domestic abuse.
- Perinatal Equity and Equality Action Plan developed with a focus on mothers from more deprived areas and ethnic minorities, young mothers and Traveller communities
- A young mums' support group is delivered by Forest Voluntary Action Forum (FVAF), who has identified the needs of the young people and encourages social inclusion, helps build confidence, learn new skills and increase parenting social circles.

Outcome 1C: When patients (service users) use the service, they are free from harm
Cancer Services:

- Gloucestershire residents are able to access reasonably high quality, safe healthcare. The Care Quality Commission has rated both main providers as ‘Good’. In Primary Care settings, residents can also access good quality GP services, most of which are rated as either ‘Good’ or ‘Outstanding’.
- System Safety Group established to oversee the implementation of Patient Safety Incident Response Framework (PSIRF) at system level.
- Patient safety policies and procedures in place with all providers: additional needs are supported by LD Liaison Nurse Service; Admiral nurse for inpatients with dementia diagnosis; Transgender policy.
- Embedded through Professional Registration, Staff training, Risk Assessments, Information Governance, DATIX reporting, Freedom to Speak Up Guardians, Duty of Candour.

Translation & Interpretation Services:

- Policies and procedures are in place to ensure NHS providers are compliant with contractual safety requirements – these are generic for all patients.
- DATIX reporting reviewed and actioned.
- Freedom to Speak Up Guardians, who support staff to speak up on issues relating to patient safety and the quality of care; staff experience and learning/improvement.
- One Gloucestershire Quality Framework, Quality Strategy, Whistleblowing Policy support patient safety.

Maternity Services:

- Local Maternity and Neonatal System receive regular updates on quality and safety, including the quarterly Perinatal Quality Surveillance and Safety Report.
- Maternity and Neonatal safety champions in post and meet bi-monthly, undertaking walkabouts of key areas of focus. They provide visible leadership and promote safe, personalised care, share learning and best practice from national research, local investigations and initiatives.
- DATIX reporting – a daily review of all incidents rated moderate harm+ takes place to ensure we are responding to any potential safety concerns in a timely way. In addition, the introduction of hot and cold de-brief post incident to support staff health and wellbeing
- We have strengthened the quality and safety reporting both internally and externally to support an increase in learning from our incidents and patient feedback.

Outcome 1D: Patients (service users) report positive experiences of the service
Cancer Services:

- Working with people and communities Strategy: NHS Gloucestershire's system-wide approach ensures proactive engagement across diverse communities.
- Patient experience information gathered through engagement is reported back to service leads and system partners.
- Patient Experience data is gathered, monitored and acted upon: - National cancer survey – high levels of satisfaction reported, although limited analysis by protected characteristics possible due to small numbers involved - Patient experience data gathered via Friends and Family Test (FFT) – demographic data capture extended to provide greater breakdown of ethnicity; disability; carer
- Working closely with ICB Insights Manager to build relationships with local communities and groups, including plans for engagement work and cultural competency training for staff supporting events.
- Targeted campaigns include:
    - Prostate cancer risk and awareness event with the African Caribbean Community.
    - Breast Cancer Awareness Events utilising the Information Bus to target deprived communities, ethnic minority communities (prevalence of late stage diagnosis), the homeless community and the LGBT+ community.
    - Bartongate Children's Centre event
    - female Afghani refugees, with support from GARAS.
    - All Nations Health and Wellbeing event attended by Prostate and Breast Nurses.

- General awareness, risks and prevention with Nepalese soldiers

Translation & Interpretation Services:

– We are in the final phase of re-procuring one T&I service for spoken languages across One Gloucestershire partners.

This will enable:

- Continuity of interpreter (where preferred)
- Improved access to services - Collection of robust feedback from people in our communities
- Opportunity to promote service to local communities
- Improved staff training
- Gloucestershire Health and Care NHSFT are in the process of introducing a QR code, so that when an appointment has taken place, the Deaf client will receive a text so they can send back some feedback.
- Working with Inclusion Gloucestershire, Gloucestershire Hospitals NHSFT have reviewed patient information leaflets and agreed which should be translated into Easy Read. Information to support patients in Shared Decision Making has been included on the back of each leaflet.

Plans for improvement 2024/25

Our EDS improvement programme will be reported on in our Trust Equality Report.

– Further data analysis is underway for cancer services to improve identification of variation and link further datasets to improve data quality.
– Work to provide consistency and clarity of the maternity offer for labour and delivery.
– Further improvements are made to equality data recording, in order to achieve consistency.
– Establish mechanisms for gathering patient experience of translation and interpretation services and explore innovation in improving access and visibility of the service.
– Review compliance with the Accessible Information Standard providing and evaluating the impact of additional training and support for staff.

13. Quality priority - Commissioning for Quality and Innovation (CQUINs)

1.	Commissioning for Quality and Innovation (CQUINs)	We will be focused on delivering our CQUINs

Background

The Commissioning for Quality and Innovation (CQUIN) scheme provides a framework to support improvement in the quality of services. The Trust requirement is to undertake and report on all applicable CQUINs in 23/24, with our 'top 5' (based on preference and priorities) being linked to the financial incentive part of the CQUIN.

Support remains available to all CQUIN teams via the Clinical Effectiveness Improvement (CEI) team and through the GSQIA Silver process where beneficial.

For information, the full CQUIN specifications details for 2023/24 can be found here.

How we have performed 2023/24

Our quarter 4 results have been uploaded to the National portal / emailed to the national teams as required.

With Gloucestershire Integrated Care Board, we have agreed our top 5 CQUINs for 2023/24 were:

- CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery
- CQUIN04: Prompt switching of intravenous to oral antimicrobial treatment
- CQUIN05: Identification and response to frailty in emergency departments
- CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions
- CQUIN12: Assessment and documentation of pressure ulcer risk.

Table: CQUIN results by quarter

CQUIN	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CQUIN 01: Staff flu vaccination rate	Not applicable	31.8%	56.6%	57.5%
CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	90%	96%	95%	95%

CQUIN	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CQUIN04: Compliance with timed diagnostic pathways for cancer services	Nul return	Nul return	Nul return	Nul return
CQUIN04: Prompt switching of intravenous to oral antimicrobial treatment	18%	29%	28%	21%
CQUIN05: Identification and response to frailty in emergency departments	29%	11.3%	24%	27%
CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	0.56%	1.09%	Not yet available	Not yet available
CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions	32%	42%	13%	54%
CQUIN08 Achievement of revascularisation standards for lower limb ischaemia	Normal submission to National Vascular Registry			
CQUIN10: Treatment of non-small-cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	100%	66.7%	50%	100%
CQUIN11: Improving the quality of shared decision-making conversations	This has been added to our Friends and Family Test data			

CQUIN	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CQUIN12: Assessment and documentation of pressure ulcer risk	62%	61.6%	60.3%	64.25%

Plans for improvement 2024/25

CQUINs are to be paused next year, with NHS England publishing non-mandatory indicators for Trusts to follow if they wish. Proposal to follow/report on these indicators will be only if they align with Patient Safety Incident Framework (PSIRF) Safety Priorities or other priorities.

14. Quality priority - Caring for people at the end of their lives

2	Caring for people at the end of their lives	We will support the improvement of our compliance with national guidance on care at the end of life (One Chance to Get It Right, NICE guidelines and the Quality Standards for end of life care). (NB The NACEL Audit is paused in 2023.)

Background

We have continued our work to improve people's experience of care in the last few days and hours of life. We have more than 2000 inpatients who die each year in hospital. Following the NICE Guidance 31 we have focussed on communicating respectfully and involving them and the people important to them in decisions about maintaining comfort and dignity. Our approach helps patients manage common symptoms whilst minimising side effects from drugs and maintaining comfort and hydration.

The identification of dying requires senior decision making and a multidisciplinary approach, together with robust and compassionate communication with the patients and those important to them. An individualised plan of care is developed and delivered to provide the best possible experience at this challenging time as illustrated in the report "More care, less pathway" (2013 More Care, Less Pathway (publishing.service.gov.uk)).
The Trust provides good EOL care (CQC 2018) and uses enablers to support this such as the Shared Care Plan and the SWAN model of care, and metrics to monitor the delivery of this care such as those generated by the National Audit for Care at the End of Life (NACEL). Practice is largely in line with other Trusts.

How we have performed 2023/24

Since the transition to the electronic patient record system, the use of the shared care plan has fallen as the system does not facilitate sharing the same as the paper form. We will work on how we will improve our use of the shared care plan because we know it enables a more comprehensive package of support for each patient and is a marker of good practice. In the interim we are using the SWAN feather symbol for the identification of dying and measure the patients on our electronic patient records system and we measure the prescribing of Glycopyrronium which is one of the anticipatory medications prescribed to support care of our dying patients.

We have improved the quality and quantity of our syringe pump training for nursing staff by developing and recording our syringe pump competencies on our Trust training register. A "train the trainer" model of teaching delivery has been commenced, with assured training from the specialist palliative care team. This will involve a combination of ad-hoc, bedside training as well as monthly training sessions for those clinical areas who do not have a nominated trainer. Registered nurses who work on wards who care for the dying, require a 50% competency upload by the end of 2024, increasing to 75% in 2025. This has been added into the ACE ward accreditation.

The competency report is also being refined and an aim for Q4 to see the output of above. We are measuring our 2023/4 performance, quarterly by:

	Q1	Q2	Q3	Q4
Number of adult deaths	475	447	481	514
% for whom feather icon used	31	33	38	42
Median / mean time (days) between feather icon application and death occurring	2.0 / 3.6	2.0 / 5.0	2.0 / 3.3	2.0/4.2
% for whom Glycopyrronium prescribed	77	79	81	82
Mean / median time (days) between Glycopyrronium prescription and death occurring	3.0 / 4.8	3.0 / 3.2	2.0 / 4.4	2.0/4.5
% Eligible nurses with syringe pump competency **	Not available	6.1%	Not available	17%

The proportion for whom the feather icon was placed on the tracking board has shown an increasing trend. This is a consequence of changes in EPR enabling more clinicians to apply the icon and is also due to Trust Wide Dying Matters Week comms, Grand Round, junior doctor teaching, the End-of-Life Care Leaders and PURPLE pilot and informal encouragement of use from the Palliative Care Team.

The proportion of patients who are prescribed Glycopyrronium remains high and demonstrates a similar trend which is encouraging as it suggests that the majority of dying is identified and *just in case* medicines are prescribed.

The PURPLE pilot project which is using a quality improvement approach to identify patients who are sick enough to die and to ensure appropriate management plans are in place is an initiative which aims to support appropriate and timely identification of dying. This project is now piloted over 4 wards.

The End-of-Life Care Leader project is now running with 31 junior doctors having attended an introduction session. Part of their role is to support the development and sharing of best practice through targeted QI initiatives and role modelling on their wards.

SWAN ambassadors are currently provided with an annual update and work is ongoing to ensure there is representation from all wards. The model of more frequent meetings / an end of life council proved unsuccessful as staff struggled to be released from clinical duties. The EOL council remains an aspiration as part of Pathway to Excellence.
Monitoring is undertaken via the End-of-Life Delivery Group which is now meeting monthly and where discussions are currently taking place as to the best ways for divisions to report issues and progress.

Plans for improvement 2024/25

We would like to develop an electronic version of the shared care plan to enhance communication with the patient and carers.

We will monitor registered nurses who work on wards who care for the dying, requiring a 50% competency upload by the end of 2024, increasing to 75% in 2025.
We would like to deliver a systematic and comprehensive approach for delivering and recording attendance for all staff for End-of-Life training.
Statistical analysis on the timing of anticipatory medicines being prescribed, the SWAN feather icon being applied and the patient dying, to identify meaningful improvement.

References:

- NICE Quality Standard Overview | Care of dying adults in the last days of life | Guidance | NICE
- Ambitions for palliative and end of life care ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)

Health services

The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). Maternity Services are also provided at Stroud Maternity Hospital. Outpatient clinics and some surgery services are provided by Trust staff from community hospitals throughout Gloucestershire. The Trust also provides services at the satellite oncology centre in Hereford County hospital.

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute elective and specialist healthcare for a population of more than 650,000 people. Our hospitals are district general hospitals with a great tradition of providing high quality hospital services; some specialist departments are concentrated at either Cheltenham General or Gloucestershire Royal Hospitals, so that we can make the best use of the expertise and specialist equipment needed.

Our Trust employs around 8000 staff. Our success depends on the commitment and dedication of our colleagues. Many of our staff are world leaders in the fields of healthcare, teaching and research and we aim to recruit and retain the best staff possible. Our patients are cared for by more than 2,390 registered nurses and midwives, 905 Healthcare Assistants and 992 medical staff. 257 Healthcare Scientists and 527 Allied Health Professionals. In addition, our estates are looked after by 763 NHS Gloucestershire Managed Services staff,

Further details, including our organisational chart can be found on our website
The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). Maternity Services are also provided at Stroud Maternity Hospital. Outpatient clinics and some surgery services are provided by Trust staff from community hospitals throughout Gloucestershire. The Trust also provides services at the satellite oncology centre in Hereford County hospital.

https://www.gloshospitals.nhs.uk/about-us/our-trust/who-we-are-and-what-we-do/

Information on participation in clinical audit

From 1 April 2023 to 31 March 2024, 47 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 which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals

NHS Foundation Trust was eligible to participate in during 2023/24 are as follows:

	Eligible	Participated	Status
Case Mix Programme (CMP)	Y	Y	Ongoing
Elective Surgery (National PROMs Programme)	Y	Y	Paused
Emergency Medicine QIPS (RCEM) – Care of Older People	N	N	N/A (deferred)
Emergency Medicine QIPS (RCEM) – Mental health (self-harm)	Y	Y	Ongoing
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	Y	Y	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	Y	Y	Ongoing
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	Y	N (due to closure of registry)	Closing
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Y	Y	Ongoing
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE)	Y	Y	Ongoing
Muscle Invasive Bladder Cancer Audit	Y	Y	Closed
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit	Y	Y	Ongoing
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	Y	Y	Ongoing
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP)- Adult asthma secondary care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP)- Paediatric asthma secondary care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP)- Chronic Obstructive Pulmonary Disease	Y	Y	Ongoing

	Eligible	Participated	Status
(COPD) Secondary Care			
National Audit of Breast Cancer in Older People (NABCOP)	Y	Y	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	Complete
National Audit of Dementia (NAD)	Y	Y	Ongoing
National Bariatric Surgery Registry (NBSR)	Y	Y	Ongoing
National Cardiac Arrest Audit (NCAA)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	Y	Y	Ongoing
National Child Mortality Database	Y	Y	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	Ongoing
National Joint Registry (NJR)	Y	Y	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	Ongoing
National Neonatal Audit Programme (NNAP)	Y	Y	Ongoing
National Ophthalmology Audit (NOD)	Y	Y	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	Ongoing
National Perinatal Mortality Review Tool	Y	Y	Ongoing
National Prostate Cancer Audit	Y	Y	Ongoing
National Vascular Registry	Y	Y	Ongoing
Perioperative Quality Improvement Programme	Y	Y	Ongoing
National Acute Kidney Injury Audit	Y	Y	Ongoing
UK Renal Registry Chronic Kidney Disease registry	Y	Y	Ongoing
Adult Respiratory Support Audit	Y	Y	Ongoing
Smoking Cessation Audit- Maternity and Mental Health Service	Y (but data collection deferred)	N/A	NYR
Sentinel Stroke National Audit programme (SSNAP)	Y	Y	Ongoing
Serious Hazards of Transfusion UK (SHOT) - National Haemovigilance Scheme	Y	Y	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)	Y	Y	Ongoing
The Trauma Audit and Research Network (TARN)	Y	Y	Ongoing

	Eligible	Participated	Status
UK Cystic Fibrosis Registry	Y	Y	Ongoing
National Parkinson's Audit	Y	Y	Ongoing

Ongoing – relates to continuous data collection, please note
NYR – data collection has not yet started
PTP – plan to participate in the next round

The reports of the above national clinical audits were reviewed (or will be reviewed once available) by the provider in 2023/24.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Case Mix Programme (CMP)	The CMP is an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland. ICNARC report on COVID-19 in critical care: 2023 This report presents analyses of data on patients critically ill with confirmed COVID-19, admitted up to 31 March 2023 from critical care units participating in the Case Mix Programme and increasing numbers of surge/other areas providing critical care.
Elective Surgery (National PROMs Programme)	GNHFT participated in reporting to this audit in 2023. The most recent data available for PROMs is “Finalised Patient Reported Outcome Measures (PROMs) in England for Hip and Knee Replacement Procedures (April 2021 to March 2022). Published July 2023. Changes were made by NHS Digital to the linking of data fields from Hospital Episode Statistics (HES) and Patient Reported Outcome Measures. Due to this reporting has been paused, with no current timeframe for publication of results.
Emergency Medicine QIPS (RCEM) – Care of Older People Emergency Medicine QIPS (RCEM) – Mental health (self-harm)	GNHFT participated in reporting to this audit in 2021/2. The Trust is not participating in this QIP at present due to departmental priorities. Other Trust based Care of the Elderly QIPS are ongoing including improving documentation of Clinical Frailty Scores. This QIP tracks the current performance in EDs against clinical standards in individual departments and nationally on a real-time basis over a 2-year period. This includes; - ED Mental Health Triage process - Observation of patients at risk of further self-harm or absconding - ED clinician assessment

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	The Trust continues participate in this QIP, to identify scope for improvement work and monitor real time change. Epilepsy12 has the continuing aim of helping 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. Epilepsy12 seeks to help improve the standard of care for children and young people with epilepsies. Data is collected and processed relating to the delivery of patient care and the organisation and structure of services. This information is used by the audit to highlight areas where services are doing well, and also to identify areas in which they need to improve. The Trust has ensured participation in Cohort 5 of data collection and will review the next publication to identify any scope for quality improvements.
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	The National Audit of Inpatient Falls (NAIF) audits the delivery and quality of care for patients over 60 who fall and sustain a fracture of the hip or thigh bone in acute, mental health, community and specialist NHS trusts/health boards in England and Wales. NAIF reviews the care the patient has received before their fall as well as the post fall care. From 2025 the audit will also look for evidence of examination for other injuries for patients who are found to have a fracture, or other serious injury which is recommended by NICE clinical guideline CG161 and quality standard QS86. The Trust Falls Prevention team provide ongoing and regular training for all members of the multidisciplinary health care team with the aim of keeping staff competent and confident to carry out assessments, including the correct and appropriate management of post falls assessments, thereby identifying risk factors and ensure action is taken to address these risks. This includes high quality multi-factorial falls risk assessments (MFRA) for patients over 65 and other inpatients who may be at risk. Current QIs in progress include the improvement of calculation of lying down blood pressures, with training led by Clinical Nurse Educators and Falls Link Nurses. A Post Fall Assessment document is being integrated into EPR to improve documentation of post fall checks and requirements for administration of analgesia.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	The National Hip Fracture Database (NHFD) was established to measure quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform. The Trust uploads data from all hip fracture cases admitted to GRH. These data are analysed locally and discussed at monthly governance meetings. NHFD provides 3 monthly update reports allowing us to benchmark our Trust against other hospitals, these reports are also discussed at governance meetings. Improvement work continues around consolidation and embedding of previous years' actions, together with looking at additional theatre availability.
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	The IBD Registry is closing current activities by **Easter 2024**, and is in discussions through **Spring 2024** about possible transition to an NHS organisation. The Trust has not participated in the latest rounds of data collection.
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	LeDeR summarises the lives and deaths of people with a learning disability and autistic people who died in England. It aims to; - Improve care for people with a learning disability and autistic people. - Reduce health inequalities for people with a learning disability and autistic people. - Prevent people with a learning disability and autistic people from early deaths. This year's report found that nationally there has been gentle but continuous improvement in the median age of death for people with a learning disability in 2022. There was a drop in the number of avoidable deaths since 2021 – 42% of deaths were deemed "avoidable" in 2022 compared to 50% in 2021. For most of 2023/2024 the LeDeR Quality Assurance panel were reviewing deaths which occurred in 2022/2023. Of the 28 deaths which occurred that year in either inpatients or shortly after discharge, to die at home or in a community hospital, 25 were graded at least 'Satisfactory', but 6 were graded 'excellent'. The Trust has not seen any in-hospital death graded 'excellent' before, so this was a major achievement. It has taken a lot of years of dedication by many professionals and families to achieve this.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	A single grade is given across primary care, secondary care and social care so these high gradings are a tribute to the efforts of everyone in all three areas of health and social care. Even where the grade allocated was 'Satisfactory' the deficit was not within hospital care. Only one death was graded 'Inadequate'. No death was graded less than Inadequate and 2 deaths have yet to be graded. In response to issues that have arisen in LeDeR reviews, minor modifications have been made to the alerts placed on Trakcare for Learning Disability patients, and the LD liaison nurses have adopted a more structured approach to their visits to in-patients, which has reduced the frequency of many of the concerns.
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE)	The Maternal, Newborn and Infant Clinical Outcome Review Programme includes surveillance data on women in the UK who died during or up to one year after pregnancy between *January to December 2021. This year themed reports have been published on;* - A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death. - A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death. - Maternal Deaths from haemorrhage, amniotic fluid embolism and anaesthetic causes 2019-21 and morbidity following repeat caesarean birth. - Maternal Deaths from infection, neurological, haematological, respiratory, endocrine, gastrointestinal and general surgical causes The Trust continues to participate in MBRRACE-UK data reporting and reviews the recommendations at the Maternity Clinical Governance meeting to identify any action plans including quality improvement work. Report findings are shared on the MDT PROMPT study day to ensure National learning is shared amongst the team. Improvements in Health inequalities is a key focus in the Trust's maternal death action plan.
Muscle Invasive Bladder Cancer Audit	This BAUS snapshot audit was launched in January 2022. National and local results were published in August. Presentation of these results took place in September at a local audit meeting. Currently our time to cystectomy is better than the national average/MITRE data. However, there are gains to be made in

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit	time to TURBT, and subsequent time to restaging TURBT. One delay in this pathway is the need for repeating the pre-assessment clinic before each operation, which often is unnecessary If patients are having similar operations in a short period of time – we are looking at bypassing the need for a second pre-assessment prior to restaging TURBT. NDISA reviews inpatient service provision in England and Wales. Service provision is assessed against recommendations in the 2020 Diabetes Getting It Right First Time (GIRFT) report. The rates and risk factors are reviewed for serious diabetes-specific inpatient harms that can occur to inpatients with diabetes in acute hospitals in England. The Trust continues to submit to NDSIA Harms on harms that are reported, errors are discussed by the Diabetes Team. It is recognised that staff shortages have impacted the ability to meet all GIRFT recommendations. The Trust has introduced insulin prescribing on EPR, as of early December 2023, as a result there are less insulin related incidents occurring.
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	NPID is a work stream of the National Diabetes Audit (NDA) and measures the quality of pre-gestational diabetes care against NICE guideline-based criteria and the outcomes of pre-gestational diabetic pregnancy. It focuses on key areas of preparing women with diabetes for pregnancy and taking appropriate steps to minimise adverse outcomes to the mother. The Trust continues to participate with ongoing data collection. Data is published nationally and reviewed at the annual Diabetes in Pregnancy conference.
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	NDA provides a view of diabetes care in England and Wales. It measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards. This supports Trusts to Identify and share best practice and identify gaps or shortfalls that are priorities for improvement. The Trust has continued to participate in the NDA. Reports and Trust data are reviewed at Diabetes Team Operational Meetings and the Gloucestershire Diabetes Clinical Program Group. Improvements have been made and are ongoing for access to and training on diabetes technologies. Ongoing planning is in progress for management of Type2 Diabetes.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Respiratory Audit Programme (NRAP) - Adult asthma secondary care	NRAP's adult asthma secondary care work stream includes a continuous clinical audit of people admitted to hospital with asthma attacks, and a snapshot audit of the organisation and resourcing of care. The audit is continuous and collects information on adults admitted to hospital in England and Wales with asthma attacks. Snapshot organisational audits collect information on how services are organised and what resources are available to them at a given point in time. The Trust continues to participate in this audit, combining data for both sites. The data is used to identify improvement priorities which can drive improvements to care.
National Respiratory Audit Programme (NRAP)- Children and young people's asthma secondary care asthma secondary care	NRAP's children and young people's asthma secondary care work stream includes a continuous clinical audit of people admitted to hospital paediatric services in England and Wales with asthma attacks, and a snapshot audit of the organisation and resourcing of care. This audit aims to collect information on children and young people aged 1-18 years, admitted to hospital paediatric services with an asthma attack in England and Wales. Data is measured against key performance indicators recommended by NRAP to support good practice in the delivery of acute asthma care. The Trust has completed data for the organisational audit for this year. Outcomes from previous years' reports include staff working with CYP and families continuing to be appropriately trained to explain the risk of asthma exacerbations linked to smoking and indoor air quality and making referrals to smoking cessation specialist services. A formal transition service is in place for from child to adult asthma services. The Paediatric Respiratory service is reviewing options to meet recommendations on dedicated in-patient time for asthma.
National Respiratory Audit Programme (NRAP - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	NRAP's COPD secondary care work stream includes a continuous clinical audit of people admitted to hospital with flare-ups of COPD, and a snapshot audit of the organisation and resourcing of care. Data is measured against the key performance indicators recommended by NRAP to support good practice in the delivery of acute asthma and COPD secondary care. The Trust are continuing to undertake the NRAP organisational audit. The business intelligence spreadsheets tracking admissions is supporting accuracy of data and the identification of patients with COPD.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Audit of Breast Cancer in Older People (NABCOP)	NABCOP is a national clinical audit run by the Association of Breast Surgery (ABS) and the Clinical Effectiveness Unit (CEU) of the Royal College of Surgeons of England (RCS). 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 NABCOP audit pulls the anonymised data it requires automatically. The Trust reviews cases and reports at specialist departmental meetings. The NABCOP Patient information sheet for >70s is now used within clinics.
National Audit of Care at the End of Life (NACEL)	NACEL is designed to measure the experience of care at the end of life for dying people and those important to them, and to provide audit outputs which enable stakeholders to identify areas for service improvement. GHT took part in the 2022 round of the audit, the most recent publication was shared at Quality Delivery Group, Trust Mortality Group and End of life Delivery Group. An action plan has been developed and is overseen by the End of Life Delivery Group.
National Audit of Dementia (NAD)	The National Audit of Dementia (NAD) audit relates to the quality of care received by people with dementia in general hospitals. The latest NAD report has been reviewed by the Trust's Dementia Delivery Group and an action plan is in place to include; - Widening opportunities for patient engagement - Improved EPR capture of Dementia and Delirium - Increased levels of Datix reporting with refined reporting of falls, pressure ulcers, violence and aggression and complaints - Review and development of current Dementia training - Initiative for ensuring Trust hospitals are Dementia Friendly environments.
National Bowel Cancer Audit (NBOCA)	The annual report was published in January 2023 and discussed at the Upper GI clinical governance meeting in February 2023. Discussion of results has highlighted areas for work over the coming 12 months, looking at: Ileostomy closure, adjuvant chemo and laparoscopy rates.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Bariatric Surgery Registry (NBSR)	The State of the Nation Report was published in early 2024 and was reviewed at the Colorectal Governance Meetings. NBOCA has also been discussed in several CRUM Meetings due to concerns regarding the accuracy of the data. The National Bariatric Surgery Registry is the result of a collaboration between ALSGBI (Association of Laparoscopic Surgeons of Great Britain and Ireland), AUGIS (Association of Upper Gastrointestinal Surgery), BOMSS (British Obesity & Metabolic Surgery Society) and Dendrite Clinical Systems. The key objective of the registry is to accumulate sufficient data to allow the publication of a comprehensive report on outcomes following bariatric surgery. This will include reportage on weight loss, co-morbidity and improvement of quality of life. 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)	We subscribe to 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 aims of the audit are to: improve patient outcomes; decrease incidence of avoidable cardiac arrests; decrease incidence of inappropriate resuscitation as well as to promote adoption and compliance with evidence-based practice. All NCAA reports are reviewed as a department as well as quarterly at the Deteriorating Patient & Resuscitation Committee. The reports are also available on the Deteriorating Patient & Resuscitation Committee shared drive so that they can be accessed and be reviewed by appropriate clinicians with access. We also publish the Audit data within the department newsletter issued across the Trust as well as being accessible on the Intranet, staff notice boards, and shared with department heads for dissemination. The Trust continues to share the results at Induction sessions and Mandatory updates. Any inappropriate

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	CPR attempts are highlighted and reviewed, and if appropriate, simulated to help focus teaching and lessons learned. The NACRM report details activity in cardiac rhythm management device and ablation procedures for England & Wales and covers data from April 2021- March 2022. On a national scale, following a 17% drop in therapeutic implants in 20/21, there was an 11% increase in activity in 21/22, but overall activity was still 7.7% lower than pre-pandemic levels. Ablation rates have improved nationally, but remain 11% down from 19/20. Use of leadless pacemakers increased. Trust reports are reviewed at the Arrhythmia Group meeting and with the clinical lead and pacing operators, where Trust data and scope for quality improvements are reviewed alongside national recommendations from the audit.
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	This year's report covers April 2022 to March 2023. Total PCI procedures increased nationally over this period. The number of primary PCIs for patients with ST-elevation myocardial infarction (STEMI) returned to pre-pandemic levels and PCI for other acute coronary syndromes almost did so. Elective PCI numbers were lower. The report focuses on several specific quality improvement metrics derived from national and/or international standards and guidelines. The Trust meets recommendations substantially, specifically in the use of adjunctive imaging in LMS intervention and use of newer antiplatelet agents in the STEMI setting. Day case PCI for elective work is the default as was recognised by the GIRFT report in March 2023 and rates for the unit (87.4%) continue to be well above the national average of 71%, improving access to PCI for local population without impacting IP patient care/bed use. Recommended antiplatelet drug use in STEMI cases is higher at 76.8% than national average of 40%. 30day mortality at 1.71% is lower than national average for matched activity/volume.
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	This report summarises the care provided within hospitals in England, Wales and Northern Ireland people who suffered a heart attack during 2021/22. Quality of care is assessed against a set of quality improvement (QI) metrics derived from national and/ or international standards and guidelines. These cover patients diagnosed with higher-risk ST-segment elevation myocardial infarction (STEMI) heart attacks and those with non-ST-segment elevation myocardial infarction (NSTEMI) heart attacks.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	The Trust has used QI methodology to improve data completeness for MINAP and continues to do the primary PCI timings. Cardiology is now on one site at GRH and will certainly have a positive impact on the service. This report summarises selected key findings from the National Heart Failure Audit (NHFA), part of the National Cardiac Audit Programme (NCAP) and covers the period of 2021/22. It deals with a specific and crucial phase in the disease trajectory of patients admitted to hospital with heart failure in England and Wales. There is a particular focus on a set of quality improvement metrics, based on standards and guidelines, which aim to drive up standards of care during an acute admission to achieve better patient outcomes. The Trust has continued to participate in this audit and recent initiatives include; - Initiation of a pilot 1 year project for a nurse-led inpatient heart failure service in GRH - Work towards establishing a 'Virtual ward' to manage ambulatory heart failure patients within a virtual environment at home rather than in hospital
National Child Mortality Database	NCMD aims to understand patterns and trends in child deaths where an event before, or around, the time of birth had a significant impact on life, and the risk of dying in childhood. Over the past 12 months this has included thematic reports on infection related deaths of children and young people and death due to traumatic incidents. The Trust continues to participate in the NCDM and reviews local data at Perinatal and Paediatric Clinical Governance meetings, which, by also reviewing national or local recommendations, identifies action plans and quality improvement work. The Trust also works closely with the ICB in these respects.
National Early Inflammatory Arthritis Audit (NEIAA)	The NEIAA assesses the provision of care and the impact of that care on outcomes for people with Early Inflammatory Arthritis in England and Wales. NEIAA determines whether the care provided is consistent with current recommended best practice defined by NICE QS 33. The audit assesses seven key metrics of care for people with new symptoms of suspected inflammatory arthritis attending rheumatology services. The Trust continues to participate in the audit and reviews the report and local data at the departmental governance meeting. The Trust is identified as an outlier for Quality Standard 2 and is

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	working towards improving data capture to support potential quality improvements for the referral and assessment pathways. 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.
National Emergency Laparotomy Audit (NELA)	NELA is carried out by the National Institute of Academic Anaesthesia's Health Services Research Centre (HSRC) on behalf of the Royal College of Anaesthetists (RCoA), in conjunction with surgical and other key stakeholders. The most recent report was published February 2023. This was discussed at the NELA MDT and an action plan set. Data continues to be uploaded to the NELA website, with quarterly joint surgical and anaesthetic NELA meetings to review results.
National Joint Registry (NJR)	The National Joint Registry (NJR) collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery. The results of the NJR are shared with the Medical Director and Chief Executive, and are discussed at hip and knee MDT meetings amongst all hip and knee surgeons. Individual reports are used as part of the appraisal process. 22/23 info Gloucestershire Hospitals has been found to have a revision rate for primary hip replacements over the last 5 years to be above that which is expected based on national data. A review of cases has been registered with the clinical effectiveness team to analyse the factors relating to these revisions, with a view to undertaking a Quality Improvement project if required following this diagnostic phase of the project.
National Lung Cancer Audit (NLCA)	Most recent report not reviewed yet. 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 most recent publication was included in last year’s quality account, and the next report is due. Outcomes will be reviewed at the Lung AGM and appropriate specialty and governance meetings. Quality improvement projects to improve our service

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Maternity and Perinatal Audit (NMPA)	and pathways are ongoing. To be reviewed on 14/5/24. The National Maternity and Perinatal Audit (NMPA) is a large-scale project established to provide data and information to those working in and using maternity services. It helps us understand the maternity journey by bringing together information about maternity care and information about hospital admissions. The NMPA aims to cover 2019-2023 data in their next publication. The Trust continues to participate in the NMPA and reviews reports alongside local data to highlight areas of potential service improvement.
National Neonatal Audit Programme (NNAP)	NNAP assesses whether babies admitted to neonatal units receive consistent high-quality care. This includes measuring key outcomes of neonatal care, measures of optimal perinatal care, maternal breastmilk feeding, parental partnership, neonatal nurse staffing levels, and other important care processes. Trust data is submitted nationally and reviewed quarterly, alongside recommendations from the report to identify any scope for local quality improvement work. Current QIs include; - improving timely administration of full course of antenatal steroids, and administration of magnesium sulphate. - Increased capacity for undertaking 2 year developmental assessments
National Ophthalmology Audit (NOD)	The National Ophthalmology Database Audit (NODA) is the latest dataset to be published on the National Clinical Audit Benchmarking (NCAB) website. This data was updated on NCAB on 03/11/2023. This Audit looked at Risk-adjusted posterior capsule rupture rate where GNHFT sits, 'Within Expected Range' and Risk-adjusted Visual Acuity Loss where GHNHSFT sits as, 'Better Than Expected'.
National Paediatric Diabetes Audit (NPDA)	The NPDA measures effectiveness of diabetes care received by the children and young people with diabetes against NICE guidelines. This includes treatment targets, health checks, patient education, psychological wellbeing, and assessment of diabetes related complications including acute hospital admissions. Ongoing Trust based QIs include; a new telephone advice sheet and inpatient guidelines for management of patients admitted to the ward, improving foot checks during annual review clinics, encouraging patients to send an early morning urine sample to the

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	lab and visits if patients do not attend or cancel annual review appointments. A GSQIA Silver project is in progress looking at preparing 14-16 years' olds with diabetes to transition to adult services with a view to increase confidence in self-management.
National Parkinson's Audit	The National Parkinson's Audit provides data about the state of Parkinson's services across the UK, which inform priorities and help drive service improvement and measure change. The audit uses evidence-based clinical guidelines as the basis for measuring the quality of care in the outpatient setting. Trust data reports on Neurology, COTE and Physiotherapy have been reviewed as part of a planned collaborative approach to identify quality improvement initiatives. A Training programme and educational pathways are in progress to upskill staff in providing care for patients with Parkinson's. This has included initiatives for earlier referral and resources from the Parkinson's Excellence Network, such as the 'Get in on Time' campaign to ensure patients receive timely medication.
National Perinatal Mortality Review Tool	The PMRT supports objective, robust and standardised local reviews of care when babies die. This includes baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths and neonatal deaths. It helps to ensure local and national learning results improve care, reduce safety-related adverse events, and prevent future baby deaths. The main focus of this year's report is 'quality' in terms of parent engagement, the review process, and subsequent actions plans. The Trust continues to participate in PMRT data reporting and inputs all stillbirths and early neonatal deaths. All parental feedback is gathered using locally adapted PMRT parental engagement materials and is shared and discussed monthly. Local PMRT summary reports are completed and shared with the Trust Board. Actions are reviewed at monthly PMRT meetings.
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 cancer in England and Wales. The findings help to define new standards and help 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

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
	released. Trust specific results are freely available on the NPCA website providing clear data for patients. Improvements made during 2020/21 have been maintained with results showing GHT is within the recognised 'normal' limits for emergency readmissions and genitourinary complications requiring intervention. The National Cancer Audit Collaborating Centre (NATCAN) published a State of the Nation report from the National Oesophago-Gastric Cancer Audit (NOGCA) on the care received by people with oesophago-gastric cancer in January 2024.
National Oesophago-gastric Cancer Audit	Previous Audit review: Specific recommendations received from publication around the nutritional status and dietetic support for patients. A second specialist cancer support dietician was employed in August 22 and all patients undergoing curative surgery for OG cancer now have access to specialist dietetic support before, during and after surgery in our trust. Plans are in place to develop a nutritional database to allow submission of these results increasing completeness of the NOGCA data set.
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 (Patent outcomes (mortality and revision rate) within expected boundaries). National Vascular Registry Sate of the Nation report reviewed in Sept 23, at the Vascular department away day. GNHFT continue to participate in reporting to this registry in 2023/4.
Perioperative Quality Improvement Programme	The Perioperative Quality Improvement Programme (PQIP) measures complications, mortality and patient reported outcome from major non-cardiac surgery. The ambition is to deliver real benefits to patients by supporting clinicians in using data to improve patient outcomes across the UK, reducing variation in processes of care and supporting implementation of best practice. This work links to the DrEaMing CQUIN (**Dr**inking, **Ea**ting, **M**obilis**ing**) the Trust participated in during 22/23 (and continues into 23/24) where the provision of fluids, food and mobilisation within 24 hours of surgery are assessed. Excellent results were found from this CQUIN.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
National Acute Kidney Injury Audit	Acute kidney injury (AKI) is a sudden deterioration of kidney function, and is associated with about 100,000 deaths every year in hospital in the UK. The audit has objectives; - To demonstrate the impact of AKI on the English population, through analysis of the AKI rate and outcomes at the level of the Integrated Care Boards. - To show the different demographics and outcomes of various groups of people with AKI, but in particular, people who are entirely cared for in the community versus those who are admitted to hospital with their AKI, or develop it during their stay. The Trust continues to participate and registry data is used for quality assurance and feeds in to other audit and quality improvement activity along with the UK Renal Registry annual report.
UK Renal Registry Chronic Kidney Disease registry	The UK Renal Registry (UKRR) collects and reports data annually on approximately 70,000 patients with Chronic Kidney Disease (CKD) (including people pre-KRT and on KRT) at each of the UK's adult and paediatric kidney centres. The data is analysed against the UK Kidney Association's guidelines The Trust continues to submit data, with a quarterly annual validation and query resolution. Registry data is used for quality assurance and feeds in to other audit and quality improvement activity and is discussed in other meetings, such as GIRFT, regional Kidney Quality Improvement Partnership and the renal regional network.
Adult Respiratory Support Audit	The Adult Respiratory Support Audit captured data as an on patients outside critical care that have required respiratory monitoring or intervention (i.e. either admitted to an acute respiratory support unit or treated in another ward setting with NIV/CPAP/HFNO), with a view to better understanding variations in clinical practice and outcome.
Smoking Cessation Audit-Maternity and Mental Health Service	This audit was cancelled by the British Thoracic Society.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Sentinel Stroke National Audit programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) measures how well stroke care is being delivered in in England, Wales and Northern Ireland. The clinical audit measures the processes of care provided to stroke patients in inpatient and community settings against evidence-based standards. The organisational audits measure the structure of stroke services in acute hospital settings and community settings. The Trust SSNAP data is reviewed on a regular basis by ED, radiology, stroke nurses, consultants and the wider stroke team. Trust Improvements include: 1. Improved GRH pathway to reduce delays and missed thrombolysis/thrombectomy 2. Improved access to CT/CT angiograms and MRI scans to improve time to diagnosis, especially valuable for stroke mimics. Further work is underway to provide access to MRI 7 days a week. 3. DIDO pilot project launched Jan-April 2024 with SWAST to reduce delays to transfer to Southmead for thrombectomy patients. 4. Reduction in vacancies in therapy for Physio, OT, SALT and psychology 5. Pilot of Activity coordinator roles on Woodmancote ward to improve wellbeing and rehab of ward patients 6. Launch of Community Neuro Rehab team to increase community therapy offer and improve access to stroke Early Supported Discharge team 7. Work with ward nurses to improve training and management of continence and low mood/anxiety 8. Move of HASU into a dedicated ward with therapy room and co-located ambulatory area for SDEC reviews 9. Discussions with ICB regarding resource for the TIA service due to significant increased demands for TIA clinics.
Serious Hazards of Transfusion UK (SHOT) - National Haemovigilance Scheme	SHOT is the UK's independent, professionally-led haemovigilance scheme. Since 1996 SHOT has been collecting and analysing anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom. The SHOT report was published in July 2022 and circulated to members of the Hospital Transfusion Committee. It was presented at the October HTC meeting.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
Society for Acute Medicine Benchmarking Audit (SAMBA)	GAP analysis resulted in review of the following areas to ensure compliance: • storage processes, • SOP • planning and delivery of staff training/retraining • removal/restocking of expired components from storage locations. SAMBA provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 22nd June 2023. Maintaining and improving the quality of care provided to patients within acute medicine services is vital, but presents an ongoing challenge given the continual pressures felt across the urgent and emergency care system. The Trust has continued to participate in SAMBA, the insights gained through SAMBA are used to improve the care provided for acute medical patients. This has included; - Increased AMU PTWR in ED by using 2 AMU consultants as well as regular involvement of front door specialists as a result of re-structuring consultant PTWR rota - Electronic PCR and e- prescribing - 2 more acute consultants employed in 2023 (LTFT so 1.5 total WTE) - New medical assessment zone in the AMU which opened March and has improved flow from GP admissions to reduce numbers in ED
The Trauma Audit and Research Network (TARN)	TARN was developed by the Trauma Audit & Research Network to help patients who have been injured, with reports being reviewed every two months within the Major Trauma meeting. We excel in obtaining timely scans of our trauma patients on their arrival in the Emergency Department, but have faced a number of challenges over the past couple of years with our mortality rates and senior decision-makers seeing patients within target time. To tackle this there has been an integrated approach with close co-operation with our colleagues in the trauma network. 22/23 info

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database?
UK Cystic Fibrosis Registry	Having moved into the new ED at GRH, we have already implemented a number of initiatives and are embarking on a deep dive of our data. The UK Cystic Fibrosis report is aimed at anyone who is interested in the health, care, and outcomes of people with cystic fibrosis (CF) in the UK. It has the purposes of; - helping people with CF and their families understand CF and make informed decisions - giving clinical teams the evidence they need to improve the quality of care - Monitoring the safety and effectiveness of new treatments for cystic fibrosis - Providing data for research to find the best ways to treat cystic fibrosis - Helping commissioners provide funding to NHS CF centres that is proportionate to the severity of their patients' condition There two patients under care of the Trust that have now completed the study, out of 3 current patients. The annual CF Registry Conference in October is attended by the Trust. The annual report provides regional feedback and highlights opportunity for quality initiatives.

The reports of 182 local clinical audits and Quality Improvement projects were registered in 2023/24 and these are reviewed and actioned locally. In addition, 22 'Silver' quality improvement projects which graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2023/24. Some examples of actions associated with audits and completed QI projects are as follows:

Aim: To Improve the documentation of Post Return of Spontaneous Circulation (ROSC) following cardiac arrest by 30%
Changes: Creation of a post resuscitation care bundle with related awareness and teaching sessions.
Results: Initial good response with completion, ED staff were engaging and had good understanding of post ROSC care. When the ROSC care bundle was used, it provided a cohesive template for documentation.
Next steps: Roll out onto wards/clinical areas for all CA, have a digital version on EPR with post ROSC care listed to aid documentation compliance increase.
Aim: To improve the self-reported quality of sleep of awake patients in critical care to an average

of 7/10 on the sleep quality scale
Changes: This project focussed on tests of change related to music/audio therapy for sleep, which supported other projects that also looked at sleep quality/delirium such as the use of light therapy and sleep bundle, alongside the rehabilitation pathway.
Results: Median score of 7/10 achieved.
Next steps: Share learning within the trust and also to the southwest network.
Aim: 50% increase in the number of patients receiving iron transfusions in anaemic colorectal patients undergoing elective resection surgery over a 3-month period
Changes: Creation of an endoscopy checklist, creation of a central pathway by which to identify and transfuse patients with pre-op IDA, raising awareness amongst staff on how to use it
Results: 75% referred via 2WW colorectal clinic or endoscopy, 100% received IV iron transfusions pre-operatively, Median 29.5 days between initial Hb check and IV iron
Next steps: Implementation of pre-operative anaemia protocol across all surgical specialties
Aim: To improve storage to eliminate confusion and reduce wrong implant selection, increasing the percentage of staff who find the storage room clear and easy to use to 100% within 12 months
Changes: Surveys to staff and review of storage options. New purchase of storage and testing of clear labelling options
Results: Clarity of labelling and storage has promoted confidence in selection. Sharing of information and collaborative working across site has been beneficial to both areas. A delay in the roll out at GRH allowed for a smoother transition as the adopted tests of change from CGH could be easily imbedded into GRH
Next steps: Additional of information on stock levels

Participation in clinical research

Research and Innovation

Research and innovation (R&I) are recognised as important pillars in enabling the NHS to provide quality care for its patients. Research active organisations are known to provide better care for patients and more stimulating environments for staff to work in. We need to ensure that
R&I are integral to the day-to-day business of the Trust as they provide the organisation, its patients and its staff with access to new drugs, devices and developments in the delivery of care that they would otherwise have to wait for.

In 2023/2024, the R&I team have supported a significant increase in research activity almost doubling the number of open studies from 53 last year to 100; 21% of which are commercial studies. We have recruited 1522* patients into studies this year in spite of a change in study portfolio and a reduction in high recruiting trials from 6 to 2. We are regularly approached to act as a site for commercial studies with 398 expressions of interest (EOIs) sent to the team this year. Not all studies are suitable for the Trust's population but we managed to convert 93 of these EOIs into future studies. This activity has been achieved against a backdrop of a major reorganisation and staffing issues in the team.

We also have exciting new developments in our medical technology partnerships and these innovations will be led by focussing on understanding and addressing the most critical challenges the NHS faces. In particular, tackling the issues the impact on patient experience, resource allocation and health outcomes. Although these projects are at an early stage, we anticipate being able to report that a number of these projects will be up and running in the next six months.

*this figure is likely to increase as data are uploaded by contract research companies

Care Quality Commission

As a healthcare provider, we hold registration with the Care Quality Commission (CQC). CQC monitor, inspect and regulate our services. This section outlines any breaches to those obligations and provides assurance that improvement action plans have been put in place to enable us to meet the requirements.

Inspections

Like last year, the year started in April 2023 with unannounced inspection in our core services of Maternity and Surgery. This inspection activity was followed with inspections in Children's and Young People's Service, the Emergency Department and then Stroud Maternity.

The ratings for the Trust are as follows:

- The overall rating for the Trust remains as "**Requires Improvement**".

Core services

- Maternity at Gloucestershire Royal site was again rated as "Inadequate" after the report was published in November 2023.
- Surgery remain as "Inadequate" as the service was unrated at the inspection in November 2023.
- For the Children and Young People's Service inspection we are still awaiting our report.
- For the Gloucestershire Royal Emergency Department inspection, we are still awaiting the report.
- The Stroud Maternity Service was rated as "Requires Improvement" and the report was published 20 March 2024.

Table: Summary of inspection activity and reports received

Inspection	Dates	Reports published and link	Rating	Must Do / Should do actions
Well Led	13 & 14 July 2022	7 October 2022 Report	Requires Improvement **No change in rating over 2023/24**	7 Must do 1 Should do
Core Service – Maternity (Unannounced	25 April 2023	10 November 2023	Inadequate	S29a 2 actions 1 Must do

Inspection	Dates	Reports published and link	Rating	Must Do / Should do actions
focused Inspection) **Section 29a Warning Notice**		GRH link here		4 Should dos
Core Service - Surgery (Unannounced inspection)	25 & 26 April 2023	10 November 2023 CGH link here GRH link here	Unrated – previous rating inadequate	3 Must do 2 Should do
Children and Young People Services (GRH) (Unannounced)	20 September 2023			Report awaited
Emergency Department (GRH) (Unannounced)	13 December 2023			Report awaited
Maternity Stroud (Announced)	12 December 2023	Report published 20 March 2024	Requires Improvement	6 Must Do 4 Should Do
Maternity (GRH) (Unannounced)	26 March 2024			Awaiting report Currently collating data for return.

Improvement plans are in place for all “Must do” and “Should do” issues and these are monitored through the Divisions and the Quality Delivery Group.

Warning and improvement notices

In 2023/24 published in the inspection report, the Trust was served with 1 section 29a warning notices where significant improvement was required.

Core Service area	Inspection date	Issues	Action
Maternity GRH	25 April 2023	Level 3 safeguarding training not at compliance level and clinical incidents not reviewed within 30 days	The safeguarding training plan has been updated and L3 training rates have increased across the professional groups. New processes are being put in place for review of clinical incidents with low risk ones being closed within 30 days.

CQC new assessment framework

CQC's new assessment framework applies to providers, local authorities and integrated care systems. Their 5 key questions and ratings (outstanding, good, requires improvement and inadequate) are still central to their approach. All inspections in 2024 will be carried out in the new framework.

Information governance Incidents

Information governance incidents are reviewed and investigated throughout the year and reported internally. Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the UK General Data Protection Regulation (UK 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.

Nine incidents have been reported to the ICO during the 2023/24 reporting period. This compares to 15 reported in the previous period.

Table: Summary of incidents reported to the Information Commissioner

Month Incident Reported	Nature of Incident	Number Affected	How Patients informed
April 2023	Gynaecology patient list was found by patient in her maternity notes - these are a set of health records taken home by maternity patients.	10	Letters sent to all 10 patients 21/09/23
	Lessons learnt – Management of handover sheets under review to ensure data minimisation requirement adhered to		
June 2023	Audio recording from a family complaint meeting (run time 1hr 10mins) copied to an additional complainant via the AMS portal, in error.	1	Patient contacted by IG team via email
	Lessons learnt – Human error, staff reminded to double check recipients prior to file transfer		
June 2023	A sanctions letter relating to unacceptable conduct by a patient was sent to an unrelated person of same name.	1	Contacted by service
	Lessons learnt – human error, staff reminded to double check recipients prior to sending communication		
July 2023	Data relating to one patient included in error in another patient's report. Data integrity breach due to report with incorrect data being used to support referral / application process with partner organisations. Error compounded when apology made as details of root cause shared with the complainant, including the fact that the incorrect data was from another patient with the same name and going through the same application process, therefore putting the second patient's confidentiality at risk	2	Patient contacted Trust to report integrity breach

Month Incident Reported	Nature of Incident	Number Affected	How Patients informed
	Lessons learnt – under investigation		
July 2023	Patient record reported by member of the public to have been inappropriately accessed and information shared via a WhatsApp group	4	Under investigation
	Lessons learnt – under investigation		
Oct 2023	A letter that was written to update a patients GP on their condition and progression of their cancer treatment was sent to another patient in error	1	Awaiting confirmation from service
	Lessons learnt – under investigation		
Nov 2023	Disciplinary details relating to a member of staff, documented as part of a People & OD investigation report, shared in error as part of another member of staff investigation panel process. The section of the report had previously been agreed to be redacted as containing third party PID. A copy of a report with the section not redacted has been shared in error to another member of staff, their representative and the investigation panel	1	Staff member contacted by IG team via email
	Lessons learnt – under investigation		
Nov 2023	A copy of a patient's discharge summary has been shared in error with another patient on discharge	1	Awaiting confirmation from service
	Lessons learnt – under investigation		
Jan 2024	A printed sheet detailing patient identifiers and clinical details for a MDT meeting found in a public place	11	Awaiting confirmation from service
	Lessons learnt – under investigation		

All of the above 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, and requiring no further action, unless new matters came to light. In the case of breaches by staff we are also requested to report the outcome of disciplinary action when concluded so that ICO can further consider the issue of criminal liability under s170 Data Protection Act 2018 for unauthorised access or disclosure.

Table: Summary of confidentiality incidents internally reported 2023/24

Summary of confidentiality incidents internally reported 2023/24	
Reportable breaches	(detailed above) 9
Number of confirmed non-reportable breaches	195
Number of no breach / Near miss incidents.	272
Total number of confidentiality incidents internally reported	476

A large number of the 272 no breach/near miss reported incidents (169) relate to lost Smartcards which are disabled when reported as missing.

The effectiveness and capacity of these systems has been routinely monitored by our Trust's Digital and Information Service governance group, Digital Care Delivery Group. A performance Summary is presented to our and Finance and Resources Committee twice a year.

Learning from deaths

During 2023/ 2024 there were 3326 Gloucestershire Hospitals NHS Foundation Trust patients who died. This comprised the following number of adults in hospital deaths which occurred in each quarter of that reporting period:

Q1 – 814

Q2 – 788

Q3 – 885

Q4 - 859

Due to the time required for SJR review the following figures are not complete as Q4 will be outstanding until June/July 2024.

Total Number of Gloucestershire Hospitals NHS Foundation Trust patients who died up to Q4 is 2487

Of these 2487 deaths 338 have been triggered for an investigation by structured judgement review (SJR).

Of these 2487deaths 7 have been reviewed by other means (harm review/ investigation, PIR, complaint)

Of these 338 SJRs carried out, 1 has been identified that the cause of death is judged to be more likely than no to have been due to problems in the care provided to the patient

1. The percentage of deaths which were selected for SJR=14%
2. The percentage of deaths which have been reviewed as an SJR=66% (Q4 deaths may not have been completed due to 4-month time lag for review)

1. The percentage of deaths reviewed by other means =0.28%
2. Out of all 338 SJRs conducted (in respect of deaths occurring up to 31/12/2023 and as at 07/04/24), the percentage of deaths identified as having sub-optimal care as a contributing factor to the death = 5.6%

Therefore, out of the total number of deaths reported across the Trust, the percentage of deaths for which sub-optimal care was a contributing factor (in respect of deaths occurring up to 31/12/2023 and as at 07/04/24) = 5.6%.

Statement from NHS doctors in training rota gaps

Context and Background
Rota gaps significantly impact not only the doctors in training—who may face longer hours and additional responsibilities—but also patient safety and the quality of care delivered. Addressing this issue is crucial to ensure that doctors in training maintain a safe and sustainable workload.

The prevalence of training rota gaps varies by specialty, with medicine experiencing notably larger gaps compared to other specialties within our trust.

Monitoring, Delivery, and Assurance
The Guardian of Safe Working has been providing quarterly reports on rota gaps across specialties to the Trust Board, along with exception reports.

Quality Panel (QP) Reports
Annual reports from South West Health Education England, through the Quality Panel, offer feedback from NHSE-appointed trainees concerning rota gaps and workload.

National Training Survey
This survey provides a nationwide overview of workload and rota design, encompassing feedback from both NHSE-appointed trainees and locally employed doctors.

Rota Gaps Mitigation Strategies for 2024/25
Efforts to mitigate rota gaps include discussions with rota gap leads across all specialties and the implementation of several strategies:
- Utilisation of advanced practice roles, utilising agenda for change staff.
- Recruitment of international medical graduates (IMGs).
- Expansion of Physician Associate (PA) roles across all specialties.
- Employment of locally employed doctors (LEDs).

Challenges for 2024/25
- A significant increase in less than full-time (LTFT) applications, leading to fewer whole-time equivalent staff despite stable or increased staff numbers.
- High rates of maternity leave.
- Trainees requiring amended duties or coming off on-calls.
- Misallocation of doctors under incorrect cost codes, especially in medicine.
- Communication breakdowns between rota/department leads, medical staffing, and finance departments.
- Issues with community placements and GP supervision due to part-time GPs, practice mergers, and retirements.

Next Steps for 2024/25
- Continued focus on integrating LEDs and IMGs into the workforce.
- Assess where long standing gaps rotas and build a case for IMG/LED permanent back fill
- NHSE Education & Training continue to adjust the number of trainees to balance the workload

- A coordinated effort involving medical staffing, finance, rota leads, and Postgraduate Medical Education (PGME) to proactively address rota gaps.
- Expansion of roles for Advanced Care Practitioners (ACPs), Physician Associates and Advanced Nurse Practitioners (ANPs) to move towards a self-sustaining workforce in critical departments.

Summary
In summary, our trust is implementing a comprehensive range of measures to address training rota gaps, aiming to ensure that doctors in training can continue to provide high-quality patient care. However, the increasing trend in LTFT applications requires urgent and coordinated workforce planning to manage the widening gaps effectively.

Bibliography:
[1] https://nhsproviders.org/news-blogs/news/workforce-strategy-vital-to-tackle-demoralising-rota-gaps
[2] https://www.rcplondon.ac.uk/news/trainees-are-under-pressure-fill-rota-gaps-which-leads-patient-safety-concerns-regular-basis
[3] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/nhs-medical-staffing-data-analysis

Veteran Aware Hospital

Background

Gloucestershire Hospitals NHSFT was re-accredited as a Veteran Aware hospital in August 2022, recognising the work and sharing best practice across the NHS as an exemplar of the best standards of care for the Armed Forces community. A 1-year in assurance visit was conducted by the Veterans Covenant Healthcare Alliance in November 2023.

Performance 2023/24

This year saw the appointment of a new Armed Forces Lead and the two Armed Forces Advocates complete their 2-year secondment for the research study into Veterans in Acute Care Setting research project funded by the Armed Forces Covenant and Chester University. 171 Veterans had their service and clinical details entered into the study, which was in line with the other 16 NHS Trusts. We await the publication of the study next year. Early indications identify veterans in acute care as mainly male, 75 years of age with multiple morbidities.

The Veteran Aware work has focussed on improving the quality of the patient experience by filtering the results from the Friend and Family test for Veterans and Armed Forces personnel. The results demonstrated a 2% average below the Trust average of 90%, but given the small numbers of Veterans and Armed Forces personnel, this was not statistically significant. New Veterans and Armed Forces ward posters were distributed to wards to encourage patients to advise us of their Veteran or Armed Forces status. New patient information leaflets have been produced to advise staff and patients of the NHS approved pathways for mental health, physical health, homelessness and the judicial system, as well as the main charities that provide emotional and practical support to Veterans, Armed Forces personnel and their families. Banner scrolls are on display in out-patient departments across the Trust to encourage patients to advise us of their Armed Forces status.
The patient administration system has been amended to capture all Veteran, Armed Forces serving personnel and their immediate partner/spouse and child/dependents, in order the Trust can understand the Armed Forces demographic and ensure no-one is disadvantaged in healthcare. There were 1213 veterans registered in the adult acute in-patient electronic records for the year 2023-2024. The capture rate of Armed Forces personnel in acute care remained steady at 80%. The average length of stay for Armed Forces patients at 7, 14 and 21 days was the same as for non-Armed Forces patients.

Trust induction training has been updated to advise that the Patient Advisory and Liaison Service team have been trained by the NHS Armed Forces Network, as Service Champions, and will be the first point of contact for a Veteran or Armed Forces patient need. NHS e-learning for Veteran Aware responsibilities has been requested on all staff training, to comply with the Armed Forces covenant.

The Trust has continued to support training and development of employees from the Defence Medical Services in placements in the emergency department and critical care clinical areas. The Trust also supports visits to Open Days from the 243 Multi Role Medical Regiment (previously Field Hospital) from Bristol and engages with them over the annual NHS-Military Challenge.

The Armed Forces Lead continues to represent the Trust on the Gloucester County Council Armed Forces Network forum, with other Health and Social Care organisations. The Trust celebrated Armed Forces week by the Chief Executive re-signing the Armed Forces Covenant. Remembrance Day was commemorated by ornamental displays in the Atrium and a service of remembrance in both the Gloucester and Cheltenham hospitals.

Improvements for 2024/2025

- Re-establishment of the Armed Forces Council to embed the Veteran Aware work throughout the Trust
- Embed the Step-Into-Health programme to actively encourage Armed Forces leavers into the NHS
- Analysis of the Patient Administration System data to capture patients in paediatrics and maternity, where there are known health inequalities for Armed Forces serving personnel
- Publication of the Veteran Aware Policy
- Preparation for re-accreditation for the Gold Employer Recognition Scheme, due to be re-accredited in 2025.

Freedom to Speak Up

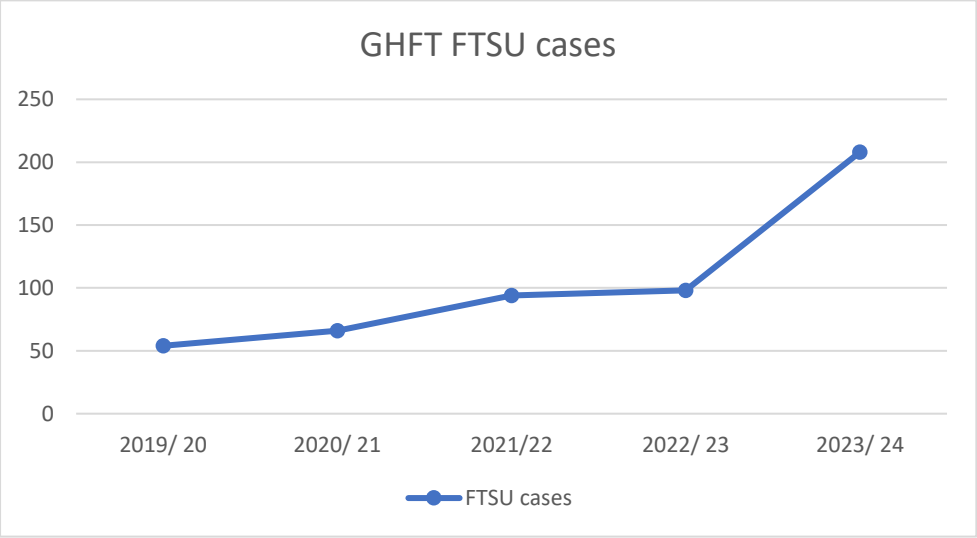
Our Trust is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life and in all of its practices. The Trust recognises that those who work for our organisation are in the best position to recognise when something is going seriously wrong within it, and may want to voice concerns.

The Trust has invested in the Freedom to Speak Up Service this year with a new WTE Lead Freedom to Speak Up (FTSU) Guardian to further develop the service and an additional 0.4WTE FTSU Guardian. This is to ensure all staff have access to safe speaking up in the Trust. Guardians have access to any leader in the organisation to raise and escalate issues and also access external speaking up routes if barriers are met in the organisation. There has been a fresh focus in the FTSU function to align the FTSU service with National Guardians Office (NGO) guidance values, training and data collection.

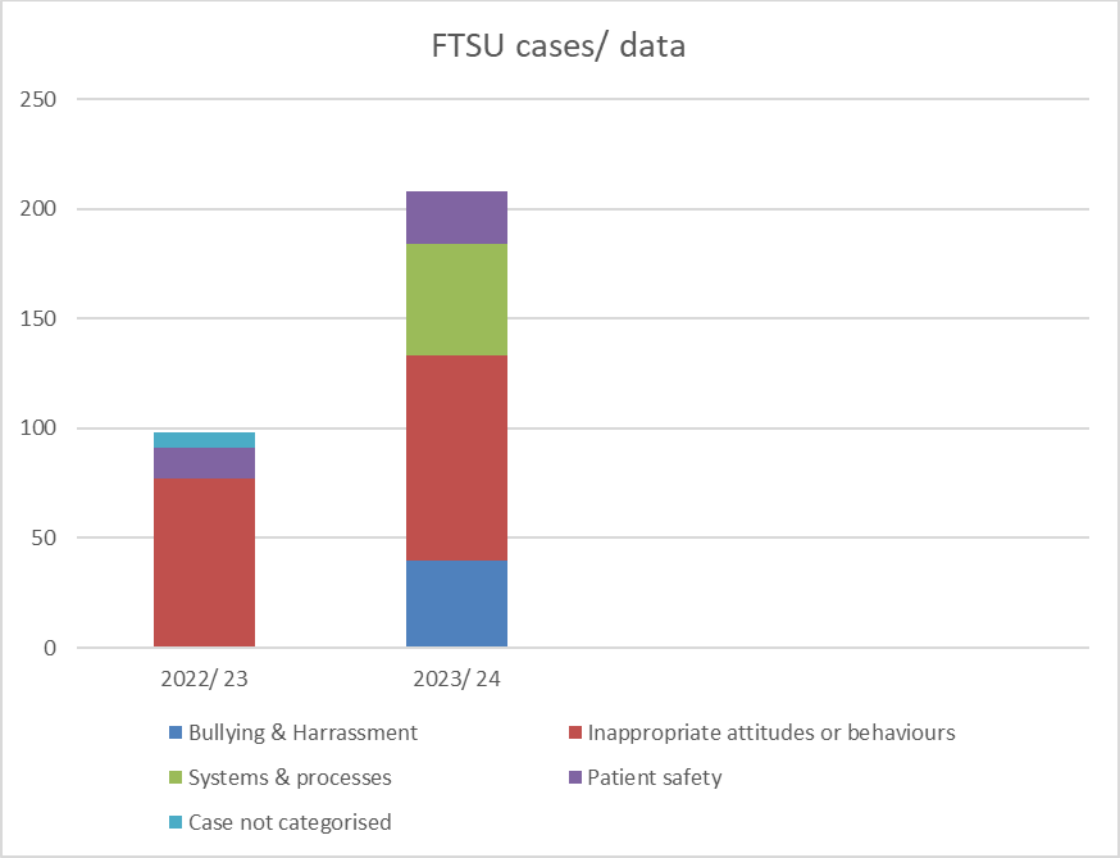
Trust Data

At our Trust, In the year 2023/ 24 208 staff spoke up in comparison to 98 staff last year.

Graph: Total number of cases per year

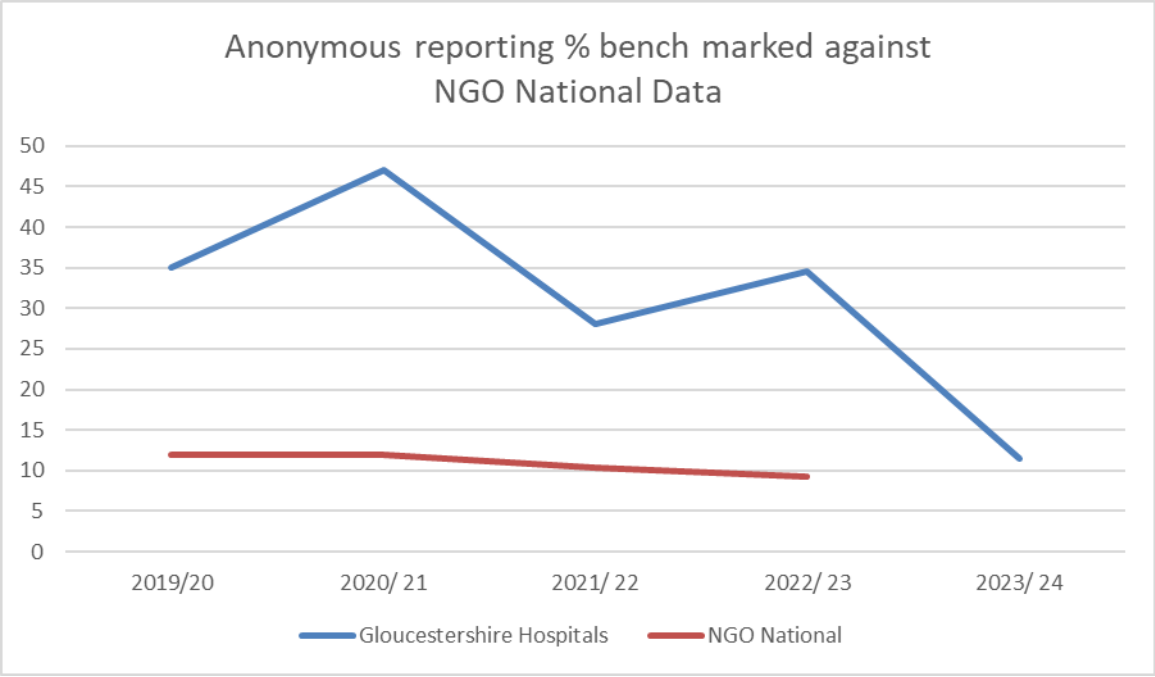


Staff have spoken up about a variety of concerns but inappropriate attitudes or behaviours (previously captured as behaviours), remain the organisations highest reason for contacting FTSU with nearly half of all total cases. Themes have been captured in the FTSU service as fear of speaking up; discrimination; poor experience as new starters; poor experience as a disabled person requiring reasonable adjustments; nepotism in recruitment and general poor behaviours witnessed or experienced in the organisation.



It has been noted that anonymous reporting at Gloucestershire Hospitals has been higher than the national average sitting at 34.5% last year.
The graph below shows the anonymous reporting trends bench marked with National Data over the last 5 years.

Graph: Anonymous reporting % benchmarked against National Guardian Office data



Anonymous reporting is highlighted by the National Guardians Office as an indicator of staff potentially feeling a lack of trust in the organisation and fear of detriment. As expected, the stability of a Lead Guardian with protected time has decreased anonymous reporting to more open concerns and less anonymised concerns raised.

Freedom to Speak Up is designed to support staff have a voice in the organisation where there are barriers to speaking up. The FTSU service has focused on case management this last year to provide staff with an excellent speaking up experience, where speak up, listen up and follow up is supported by the organisation. With anonymous reporting reducing, there is evidence to suggest that trust is gaining in the service and the organisation is more trusted by staff to respond to their concerns.

Cases have increased and the organisation has responded by supporting the recruitment of a new 0.4 WTE FTSUG to support the need of growing a dedicated FTSU team with protected time.

There is genuine support from senior leaders to respond to cases and support staff speaking up. With the continued alignment with the National Guardians Office and communicating those processes to staff through training and education, it is hoped FTSU will continue to develop into a valued and trusted service by staff to further impact speaking up being ‘business as usual’ in the organisation.

Data quality

Data quality (DQ): 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 DQ 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.
- We regularly send data submissions to secondary users service (SUS) and via these submissions we receive DQ reports back. Based on SUS DQ reports we action all red and amber items highlighted in report to improve data quality.
- In data published for the period April 2023 to March 2024, the percentage of records which included a valid patient NHS number was:
    - 99.8% for admitted patient care (national average: 99.7%)
    - 100% for outpatient care (national average: 99.8%)
    - 99.2% for accident and emergency care (national average: 98.9%)
- The percentage of published data which included the patient's valid GP practice code was:
    - 99.9% for admitted patient care (national average: 99.3%)
    - 99.9% for outpatient care (national average: 98.6%)
    - 98.8% for accident and emergency care (national average: 99.4%)
- 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 DQ 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 DQ is everyone's responsible to ensure good quality and clinically safe data.

Part 2.3 Reporting against core indications

Reporting Against Core Indicators

Domain	Indicator	Year	Trust
Domain 1 – Preventing people from dying prematurely	Most recent value of the Summary Hospital Level Indicator SHMI for trust	2023/24	1.1349
Domain 3 – Helping people to recover from episodes of ill health or following injury.	Percentage of Patients 0-15 Readmitted to hospital within 30 days of being discharged	2023/24	12.90%
Domain 4 – Ensuring people have a positive experience of care.	Staff who would recommend the trust to their family or friends	2023/24	46%
	Patients who rate the quality of their care as positive or extremely positive	2023/24	91.90%
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	Patients admitted to hospital who were risk assessed for venous thromboembolism	2023/24	69.86%
	Rate of C. difficile infection	2023/24	36
	Patient safety incidents and the percentage that resulted in severe harm or death	2023/24	88

Patient Reported Outcomes Measures (PROMs)

Below is from the national website for period April 21 – March 22 (this is the most up to data finalised data).

	EQ-5D		EQ VAS		Oxford Score	
	Trust %	*England %*	*Trust %*	*England %*	*Trust %*	*England %*
Total Hip	87.10%	89.50%	76.10%	69.80%	100%	96.90%
Total Knee	78.50%	82.10%	60.30%	61.20%	98.60%	94.80%

Quality and Performance Report

The Board see a monthly Quality and Performance Report and below are our quality and performance metrics that we have chosen to report on. Link to Board reporting (here).

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Quality category. Exception reports are shown on the following pages.

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Friends & Family Test	ED % positive	No Target	Mar-24	76.8%	
	Inpatients % positive	No Target	Mar-24	93.5%	
	Maternity % positive	No Target	Mar-24	81.4%	
	Outpatients % positive	No Target	Mar-24	94.3%	
	Total % positive	No Target	Mar-24	92.2%	
Health Inequalities	Smoking Status Compliance	No Target	Mar-24	87%	
Infection Control	C. difficile - infection rate per 100,000 bed days	↓ Lower	Mar-24	40.8	
	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target	Mar-24	27	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target	Mar-24	193	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target	Mar-24	43	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target	Mar-24	129	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower	Mar-24	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7	Mar-24	9.1	
	Number of E. coli bacteraemia cases	No Target	Mar-24	4	
	Number of Klebsiella bacteraemia cases	No Target	Mar-24	1	
	Number of MSSA bacteraemia cases	≤ 8	Mar-24	5	
	Number of Pseudomonas bacteraemia cases	No Target	Mar-24	0	
	Number of bed days lost due to infection outbreaks	↓ Lower	Mar-24	292	
	Number of community-onset healthcare-associated C. difficile cases per month	≤ 5	Mar-24	3	
	Number of hospital-onset healthcare-associated C. difficile cases per month	≤ 5	Mar-24	5	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Infection Control	Number of trust apportioned C. difficile cases per month	< 10	Mar-24	8	
	Number of trust apportioned MRSA bacteraemia	= 0	Mar-24	0	
Maternity	% PPH >1.5 litres	< 2.00%	Mar-24	5.45%	
	% breastfeeding (discharge to CMW)	= 0.0%	Mar-24	0.4%	
	% breastfeeding (initiation)	≥ 81.00%	Mar-24	74.42%	
	% of women smoking at delivery	< 7.00%	Mar-24	6.93%	
	% of women that have an induced labour	≤ 33.00%	Mar-24	25.79%	
	% stillbirths as percentage of all pregnancies	< 0.200%	Mar-24	0.412%	
	Number of births less than 27 weeks	No Target	Mar-24	5	
	Number of births less than 34 weeks	No Target	Mar-24	15	
	Number of births less than 37 weeks	No Target	Mar-24	49	
	Number of maternal deaths	No Target	Mar-24	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target	Mar-24	2.1%	
	Total births	No Target	Mar-24	487	
Mortality	Number of deaths of patients with a learning disability	No Target	Mar-24	2	
	Number of inpatient deaths	No Target	Mar-24	162	
	Summary hospital mortality indicator (SHMI) - national data	No Target	Nov-23	1.135	
MSA	Number of breaches of mixed sex accommodation	≤ 10	Mar-24	9	
Operational Efficiency	Daily Average of Boarded Patients	No Target	Mar-24	8	
Patient Advice and ..	% of PALS concerns closed in 5 days	No Target	Mar-24	75%	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Quality category. Exception reports are shown on the following pages.

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Patient Advice and ..	Number of PALS concerns logged	↓ Lower	Mar-24	257	
Patient Safety Incidents	Medication error resulting in moderate harm	↓ Lower	Mar-24	2	
	Medication error resulting in severe harm	↓ Lower	Mar-24	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Mar-24	36	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Mar-24	1	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Mar-24	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Mar-24	13	
	Number of falls per 1,000 bed days	↓ Lower	Mar-24	6.90	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Mar-24	3	
	Number of patient safety incidents - severe harm (major/death)	No Targe	Mar-24	13	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Mar-24	5	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Targe	Oct-23	58.08%	
	Number of DoLs applied for	No Targe	Mar-24	128	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Mar-24	89	
	Total admissions aged 0-17 with DSH	↓ Lower	Mar-24	23	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Dec-23	9	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Jan-24	0	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower	Aug-23	0	
	Total number of maternity social concerns forms completed	No Targe	Mar-24	61	
Serious Incidents	Number of never events reported	= 0	Mar-24	0	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Mar-24	69.9%	

Part 3: Other information

Annex 1: Statements from Healthwatch, Integrated Care Board and Health Overview and Scrutiny Committee

NHS Gloucestershire Integrates Care Board (ICB) response to Quality Account:

Thank you for giving NHS Gloucestershire ICB an opportunity to comment on your quality account. During 2023/24 a significant amount of improvement work has been in progress and it's good to see the results really making a difference to the lives of the people of Gloucestershire who find themselves in need of specialist healthcare.

The 'Slipper Trial' has demonstrated how small changes can positively influence outcomes for those experiencing frailty and we welcome the roll out of this across other areas in the coming year. Ensuring greater compliance with gold standard stroke care by improving timely access is a huge improvement for local people.

The implementation of the 'Worries and Concerns' pilot during 2023/24 is commendable, this supports families to raise live concerns if they feel their loved one is clinically deteriorating. This will now become Martha's Rule which is a requirement for all acute Trusts and the ICB will continue to support the Trust to ensure all families have a voice.
Although the Trust has delivered the quality objective requirements regarding maternity services, as outlined in the maternity incentive scheme (MIS), there continues to be a focus on improving care and experience for those who use these services. There is still work to do to ensure consistent improvements are embedded within the service and this will be a focus within the ICB throughout 2024/25.

We were pleased that the Trust was able to make the switch from the Serious Incident Framework to the new Patient Safety Incident Response Framework (PSIRF). The Trust has recognised that this is a significant cultural leap and embedding will take time.
In March 2024, the ICB ratified the Trusts' plans and supports their PSIRF ambitions focusing on staffing, culture, digital and communications, as well as the more traditional focuses on falls, pressure ulcers, flow and discharge and delay related harm. We have a good working relationship with the Trust and are working at a system level to embed the new ways of working and ensuring the focus is on learning from all adverse events.

The ICB will fully support the delivery and oversight of the quality objectives for 2024/25 in order to continually drive forward high quality, safe services for patients across Gloucestershire.

Marie Crofts,
Chief Nursing Officer,
NHS Glos ICB

Received 3 June 2024

Statement received from Healthwatch Gloucestershire 31 May 2024

31.05.2024

Statement from Healthwatch Gloucestershire

Thank you for sharing the Quality Accounts for Gloucestershire Hospitals NHS Foundation Trust for 23/24.

Healthwatch Gloucestershire congratulate the Trust on their achievements last year. We are pleased to see that identifying those living with frailty remains a priority for the coming year and note the pilots undertaken last year in relation to falls prevention and preventing deconditioning in ED. We are also pleased to see that there is an emphasis on patient safety and providing opportunities for patient and staff voices to be heard and acted upon through the appointment of a dedicated lead for Freedom To Speak Up, the launch of a PALS champion and the PSIRF plan that went live in March.

This continues to be a challenging time, with services still recovering from the impact of Covid, a nationwide shortage of certain key workers and the ongoing industrial action throughout the year having an impact on service delivery. We recognise the pro-active steps taken by the Trust and their staff in response to this to ensure essential services were able to continue and the loss of elective activity kept to a minimum.

We also acknowledge the action taken and action planned for improvements in response to the CQC inspections of Maternity services, Children's services and the Emergency Department at Gloucester Royal Hospital.

We understand that new initiatives and action plans require monitoring and evaluation, and Healthwatch Gloucestershire values the strong connections we have with the Trust to be able to share public feedback, provide insight and make recommendations for improvement. We are pleased to have one of our Board members as a Governor for the Trust who has also been able to observe the Quality and Performance Committee. Our volunteers took part in PLACE visits last year and Healthwatch Gloucestershire were also grateful to be supported by the Trust to visit their Urgent and Emergency Care services in December. This enabled us to observe and speak to people directly about the quality of care they were receiving which has been shared with the Trust.

We welcome Kevin McNamara as the new CEO and the new senior staff in the leadership team being established. We look forward to continuing to work together with the Trust in the coming year.

Statement from Gloucestershire Health Overview and Scrutiny Committee

Chair of the Gloucestershire Health Overview and Scrutiny Committee, provided a statement dated 24 June 2024

Thank you for your invitation to comment on the Gloucestershire Hospitals NHS Foundation Trust Annual Report (Quality Account) 2023/24. In what has been a challenging year, I can confirm that the Gloucestershire Health Overview and Scrutiny Committee will continue to support the Trust when considering any issues and concerns that impact on the delivery of services provided by Gloucestershire Hospitals. As in previous years, the Gloucestershire Health Overview and Scrutiny Committee value and appreciate the often innovative and lifesaving work which the staff employed by the Trust carry out on a daily basis. The Committee welcomes the co-operation of Trust staff as we continue to look at issues around system flow, ambulance discharge times, waiting times and CQC reports.

Annex 2: Statement of director's responsibilities for the quality report

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

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 2022/23 and supporting guidance
- detailed requirements for quality reports 2022/23
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2023 to March 2024 (link)
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from Gloucestershire Integrated Care System 3 June 2024
    - feedback from Healthwatch Gloucestershire dated 31 May 2024
    - feedback from the Health Overview and Scrutiny Committee 24 June 2024
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2022/23 (Link to latest published report)
    - the 2021 National Patient Survey published by CQC September 2022 (Link)
    - the 2023 national staff survey published Jan 2024 (Benchmark report (Link)
    - CQC inspection reports (RTE inspection Reports Link)

This quality report presents a balanced picture of the NHS foundation trust's performance over the period covered.

The quality 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

Deborah Evans
Chair

Chief Executive
Kevin McNamara