Gloucestershire Hospitals
NHS Foundation Trust

Quality Account

2025 – 2026

Our Quality Account 2024/25

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.

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Part ONE: Foreword by the Chief Executive

I am pleased to introduce our Quality Account and I hope that you enjoy reading about some of our highlights from 2024-2025. Over the past year, our two main hospital sites - Cheltenham General Hospital and Gloucestershire Royal Hospital - as well as our community-based services, have continued to evolve to meet the needs of our patients and local communities.

This year, we have made positive steps forward in developing a number of our key services for our patients and local community. One of our most exciting achievements has been the opening of the new Hyper-Acute Stroke Unit at Cheltenham General, providing specialist care to stroke patients at a critical time in their recovery. This is a development that will help further improve Stroke care for local people and build on the success we saw in year where our Trust had the quickest access time in the South West to get access to life saving thrombolysis for someone suffering a stroke.

Timely access to services is a key element of quality and safety and during the year our teams delivered a significant reduction in the number of patients waiting over a year for treatment – from over 2,800 at the start of the year to 94 by the end of the financial year. This work continues and we aspire to be a place where local people have some of the best access times for elective care in the country. We started the new financial year strongly and are currently in the top ten trusts in the country for reducing our longest waiting patients and we want to go further.

From an Urgent and Emergency Care perspective, historically we have experienced significant delays at the front door – particularly at our busiest times. This has resulted into ambulance handover delays and waits for beds. This continues to be a significant area of focus for us as a Trust and in year we saw a number of improvements that should give us hope and confidence that we can continue to change some of those issues that have been stubborn for some time. These improvements include a reduction in ambulance handover delays from 3600 hours per month to under 2000 hours per month during the year and almost eliminating patient boarding on wards – a process where patients waiting for a bed are placed on the wards in corridors which does not deliver the quality of care we aim for.

We have also seen some improvement in patients waiting longer than 12 hours in ED, and to make real inroads into this it is a priority for us this year given long delays contribute to greater harm for our patients. Our hope and expectation is that in doing this, we improve timely access to urgent and emergency care and we reduce delay related harm. Whilst we can see positive steps forward, we know there is more for us to do and we are committed to making the improvements our patients and the local community expect through our Clinical Vision of Flow programme.

Encouragingly, more colleagues are recommending our Trust as both a place to work and a place to receive care compared to 2023. While this is a positive step forward, we know there is much more to do and fully acknowledge our latest results build on a poor baseline from the staff survey in 2022. As our culture continues to evolve, we remain responsive to the changing needs of our workforce, ensuring we build a supportive, inclusive and thriving

environment for all our staff – in full knowledge that it is these types of cultures that deliver the safest care.

We also want to acknowledge the challenges we have faced. In January 2025, the Care Quality Commission published its delayed report on our maternity services, following an unannounced inspection in March 2024. The report rated our maternity services 'inadequate' for the second time – a disappointing outcome, but one we are meeting with determination and action. While we recognise that there is still more to do, we are making progress and remain committed not only to providing safe, high-quality maternity care but also being open and transparent in the quality of care we are providing. We are determined to ensure that maternity care at our Trust is something we can all be proud of.

We are also focussing heavily on improving complaint response times – an area that has been below standard for some time. This cross-divisional effort is focussed on not only ensuring we respond in a timely way and ensure people get the answers they need, but most importantly we pick up the learning from when we get things wrong.

Having worked in the NHS for over 20 years, I know that we can only do what we do if we work in partnership with patients, partners and the local community. Both in terms of listening to their experience and using their insight to help drive forward improvements. This continues to be a priority for us and later this year we will launch our new Trust strategy which will focus heavily on our role in the community – as an employer, a healthcare provider and a good partner so we can make the biggest difference to the people of Gloucestershire.

The NHS remains challenged, but our passion and purpose remain undiminished. The privilege of working in the NHS comes with great responsibility and we are committed to ensuring that our hospitals remain places where patients receive outstanding care and staff feel valued and supported.

I would like to thank all those who contribute to our shared mission - staff, volunteers, partners and the wider Gloucestershire community. Everything we achieve is a result of a collective effort; together, we will continue to meet challenges with innovation, compassion and determination.

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.

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

Part TWO: Priorities for improvement and statements of assurance from the board

Looking forward our priorities for 2025/2026

We continue to develop our priorities using a range of information and sources (safety, experience and clinical effectiveness data) with consultation from staff, senior leaders and our Executives. We have reviewed our performance, incidents, the learning that has taken place and how we want to take this to the next level in our Trust. We continue to experience pressure across the organisation during 2024/2025 but during this time we retained our cohesive approach to quality, safety and risk. For next year, 2025/2026, we have chosen to continue to focus on our Patient Safety Incident Response Plan (PSIRP) local safety priorities. For next year, in addition to the safety priorities, we have chosen to report on the Trust priority improvement programmes of work. Each programme will have an element of quality (safety, experience and clinical effectiveness) within them.

In September 2025, we will begin again our structured approach to reviewing the data for 2026/2027. The purpose will be to check that we are focusing on the right things by reviewing our themes and trends.

Table: Priorities for the years 2025/2026

Priorities	Focused on	Metrics/ improvement we want to achieve
1. Patient Safety Incident Response Plan - safety priorities	Continuing our improvement work within the 8 safety priorities and linking them to the transformation work within the organisation.	To continue the work started in 2024/2025 with a focus on our learning and improvement.
2. Outpatient transformation	Improving how outpatient care is delivered, with the goal of providing more patient centred and more efficient services.	Decrease in the number of hospital appointment cancellations. Decrease in numbers of patients who do not attend their appointments (with a focus on health inequalities).
3. Clinical Vision of Flow	Improving how we minimise wait times, reduce bottlenecks across all services and improve the quality of care delivered to our patients	Decrease the number of patients waiting greater than 12 hours in the Emergency Department
4. Fire prevention and safety	To safeguard the lives and wellbeing of patients, staff and visitors by minimising the risk of	Compliance with our training targets across all our hospital sites

Priorities	Focused on	Metrics/ improvement we want to achieve
	fire and ensuring safe evacuation in case of a fire.	
5. Maternity service improvements	Focused improvement in the Safety Plan priority for maternity – prevention and detection of deterioration: Meeting all of the objectives of our maternity transformation plan, including all regulatory requirements.	All 8 conditions on our CQC registration to be achieved
6. Emergency Department service improvements	Getting care right in the emergency department is crucial because timely and effective treatment can be the difference between life and death.	- Ambulance offloads - Duration in the department

Introduction to the Patient Safety Incident Response Framework

On 1 March 2024 Gloucestershire Hospitals NHS Foundation Trust introduced a new way of working and implemented the Patient Safety Incident Response Framework (PSIRF). This framework sets out the National Health Service's (NHS) approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The framework is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract.

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. It is a key part of the NHS patient safety strategy. PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

The patient safety incident response system, developed from the framework, integrates **four key aims:**

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

Patient Safety Incident Response Framework Policy

Our Trust Patient Safety Incident Response Framework policy exists to provide our structured approach to respond to patient safety incidents, focusing on learning and improvement rather than blame. This approach aims to enhance patient safety by fostering a culture where incidents are viewed as opportunities for learning and systemic improvements.

Patient Safety Incident Response Framework Policy

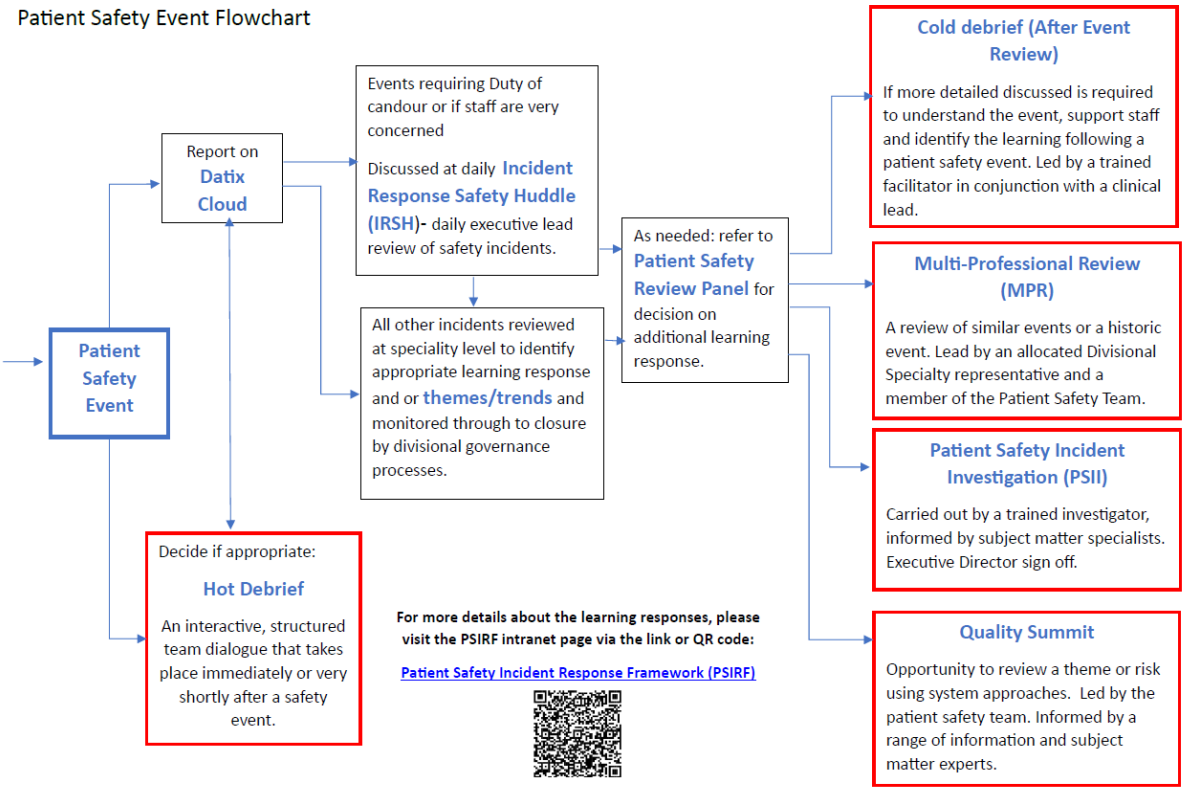
Learning Responses

Part of the Patient Safety Incident Response Framework philosophy is that our response to a safety incident should be proportionate to the opportunity to learn. To enable this, there are a number of learning responses that we may use to understand how and why something occurred, and ultimately so that we may learn and improve. Information about these learning responses and how they can be used, can be found below.

Hot debrief
Cold debrief (After Event Review)
Patient Safety Incident Investigation
Multi-Professional Review
Quality Summit

Patient Safety Event Flowchart
We have developed a Patient Safety Event Flowchart to demonstrate how our system works in practice.

Picture: Patient Safety Event Flowchart



Patient Safety Response Plan

Our Patient Safety Incident Response Plan sets out how we intend 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. We developed 8 safety (quality) priorities and last year we chose to write about them in our Trust Quality Account.

Link – Patient Safety Response Plan

Looking back - progress against our local safety priorities 2024/2025

Our Quality Account is an important way for us to report on the quality of our 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 priorities, detailed in this report, form a key element of the delivery of the Trust's objective to provide the "Best Care for Everyone". Below is a summary of progress over the year and in the next section we provide more information about each priority and its relationship with PSIRF.

Table: Summary of our Patient Safety Incident Response Plan local safety priorities and the improvements made in 2024-2025

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
Pressure Ulcer Prevention	Hospital acquired pressure ulcers	Pressure Ulcer risk assessment rate for in-patients improved by 25% from 61% – 87% in 12 months. Pressure Ulcer Improvement Group reestablished with revised Terms of Reference. Pressure Ulcer Business Intelligence Platform established to demonstrate rates and real time data for pressure ulcer occurrence. Annual quality summit planned for July 2025. Testing the use of Hot Debriefs to align with the Patient Safety Incident Framework.
Falls Prevention	Patient falls	Compliance of falls risk assessments for in-patients has remained at 75%. The incidence of in-patient falls remains at an average of 7 per 1000

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
		hospital bed days. Falls prevention masterclass offered to staff, preceptor and falls-link nurses. Annual quality summit identified 3 areas for improvement (developing Datix to collect falls information, enhancing debriefs after falls and developing the electronic patient record). Revitalised Falls Steering Group.
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.	The compliance for the Maternity Obstetric Early Warning score to be repeated when raised (amber alert) improved from 63% in May 2024 to 90% in March 2025. Compliance with NICE guidelines for fetal heart monitoring improved from 60% to 95% for risk assessments on admission, and 80% to 90% for hourly risk assessment. Accurate assessment and escalation compliance reached 100%. Hourly intrapartum peer reviews improved from 76% to 98%.
Safer Staffing	Risks and incidents where inadequate numbers of staff or skill mix have been identified.	All in-patient wards and departments have had a review calculation of the care hours per patient day. Those areas where acuity and dependency has increased or decreased will have budgets amended. Similarly, areas requiring more training time allocation such as the Emergency Department, Paediatrics and Neonates will have

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
		similar budget amendments.
Organisational Culture	Risks or incidents where team / department or organisational culture is impacting on behaviours, standards or safe delivery of services/ care.	Working on a Staff Experience Improvement Programme which included implementation of 3 key projects (Just and Restorative Culture, Report, Support and Learn and Antidiscrimination practices). Improving our safety culture by ensuring staff understand new ways of working with level 1 training for Essentials for Patient Safety at 91% across the Trust. Staff survey results demonstrating and increase to 65.8% in the question about staff feeling secure at raising concerns about unsafe clinical practice from 2023 results at 63.49% (increase of 2.34).
Digital Systems Improvement	Risks and incidents related to the introduction and use of digital clinical systems.	The allocation to the correct consultant on the digital Communicator platform was identified to have weaknesses in its design. New “unexpected result” and “cancer” alert codes have been implemented to alert the reporter 9 times as a safety net. A dashboard report has been implemented for unacknowledged radiology alerts so that Teams have oversight of their results. Local governance processes are being identified for all unacknowledged alerts.
Clinical Vision of Flow (admission and discharge)	Risks and incidents related to impeded patient	The improvements are measured in hours lost to handover delays, reduced from nearly 6000 in Oct 23 to

Patient Safety Incident type or issue	Description	Improved Position from April 2024-March 2025
	flow from assessment to discharge, including delays to discharge, excluding clinical complications.	under 2000 in March 25. Improvements for patient experience include the reduction of patients who spend over 12 hours in the emergency department from 18,000 in March 2024 to 15,000 per month in March 2025. Additional improvements include a streaming nurse in minors and a review of Pitstop process and location in majors.
Communication	Risks and incidents that relate to communication between staff and patients and their families	The 3 components of Martha's Rule have been implemented into all adult, paediatric and maternity areas. 1. Patients/ or their families/carers are being asked, at least daily, about how they are feeling. 2. All staff are able to refer to clinicians if they are concerned a patient is deteriorating. 3. There is an escalation route available to patients, their families and carers advertised across the specialities.

1. Quality priority - Pressure ulcer prevention

Background

Pressure ulcers are recognised as one of the top 10 harms in the NHS, and over the years, there have been a number of approaches to investigating these, the most recent being the Serious Incident Framework which classified higher-grade pressure ulcers as Serious Incidents and subject to Root Cause Analysis investigations. However, it became clear that the resources deployed in conducting these investigations were not proportionate to the outcomes in terms of reduction of harm. So, in 2022 NHS England brought in a new approach, known as Patient Safety Incident Response Framework. Patient safety incidents are “unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients” (NHS England 2022, p2).

Local Experience prior to PSIRF

We had a well-established governance structure for reporting and investigating pressure ulcers for several years, but in common with many other organisations the time and effort expended on conducting these investigations, particularly by the Tissue Viability Nurses, was heavy and was diverting resources away from direct clinical care.

For many years, our Pressure Ulcer Steering Group, met monthly to review all the new Datix incidents that have been reported that month for Category 3, 4, unstageable, suspected deep tissue Injuries, and multiple Category 2s. Ward Managers conducted Root Cause Analysis Investigations and then developed specific actions to prevent recurrence.

Implementing Patient Safety Incident Response Framework

Over the last year we have been focused on implementing PSIRF as this aims to look at pressure ulcer incidents through a systems-wide lens. Under the previous system, patient safety management was focussed on identifying root causes for why things happened. It focused on ‘work as prescribed’, how things should be done according to policy or procedure. It often resulted in actions such as requiring staff to undertake training, reflections or re-reading policies, which gives the impression of blame either intentionally or unintentionally.

Our new Patient Safety Incident Response Framework approach accepts that risk is inevitable and looks at the whole system, or the bigger picture, to reduce the likelihood of incidents recurring. It focuses on ‘work as done’ and how work really takes place. The approach empowers everyone to make meaningful changes that can lead to genuine safety improvements.

In April 2024, awareness events were held across the organisation, ensuring everyone was aware of the new patient safety agenda because the approach encourages all staff at all levels and grades to be involved. It is no longer restricted just to senior staff or team leads as was previously the case with Root Cause Analysis investigations.

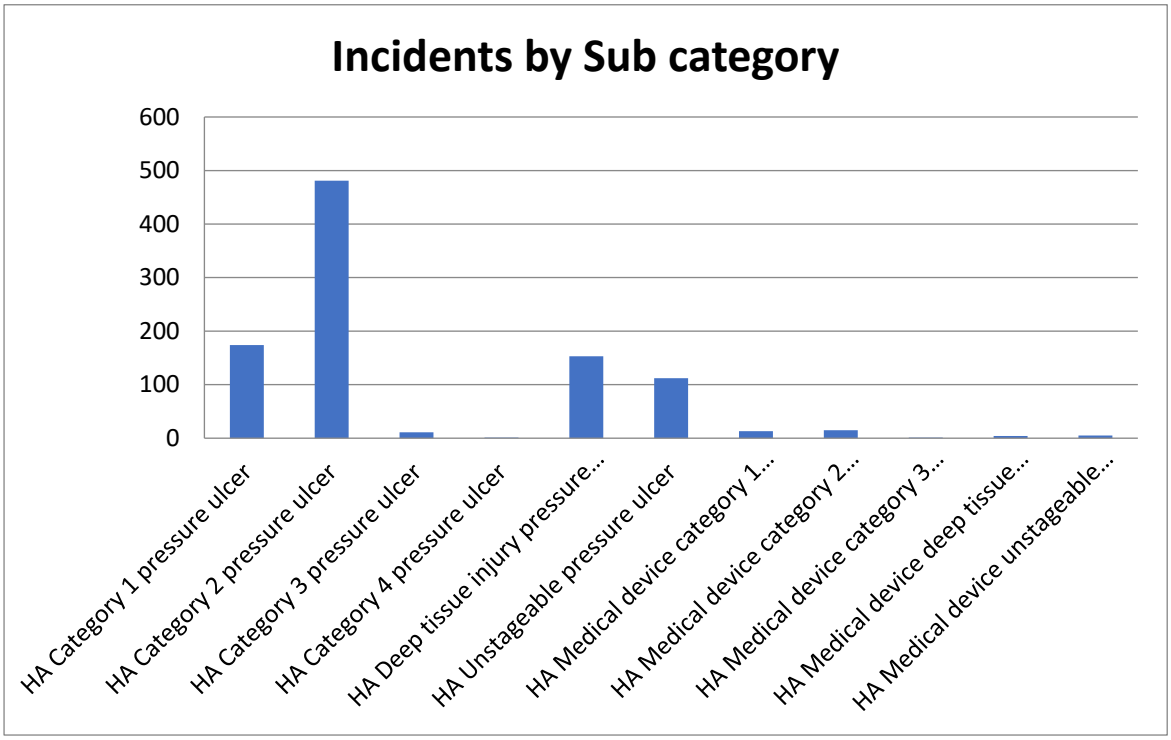
An essential tenet of the Patient Safety Incident Response Framework approach and the Trust risk management strategy is the concept of reducing harm to “As Low As is Reasonably Practical”, which acknowledges that eliminating harm completely is not achievable or realistic. As Low As is Reasonably Practical considers the human factors in any incident without attributing blame to any individual or team. It aims to look at care as expected and compare it with care as delivered and identify any learning from the difference.

How we have performed and what we have learnt in 2024/25

Our focus from learning from harm from pressure ulcer this year has been our implementation of the Patient Safety Incident Response Framework as this was a new way of working. Within PSIRF there are different learning responses that can be employed. Local incident investigation may be sufficient to identify the contributing factors and the learning response required. However, if the elements of the incident are not well understood, then other approaches (such as Hot Debrief, After-Event Review, or Multi-Professional Review), might be used. A key difference with this approach, compared with the historical Root Cause Analysis approach, is that these meetings do not require a lead or manager in attendance and this non-hierarchical approach is designed to support honesty and openness and the best opportunities for learning about ‘work as done’.

The following table demonstrates the number of hospital acquired pressure ulcer safety incidents we reported onto the safety reporting system Datix.

Graph: Total number of pressure ulcer incidents reported by sub category 2024/25



Our learning responses have been that most cases have been reviewed by the Tissue Viability Nurse Team to check the grading of the pressure ulcers (grade 2 and above) and then supporting the clinical ward teams with wound care advice and with developing clear prevention plans for further deterioration of the ulcer (or new ulcers).

In addition, we have:

- Analysed our data to understand our issues and to make improvements to preventing pressure ulcers.

- Updated the Pressure Ulcer Prevention and Management Policy. These clinical guidelines based on the best available evidence provide a framework for healthcare professionals to make informed decisions, improve patient outcomes, and reduce healthcare costs. They are developed through a rigorous process that includes reviewing scientific evidence, expert opinions, and feedback from stakeholders.

- Analysed our data from the silver Quality Improvement project (this was a questionnaire developed and sent to staff in order to understand current knowledge and key challenges at ward level). We developed an improved method of learning through simulation and gamification.

- Implemented further Electronic Patient Record changes which enabled extra opportunities for staff to document their pressure ulcer prevention care.

- Continued to implement Pressure Ulcer Prevention simulation pilot and this is now integrated into tissue viability training and the evaluation will be ongoing.
- Collaborated with Gloucestershire Health and Care Trust and the Gloucestershire Integrated Care Board to share information and ideas in our pressure ulcer prevention.
- Agreed with the senior nursing team that the Tissue Viability Nursing Team team will review all hospital acquired pressure ulcers at grade 2, 3 and 4.

- Improved our compliance with pressure ulcer risk assessment from 61.75% in 2023/2024 to 87% in 2024/25. **This is an improvement of 25%.**

  Table: Percentage of completed pressure ulcer risk assessment on adult wards by quarter

Metric	End of year average 2023/24	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of year average 2024/25
Compliance with completion of: pressure ulcer risk assessment	61.75%	87.3%	87.5%	88.8%	88.5 %	87%

Although the Patient Safety Incident Response Framework is still a relatively new change in our organisation, and there still will be challenges to work through, our initial observations and reflections are very positive and encouraging. So far, the Patient Safety Incident Response Framework appears to be a really positive shift in how we manage patient safety incidents related to hospital acquired pressure ulcers and has the potential for meaningful change to enable pressure ulcer prevention.

Plans for improvement 2025/26

We will:

- Host a Quality Summit in July 2025.

- Relaunch the Pressure Ulcer Steering Group as the Pressure Ulcer Prevention Improvement Group.

- Launch the most appropriate learning responses for pressure ulcers, as determined by our pilot.
- Continue to develop our in-hospital pressure ulcer dashboard, with the

Business Intelligence Team, which will include data for pressure risk assessments within the first 6 hrs of an admission. The dashboard also identifies the number of pressure ulcers with categories, the role of the health care worker reporting and the length of stay when a pressure ulcer developed.

- Develop an Emergency Department pressure ulcer dashboard (as they have a different process as they use the Adison screening tool and if required start using the Surface, Skin inspection, Keep moving, Incontinence/moisture and Nutrition and Hydration bundle).

Picture: Communications for Pressure Ulcer Prevention Quality Summit

Pressure Ulcer Quality Summit 31 July 2025

Save the date: Quality Summit for Hospital Acquired Pressure Ulcers, 31 July 2025

Join us for the Gloucestershire Hospitals Quality Summit on 31 Jully 2025 at Sandford Education Centre, Cheltenham General Hospital. This event is an exciting opportunity to collaborate with healthcare professionals from Gloucestershire Hospitals to tackle key issues identified from investigating hospital acquired pressure ulcers.

As a healthcare professional, your expertise and input are crucial in driving forward quality improvement initiatives that will directly enhance patient care and support your colleagues. Together, we will explore the issues arising from HAPUs in depth with staff who carry out the work thereby ensuring we are looking at the issues as 'work as done' rather than how it is envisaged. We will also be learning about improvements in the past year relating to hospital acquired pressure ulcers and the proposal for investigating hospital acquired pressure ulcers using hot debriefs.

This summit offers an exciting platform to address these challenges head-on and work towards tangible improvements in patient care. Don't miss this chance to be part of a collaborative effort that will make a real impact!

For further information and details visit the Gloucestershire Hospitals website

2. Quality Priority - Falls prevention

Background

Patient falls are amongst the most common adverse incidents reported in hospital. Of those patients who experience a fall, some suffer moderate to severe injuries that reduce mobility and/or independence and may increase the risk of premature death. We fulfil our duty to manage the risks associated with falls as far as reasonably practicable by ensuring safe systems of working through effective risk assessments, controlling hazards and personalised care planning. We aim to provide a consistent and safe approach across the trust, in the identification, assessment of risk, and the prevention and management of falls for all adult inpatients.

How we have performed and what we have learnt in 2024/5

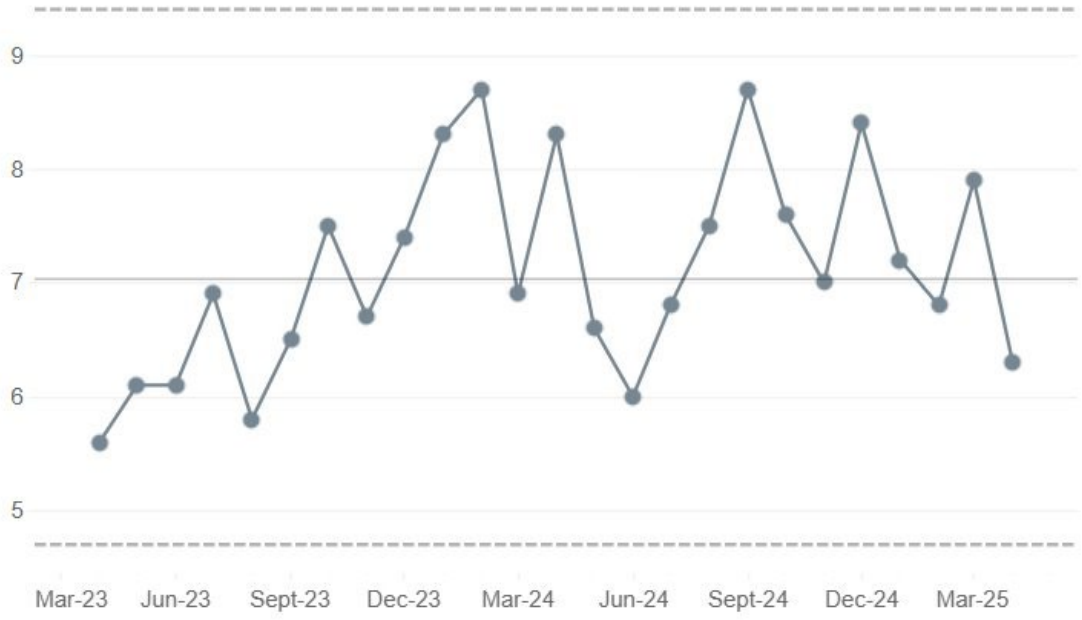
This year we continued to focus on supporting our training program for nursing and therapy staff and re-established the falls links education days to a whole day's training, incorporating all aspects of falls in more depth. Work began on incorporating how we look at all falls in line with PSIRF, to ensure that learning is gained from all falls.

Table: Falls Risk Assessment compliance for in-patients over 65 years of age

Metric	Quarter 1	Quarter 2	Quarter 3	Quarter 4	End of year average 2024/25
Compliance of falls risk assessment on admission for patients aged 65+	**74.7%**	**75.2%**	**77.1%**	**76.0%**	**75.8%**

The number of inpatient falls per 1000 bed days has remained stable as per the table below.

Table: The number of patients' falls per 1000 bed days



In addition, we have:

- Reviewed patients who repeatedly fall with prevention strategies developed by the Falls Specialist Team with the ward teams.

- Continued to provide falls prevention training, as a whole day's training. This year 199 colleagues have been trained in total. Unfortunately, several sessions were cancelled due to pressures within the hospital and team capacity.

- Provided "Falls Link Education" days (there was a total of 4 sessions this year). 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 'Clinical Psychological', 'Vision and falls' and 'Learning disabilities and falls'.

- Made changes to the bed rails assessment on the electronic patient record (EPR) for more accurate documentation of the use of bed rails.

- Replaced the Falls Steering Group with the Falls Improvement Group under the Patient Safety Incident Response Framework for system learning.

- Provided education on our Preceptorship Programme (224 staff have received education) by the specialist team.

- Trialled slippers, instead of slipper socks, on the Stroke Unit. The Medical

Division are now able to order slippers for patients who have no means of obtaining them from home.

- Completed a Sliver Quality Improvement project with regard to the correct calculation of the Lying/standing blood pressure. The project did show a slight improvement on the 3 wards chosen; however, the most significant outcome of the project was that the training provided by the falls team (to only 1 of the 3 wards chosen) proved to be the most effective change idea that reduced falls.

- Piloted a project for PSIRF around the use of Hot Debriefs on 3 wards. This provided learning from all falls, not just falls with significant injury. This resulted in themes being identified and added to the Datix investigation form, to then be able to work on the themes to improve learning.

- Held a Falls Quality summit in November 2024 and identified a number of improvement projects which included to make improvements to Datix, locations for Hot Debriefs and to improve the electronic patient record.

Plans for improvement 2025-2026

We will:

- Develop and implement an audit tool for improving falls risk assessment and implementation of the use of bed rails.

- Implement the Silver Quality Improvement project on calculation of the lying/standing blood pressure monitoring.

- Continue with the quality improvement projects following on from the Falls Quality Summit.

- Continue with the introduction of Hot Debriefs for all falls.

- Develop the nursing and medical post falls electronic form. This is to replace the ‘blue sticker’ that was put in paper medical notes to ensure that immediate post falls assessments are consistent.

- Review the Falls Prevention and Management Policy for learning on risk assessment for longer-stay patients.

3. Quality Priority: Delay to Recognition and/or Escalation of Deterioration in Maternity

Background

This quality priority focused us to review our systems that enable us to detect **deterioration of maternal or fetal condition, during pregnancy and/or delivery, and to prevent delays.** We have focused our improvement efforts to target and enhance the overall quality of care for women and birthing people. It represents our decision to prioritise this work over others and this was driven by patient safety incident data.

The Patient Safety Incident Response Framework and the detection of patient deterioration are closely related, with the framework emphasising the importance of responding to incidents involving patient safety, including cases of deterioration. Patient Safety Incident Response Framework aims to learn from incidents and improve systems. Patient Safety Incident Response Framework is designed to promote learning from patient safety incidents and to improve systems and processes that can help prevent future incidents, including those related to patient deterioration. The framework emphasises the need for timely intervention and escalation when the maternal or fetal condition deteriorates, highlighting the importance of recognizing and responding to changes in a patient's condition.

Care Quality Commission – Section 31 Enforcement Notice

The Care Quality Commission inspected the Maternity Service at the Gloucestershire Royal Hospital site in March 2024. After the inspection, in May 2024, they applied 8 conditions on our registration that related to this priority and we have written about 2 of these priorities – **Modified Obstetric Early Warning Scores** and fetal monitoring **peer reviews**.

Monitoring maternal condition

Modified Obstetric Early Warning Scores

The Modified Obstetric Early Warning Score is a scoring system used in maternity settings to identify and track the clinical deterioration of pregnant women and postpartum mothers. It helps healthcare professionals quickly assess a woman's condition, determine the appropriate level of monitoring, and initiate timely interventions. Modified Obstetric Early Warning Score assigns points based on a woman's vital signs (heart rate, respiratory rate, blood pressure, temperature, oxygen saturation, and mental status) and other relevant factors. The score determines the urgency of the situation and the level of care required, ranging from

routine monitoring to immediate transfer to critical care. Modified Obstetric Early Warning Score provides a standardised approach to assessing maternal well-being, ensuring consistent care and communication within the healthcare team. By focusing on early signs of deterioration, Modified Obstetric Early Warning Score can identify women at risk of developing critical illnesses, allowing for proactive management.

Benefits of MOEWS:

- **Improved Early Detection:** Modified Obstetric Early Warning Score helps identify women at risk of developing critical illnesses before they become severely ill.
- **Enhanced Communication:** It facilitates clear and efficient communication within the healthcare team.
- **Standardised Assessment:** It provides a consistent and standardized approach to assessing maternal well-being.
- **Increased Awareness:** It raises awareness among healthcare professionals about the signs and symptoms of maternal deterioration.

In essence, Modified Obstetric Early Warning Score is a tool that empowers healthcare professionals to proactively manage the care of pregnant and postpartum women, potentially saving lives and reducing maternal morbidity. Within the chart are coloured zones and so if vital signs were recorded within these zones (a “trigger), then an action should be prompted. An amber zone ‘trigger’ should alert the clinician to increase the frequency of monitoring and red zone ‘trigger’ should prompt a medical review by a doctor.

Quality Improvement

Our approach for the Care Quality Commission section 31 enforcement notice has been based on the empowerment of frontline teams. We identified 2 clinical leads (Matron and Consultant Obstetrician) and they commenced a quality improvement project to improve compliance of completing clinical observations and to ensure that they were escalated accordingly. The Team was initially tasked with completing a quality improvement plan on a page that they updated on a 2-weekly basis with the actions they had taken and the actions they were going to take in the next period.

The Modified Obstetric Early Warning Score Improvement Team identified a

SMART AIM
To increase compliance with acting on amber scores to 80% within 3 months (July), and 95% within 1 year (March 2025).

SMART aim:

What did the data demonstrate and what did we learn?

Amber triggers

Amber zone triggers indicate to the clinician to repeat the Modified Obstetric Early Warning Score observations. Since May 2024 we have improved our compliance with “act on amber” scores from 75% to 83% across all 3 clinical areas.

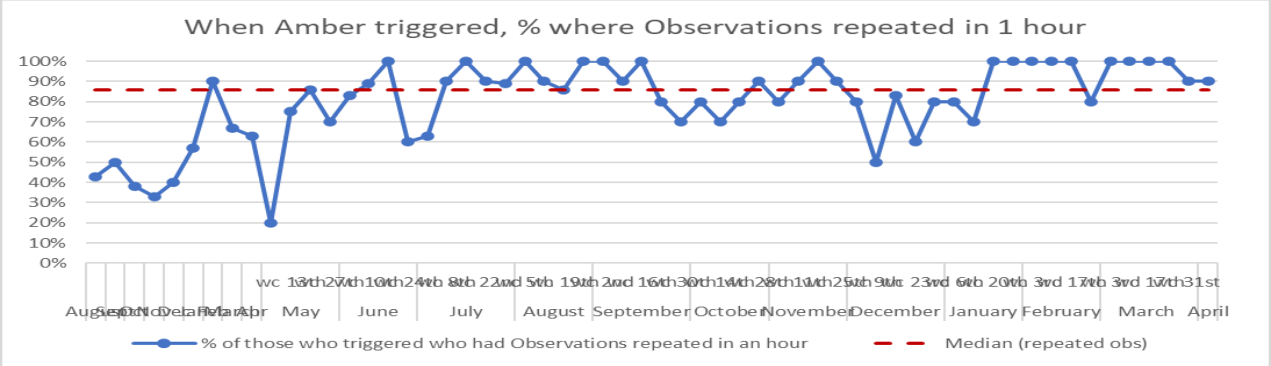
The area that continues to flag decreased compliance is the Birth Unit with only 70% women getting repeated observations when the amber score is triggered. Continued actions are being driven in this area to improve compliance which is the Birth Unit Lead is supporting individuals, teaching/training has been repeated within the service and also focused work to discuss with staff the barriers to retaking observations within 1 hour.

Table: “Act on Amber” compliance

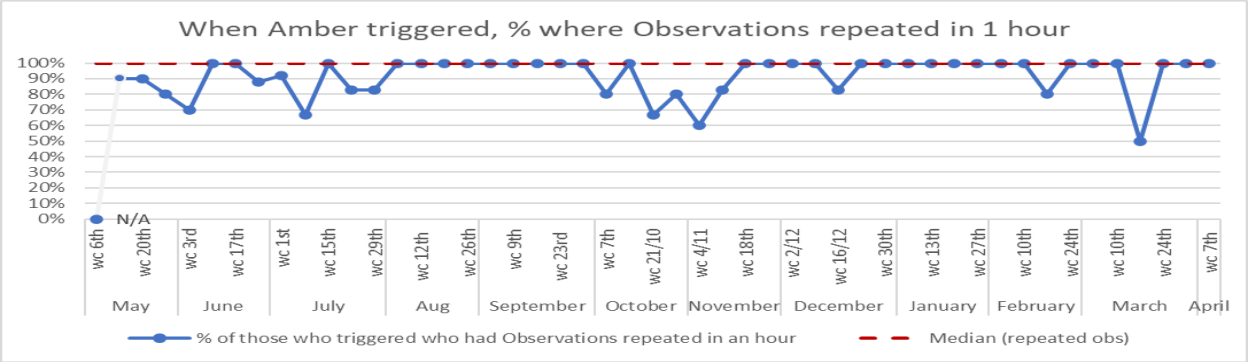
Area	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Maternity Ward	63%	83%	86%	94%	89%	80%	95%	71%	100%	95%	90%
Delivery Suite	87%	90%	83%	100%	100%	*60%	85%	97%	100%	95%	90%
Birth Unit GRH	75%	80%	100%	100%	100%	100%	70%	83%	83%	70%	70%

Charts: When amber triggered % where observations repeated in 1 hour – Maternity Ward

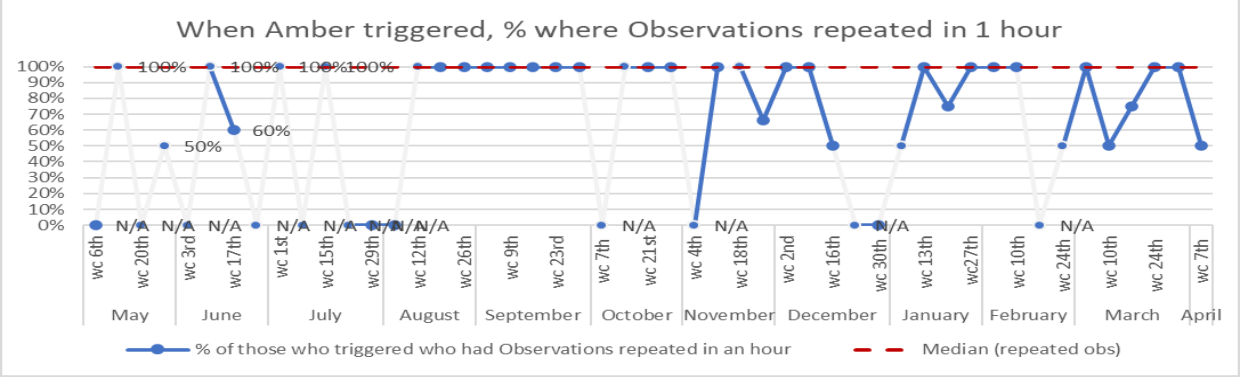
Graph: Maternity Ward



Graph: Delivery Suite



Graph: Birth Unit



Early Warning Scores, like the Modified Obstetric Early Warning Score, are tools used to identify and track patients at risk of clinical deterioration. In essence, the Patient Safety Incident Response Framework has provided us with the framework for how we review and responds to safety incidents whilst we have an improvement programme running as we have linked the two together by reviewing safety incidents whilst we improved our processes within a quality improvement programme.

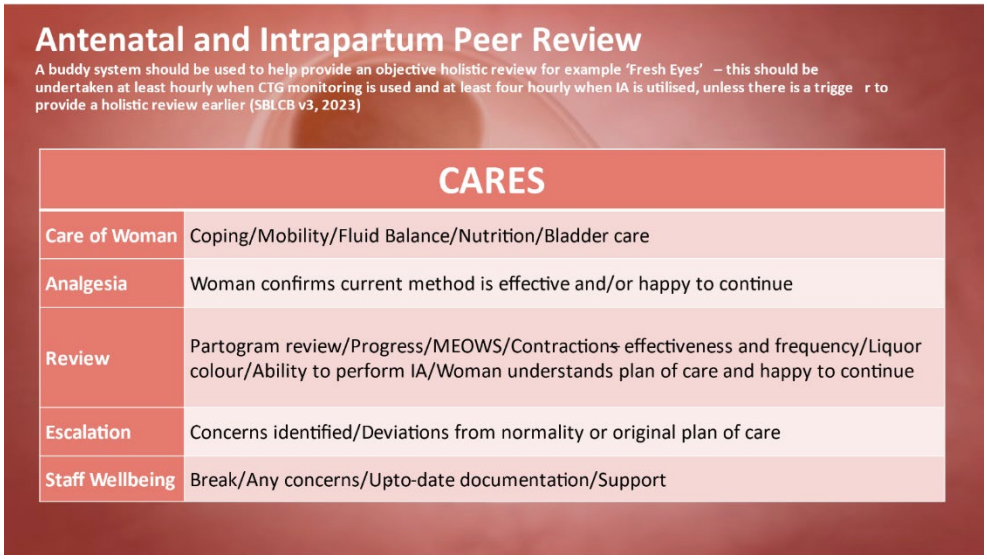
Plans for improvement 2025-2026

- There had been no national standard for the Maternity Early Warning Score but this has now been developed and will be rolled out in the Trust in December 2025. We have a plan for its implementation as this will change our coloured triggers to numerical triggers.
- We will continue monitoring compliance with “act on amber” until we see improvement within the Birth Unit and sustained compliance across all the other clinical areas.
- We will continue to introduce the Martha’s Rule project for patient and carer concern for clinical deterioration to be documented in the clinical notes and lead to clinical escalation.
- Once we have sustained our improvement target, we will invite Care Quality Commission to inspect against the conditions and this will likely to be at the end of the Summer 2025.

Monitoring fetal condition: Cardiotocograph peer reviews

In the UK, National Institute for Clinical Excellence guidelines recommend that a CTG (cardiotocograph - continuous fetal heart rate monitoring) trace should be assessed and documented at least every hour in labour, with more frequent assessments if there are concerns. A "fresh eyes" or peer review, where another midwife or doctor skilled at CTG interpretation reviews the trace, should also be completed every hour. The purpose is to identify any deterioration, or any concerns, about fetal condition. We have utilised a *CARES* model peer review, which is a more comprehensive review that includes a discussion of the woman's care, risk factors, and the progress of labour.

Picture: CARES for fetal monitoring peer review



Remember that:

- fetal heart rate monitoring is a tool to provide guidance on fetal condition, and not a standalone diagnostic tool
- the findings from fetal monitoring need to be looked at together with the developing clinical picture for both woman and baby.

Benefits of peer reviews: enhanced accuracy and interpretation

A second clinician reviewing the fetal heart rate trace can offer a fresh perspective and potentially identify subtle changes or patterns that might be missed by the initial observer, leading to more accurate interpretation of the trace.

Benefits

Improved Decision-Making: The "fresh eyes" peer review approach allows for a safety net check of the situation.

Reinforcement of Good Practice: The peer review process encourages consistent and accurate interpretation of fetal heart rate traces, reinforcing best practices in fetal monitoring and ensuring a high standard of care.

Improved Communication and Collaboration: The peer review process fosters communication and collaboration between healthcare professionals, leading to a more coordinated and effective approach to fetal monitoring and management.

Cost-Effectiveness: While it might seem like an extra step, peer review can be cost-effective in the long run by reducing the risk of complications and ensuring that interventions are appropriate and timely.

In essence, peer review is a tool that may help improve accuracy, reduce interpretation errors, and reinforces good practice by leveraging a fresh perspective. It also allows for a learning process if a coaching approach is taken at each review.

Quality Improvement

Our approach for the Care Quality Commission section 31 enforcement notice has been based on the empowerment of frontline teams. We identified 2 clinical leads (Matron and Consultant Obstetrician) and they commenced a quality improvement project to improve compliance of completing hourly peer reviews. The Fetal Monitoring Team were initially tasked with completing a quality improvement plan on a page that they updated on a 2-weekly basis with the actions they had taken and the actions they were going to take in the next period.

The Fetal Monitoring Improvement Team identified SMART aims:

SMART AIM
To confirm through audit within one month that staff are identifying and escalating fetal compromise effectively and addressing any issues found, sharing learning and providing assurance.

- To increase initial intrapartum risk assessment on admission to 95% by 31 March 2025
- To increase hourly risk assessment to 85% by 31 March 2025
- To increase our hourly peer review rate to 85% during intrapartum care by 31 March 2025
- To increase the accurate interpretation of CTGs to 85% (escalated appropriately for their interpretation) by 31 March 2025
- 100% of CTGs escalated appropriately by 31 March 2025

What did the data demonstrate?

We have carried out an audit once a month to check that we are complying with National Institute for Health and Care Excellence fetal monitoring standards.

Risk assessment on admission

Our data demonstrates that we are now completing a risk assessment on admission in labour which means that after appropriate risk assessment the appropriate method of fetal monitoring is being offered to women.

Hourly risk assessment

Our data demonstrates that we are carrying out hourly risk assessments of the woman and her baby.

Peer reviews

In March 2025, the Team trialled a 2-week Plan Do Study Act cycle of having dedicated peer reviewers on Delivery Suite. This Plan Do Study Act cycle was successful as a thorough peer review takes 10 minutes to complete, if there are 3-6 labouring women who require hourly peer review this could be 100% of a midwife's capacity and so this will continue. We have met our target of 85% of women having hourly peer reviews.

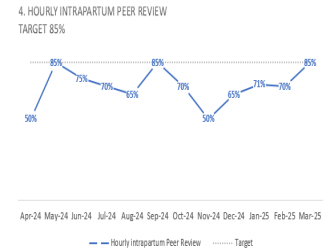
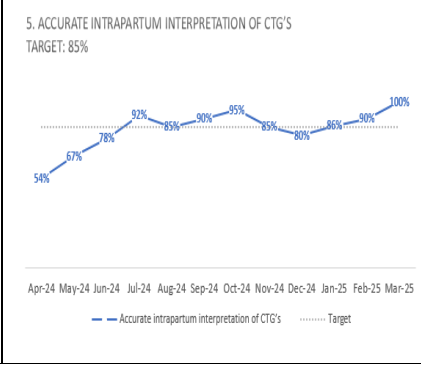
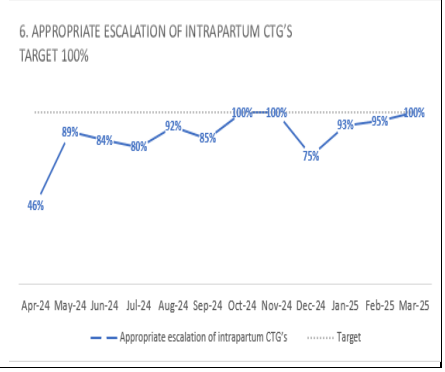
Accurate assessment and appropriate escalation

Our data demonstrates that we are carrying out accurate assessments and when appropriate care is being escalated to the obstetric team or senior midwife when appropriate.

Table: Fetal monitoring audit results

Issue	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	March 2025	Target end May 2025
Intrapartum risk assessment on admission	60%	95%	90%	95%	85%	90%	100%	100%	86%	86%	95%	Target 95%
Hourly risk assessment	80%	75%	42%	65%	85%	70%	50%	65%	67%	63%	90%	Target 85%
Hourly peer review	85%	75%	70%	65%	85%	70%	50%	82%	71%	70%	85%	Target 85%
Accurate assessment	67%	78%	92%	85%	90%	95%	60%	80%	86%	90%	100%	Target 85%
Escalation	89%	84%	80%	92%	85%	100%	100%	75%	93%	95%	100%	Target 100%
Total mean of hourly intrapartum peer reviews							77.5%	82%	95%	93%	98%	Target 85%

Graphs: Fetal monitoring compliance with standards (April-March 2024/2025)

Graph: Hourly peer reviews	Graph: Accurate assessment	Graph: Appropriate Escalation
		

Fetal monitoring safety incidents falls under the scope of Patient Safety Incident Response Framework as a specific type of incident that we can learn from. Any safety incidents that related to this improvement work stream have been shared with the team so they can identify the lessons learned and implement changes to improve

fetal monitoring practices such as better training. Our aim is always to deliver safer care for women and babies.

Next steps

- As the Patient Safety Incident Response Framework encourages a data driven approach to incident response we will review all the incident data and look for any themes/trends to inform our programme of work for the next year.
- We will continue to audit our practice against NICE recommendations and will decrease the frequency of the audits once we have sustained our performance and keep meeting the compliance targets.
- The new Maternity Incentive Scheme requirements are being scoped to ensure we have continued compliance to the national requirements for meeting the scheme requirements.

4. Quality Priority: Safer Staffing

Background

Safe staffing is crucial in the Patient Safety Response Framework because it directly impacts the ability to respond effectively to patient safety incidents, investigate them thoroughly, and learn from them to prevent future harm. Adequate staffing levels and the right skill mix ensure that staff can provide the necessary care and support to patients, which is essential for both patient safety and the successful implementation of Patient Safety Response Framework. In this section we have focused on the nursing workforce.

How safer staffing and PSIRF are linked:

- **Incident Prevention:**

  Adequate staffing allows for more effective patient care, reduces the risk of errors, and minimises the likelihood of incidents happening in the first place.

- **Incident Response:**

  PSIRF provides a framework for responding to incidents when they do occur. The framework includes compassionate engagement with affected individuals and families, system-based approaches to learning, and proportionate responses.

- **Learning from Incidents:**

  Both safer staffing and PSIRF are focused on learning to improve future care. PSIRF emphasises using system-based approaches to identify care or service delivery issues within safety incidents and implement changes to prevent recurrence, while safe staffing ensures there are enough staff with the necessary skills and knowledge to implement these changes effectively.

- **Quality of Care:**

  Adequate staffing ensures that there are sufficient staff to provide quality care, which is a key factor in preventing patient safety incidents and improving patient outcomes.

- **Patient Experience:**

  Safer staffing and the Patient Safety Response Framework both contribute to improving the overall patient experience by ensuring safe and compassionate care and by addressing incidents promptly and effectively.

In essence, the Patient Safety Response Framework provides the framework for responding to incidents when they occur, while safer staffing is crucial for preventing incidents from happening in the first place and for ensuring that there are enough qualified staff to provide safe and effective care, which aligns with the goals of the Patient Safety Response Framework.

How we have performed in 2024-2025

Safe staffing levels help prevent burnout and fatigue, which can negatively impact staff performance and patient care. All incidents, including those related to staffing shortages or staff skill gaps, were reported through our established incident reporting system. By implementing robust safe staffing practices and effectively managing safety incidents, we can improve patient safety, enhance staff well-being, and contribute to high-quality care.

We are very proud to be in a position of having very few nursing vacancies on our inpatient wards. Vacancies on adult inpatient wards at the end of February 2025 were 10.73 whole time equivalent posts, on the paediatric ward there were 16 whole time equivalent vacancies and 8.8 whole time equivalent in the Emergency Department. By way of comparison there were 434 whole time equivalent nursing vacancies in September 2022.

Our international recruitment campaign has been very successful and has brought many new colleagues to work with us from many countries including India and the Philippines. Our focus now moves from our attraction campaigns to our retention plan by increasing support for staff in post making this our key priority.

A Trust wide review of nursing workforce has been undertaken using the Safer Nursing Care Tool, which measures patient acuity and dependency and helps calculate the care hours required per patient day. From the table below five wards had planned for fewer care hours and three wards had planned for more care hours. This variation can be a reflection of the increasing complexity of the patient population, growth in services, changes in the workforce due to role development and reshaping the workforce to reflect the growth of the Nursing Associate role.

It is important we achieve optimum planned care hours to prevent harm for our patients, such as patient falls, pressure ulcers and healthcare acquired infections. Optimum care hours enhance both the patient and staff experience of care. Bespoke care hours calculations are in progress in the emergency department and critical care, which will accommodate improvements such as a streaming nurse role for the emergency department and Healthcare Support Worker roles in critical care.

Table: Data for actual and planned care hours and the variance by ward and department

ANNEX A NURSING STAFF FILL RATES Sep-24		Acutal CHPPD				Planned CHPPD			Variance		
		Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall	Registered nurses/ midwives	Care staff	Overall	Registered nurses/ midwives	Care staff	Overall
	HASU	407	11.4	3.2	14.7	11.1	3.1	14.2	0.4	0.1	0.5
	BIBURY/SNOWSHILL	486	6.6	2.0	8.6	6.5	2.4	8.8	0.1	-0.4	-0.2
	GUITING	868	4.9	3.6	8.5	4.8	3.1	7.9	0.0	0.5	0.5
	TIVOLI	445	5.8	4.0	9.8	6.1	4.4	10.4	-0.2	-0.4	-0.7
	KNIGHTSBRIDGE	504	5.4	2.8	8.3	5.4	3.0	8.3	0.1	-0.1	-0.1
	LILLEYBROOK	425	5.4	2.2	7.6	5.3	2.8	8.1	0.1	-0.6	-0.5
	RENDCOMB	568	6.1	2.0	8.1	6.1	2.1	8.2	0.0	-0.1	-0.1
	RYEWORTH	939	4.1	3.2	7.3	4.2	3.2	7.3	0.0	0.0	0.0
	WOODMANCOTE	915	4.5	3.4	8.0	4.6	3.3	7.9	0.0	0.1	0.1
GRH	AMU	1562	5.5	2.5	8.0	5.1	2.7	7.8	0.4	-0.2	0.2
	FRAILTY UNIT	409	6.9	3.2	10.1	6.6	3.7	10.3	0.3	-0.5	-0.2
	CARDIOLOGY	726	12.5	2.5	15.0	11.6	2.7	14.3	1.0	-0.2	0.7
	DCC	414	29.7	1.7	31.5	36.2	1.8	38.0	-6.5	-0.1	-6.6
	SCBU	517	11.6	1.7	13.3	11.6	1.5	13.1	0.0	0.2	0.2
	CIPD	459	12.6	3.6	16.2	16.3	4.5	20.9	-3.7	-0.9	-4.6
	ZA	596	5.6	3.9	9.6	5.8	4.2	9.9	-0.1	-0.2	-0.4
	ZB	611	4.4	3.1	7.6	4.4	3.2	7.6	0.0	-0.1	0.0
	3A	881	3.4	3.4	6.8	3.1	3.4	6.5	0.3	0.0	0.3
	3B	851	4.1	3.0	7.1	4.2	3.2	7.4	-0.1	-0.2	-0.3
	4A	872	3.9	2.7	6.6	4.2	2.8	7.1	-0.3	-0.1	-0.4
	4B	822	4.1	3.0	7.1	4.2	3.3	7.5	-0.1	-0.3	-0.3
	5A / SAU	869	4.1	2.9	6.9	4.0	3.0	7.0	0.1	-0.1	-0.1
	5B	541	6.9	3.5	10.3	7.2	3.6	10.8	-0.3	-0.1	-0.5
	6A	685	5.2	4.3	9.5	5.0	4.4	9.4	0.1	-0.1	0.0
	6B	1031	4.1	3.1	7.2	4.1	2.9	7.0	0.0	0.2	0.2
	7A	890	4.5	2.5	7.0	5.0	2.6	7.6	-0.5	-0.1	-0.6
	7B	655	4.7	2.1	6.8	4.8	2.3	7.1	-0.1	-0.2	-0.3
	8A	1649	5.0	2.9	7.9	5.0	3.1	8.1	0.0	-0.2	-0.2
	9A / AMU3	336	4.5	2.1	6.5	4.5	2.2	6.7	0.0	-0.2	-0.2
	9B	807	4.8	3.1	8.0	4.8	3.3	8.2	0.0	-0.2	-0.2
	GALLERY WING 1	710	4.2	2.9	7.1	3.7	3.2	6.8	0.6	-0.3	0.3
	GALLERY WING 2	712	3.8	3.1	6.9	3.8	3.2	7.0	0.0	-0.1	-0.1

Chart I versus Actual CHpPD (Trust).

Plans for Improvement in 2025-2026

- We are working towards facilitating Band 6 Nurse in Charge cover for 24 hours a day consistently across all departments.
- We are assessing the Department of Critical Care to reflect the need to have Health Care Assistant cover on both sites, 24 hours a day.
- In the Department of Critical Care, we are going to set the training provision at 28% as per the Guidelines for the Provision of Intensive care Services.
- In the Emergency Department we are working to set the training provision requirements at 27% as per the Royal College of Emergency Medicine Nursing Workforce standards.
- Within the Specialities of Paediatrics and Neonates we are going to set the training provision at 25% as per the Royal College of Nursing and Neonatal Nursing Workforce tool respectively.
- Also, we will set nursing budgets to reflect actual staff pay point and any in year incremental drift.
- We will backfill maternity leave to at 100% for inpatient departments.
- On Guiting Ward, Ryeworth Ward, Ward 3a and Ward 3b the budgets are to be set to reflect the changes in patient acuity.

5. Quality Priority: Safety Culture

Background

The Patient Safety Incident Response Framework is designed to enhance staff culture by fostering a learning environment where mistakes are viewed as opportunities for improvement and where staff feel supported in reporting incidents. It emphasises a compassionate and "just culture" where staff are treated fairly and are not unfairly blamed for incidents, promoting open communication and a proactive approach to safety.

Here is how PSIRF impacts staff culture:

- **Promotes Open Communication:**

  The Patient Safety Incident Response Framework encourages staff to speak up about incidents, recognising that learning from mistakes is crucial for improving patient safety.
- **Fosters a Just Culture:**

  It emphasises fairness and transparency in how incidents are investigated and responded to, ensuring staff are not unfairly blamed for mistakes.
- **Empowers Staff:**

  The Patient Safety Incident Response Framework empowers staff to be involved in the learning and improvement process, recognising their valuable insights and contributions.
- **Supports Psychological Safety:**

  By promoting a supportive and non-punitive environment, the Patient Safety Incident Response Framework contributes to staff's psychological well-being and their willingness to report incidents.
- **Focus on Systemic Issues:**

  The Patient Safety Incident Response Framework encourages a systems-thinking approach, recognizing that many incidents are caused by systemic flaws rather than individual errors.
- **Compassionate Engagement:**
  The Patient Safety Incident Response Framework emphasises the importance of compassionate engagement with patients, families, and staff following an incident, fostering trust and building positive relationships.

In essence, the Patient Safety Incident Response Framework further shifts the focus from blaming individuals to learning from systems, creating a culture where staff feel valued, supported, and empowered to contribute to safer patient care. By fostering a positive safety culture, the Patient Safety Incident Response Framework ultimately improves patient safety and staff wellbeing.

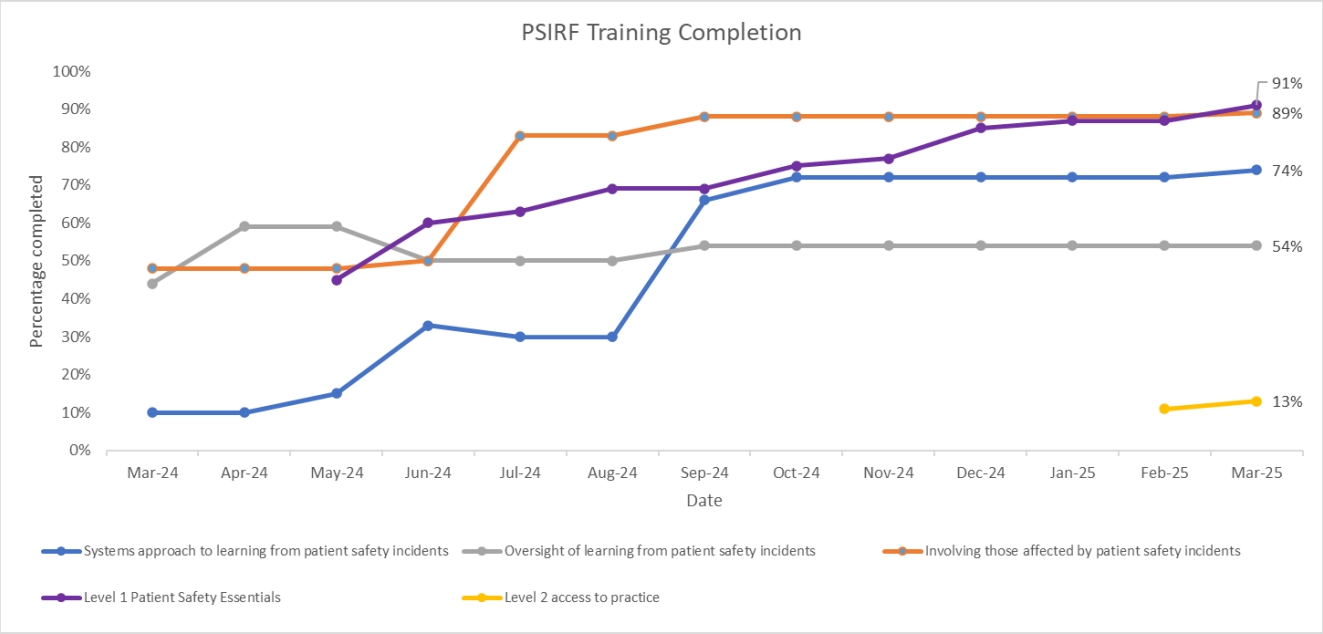
How have we performed and what we have learned in 2024/2025

Training is crucial for improving a culture that supports the Patient Safety Incident Response Framework by equipping staff with the knowledge and skills to effectively respond to incidents and learn from them.

The Patient Safety Incident Response Framework Training

The Patient Safety Incident Response Framework introduced new training requirements for those leading learning responses and those responsible for the oversight of the application of the framework. The chart below, shows current percentage completion across the three training courses introduced by PSIRF and the level 1 and 2 patient safety training, which is also a requirement, for those in Patient Safety Incident Response Framework roles.

Graph: Patient Safety Incident Response Framework training requirements, completion status.



Patient Safety Associate Programme

The Gloucestershire Safety and Quality Improvement Academy Faculty has been running the Patient Safety Associate Programme to develop a network of Patient Safety Associates across the Trust to support and promote patient safety. This programme was recently awarded a Staff Award (Nov 2024) for **Exceptional Contribution to Research, Teaching or Innovation**. The programme aims to build knowledge and skills to enable staff to be a resource in Patient Safety (human factors, safe systems, risk management, incident management and creating a just culture) within our teams and support patient safety

improvement. The programme runs over 6 months with one study day a month and self-directed learning. It is aimed at all clinical and non-clinical staff with an interest in patient safety, and/or leadership or teaching aspect to their roles.

Human Factors

The Human Factors Faculty offers a Human Factors Educational programme as part of the Gloucestershire Safety & Quality Improvement Academy (GSQIA). This is open to all staff to embed Human Factors awareness in our day to day working lives and the systems we work with the aim of improving the safety of our patients, the culture and environment we work in. The programme includes an **Introduction to Human Factors,** a half day workshop, which is open to all staff. This workshop explores how human factors impact on our working lives in healthcare from communication, team working and situational awareness to the systems we work in (for all clinical and non-clinical staff). An additional day and a half **Human Factors in Practice** training, builds on this baseline knowledge, introducing HF tools and approaches.

The Learning and Organisational Development Team have focussed on implementing specific programmes within a **Staff Experience Improvement Programme** which includes:

Restorative, Just and Learning Culture: Launch of a *Case Assessment Framework*, new policies introduced (*Mutual Respect, Disciplinary, Grievance, Sexual Behaviour*), and training/ Masterclasses for managers. This programme is strongly linked to PSIRF as they both emphasise the on learning, accountability and compassionate engagement after a patient safety incident.

Speaking Up Culture: Training for managers, champion network launched, new *Freedom to Speak Up* policy finalised. PSIRF emphasises open communication and learning from errors and freedom to speak up provides channels for staff to safely report concerns and issues without fear.

Anti-Discrimination: Relaunch of the Equality Diversity and Inclusion intranet page, establishment of a campaign task force, procurement of an external reporting platform. Anti-discriminatory practice significantly impacts the Patient Safety Incident Response Framework by ensuring that responses to patient safety incidents are fair, equitable and address potential disparities in safety risks. It promotes a culture of inclusion and respects the rights of all patients and staff, contributing to better patient outcomes and a more just healthcare environment.

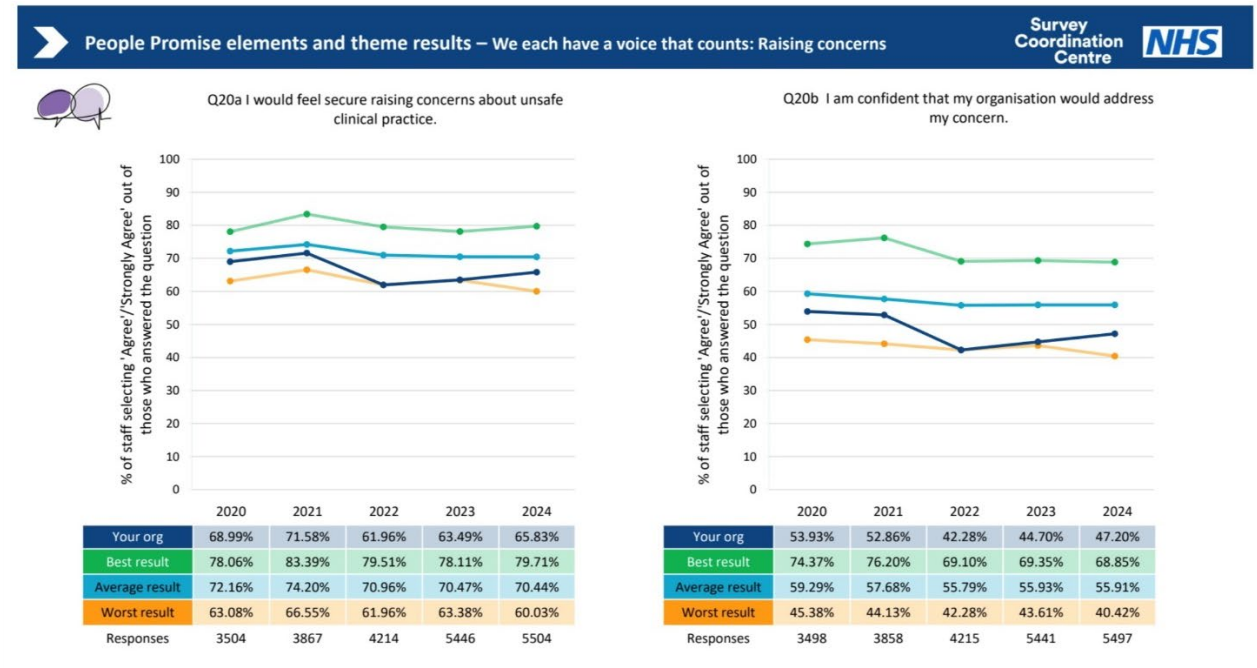
Our culture for raising concerns

The 2024 NHS Staff Survey, assesses employee experiences across seven People Promise elements. Each element is mapped to sub-scores and relevant questions. The results are scored on a 0-10 scale, where a higher score is more positive. The table below illustrates where our Trust scores (dark blue column) against the average Trust score (light blue column) and the best (green line) and worst (yellow line) Trusts.

For the purposes of this Account, we have highlighted 2 questions which demonstrates aspects of our safety culture. The results show that in 2024 we have moved from being in

the worst performing Trusts towards being an average scoring organisation. This is a sign that we are improving our reporting culture but we have a long way to go to be rated the same as the best organisations.

Table: Staff Survey scores for raising concerns and addressing concerns



Patient safety must be at the centre of our Trust's operating model, with our leadership team supported and held to account in creating a culture where staff feel safe to speak up.

Plans for Improvement in 2025-2026

The Safety Team and the People and Organisation Development Team will continue with delivering the training requirements and programmes which will in turn enable us to continue to build our safety culture within the Patient Safety Investigation Framework.

6. Quality Priority: Digital Systems Improvement

Radiology Results Acknowledgement and Alerting

Background

There are many benefits to digitising diagnostic results. We have made efficiency savings as we have stopped printing, distributing and filing paper results. We have removed delays in getting results into the patient records and there is now less chance of results getting lost or misfiled. However, when we had paper, a clinician used to “sign off” the result before it was filed. So, rather than doing a “sign off” before filing the result, we now need to “acknowledge” the result as soon as practicable after it is filed in the record. We call that “result acknowledgement” to signify it is done after the result is issued. That acknowledgement step in the digitised workflow is quite complex which is why we have set up an improvement workstream to tackle this. Acknowledging and acting upon test results is crucial for patient safety. Timely communication and verification that results have been acknowledged and acted upon, if necessary, helps prevent delays in care and ensures appropriate follow up, potentially minimising harm.

A prolonged delay in diagnosis can allow disease to spread and reduce treatment options and whenever there is harm, we report this as a safety incident under PSIRF and the most appropriate learning response is agreed at the Trust Patient Safety Review Panel.

How have we performed in 2024-2025:

Why is it important?

- **The Royal College of Radiologists guidelines state:**

  “It is the responsibility of the requesting Doctor and/or their clinical team to read and act upon the report findings and fail-safe alerts as quickly and efficiently as possible.”

- **Patient Safety:**

  Failure to follow up on test results can lead to delayed treatment, increased morbidity, and even mortality, particularly when abnormal results are not recognised promptly.

- **Improved Communication:**

  Result acknowledgements can improve the flow of information between clinicians and ensure that results are seen and acted upon.

- **Enhanced Accountability:**

  Systems that track acknowledgement and follow-up can help hold clinicians accountable for their actions.

- **Proactive Risk Management:**

  Acknowledging results helps identify potential issues early on and allows for timely intervention.

- **Reduced Inefficiencies:**
  Electronic result acknowledgement systems can streamline workflows and reduce time spent on manual processes.

Quality Summit

A quality summit was previously held in October 2023. A quality summit is a multi-disciplinary collaborative designed meeting to use collective knowledge and wisdom to explore a complex issue with the intention of bringing about measurable and sustainable improvement. Quality summits use a variety of systems based diagnostic approaches combined with quality improvement methodology. A number of issues were identified for improvement including, those listed below.

We were not always able to:

- Alert the correct consultant on our digital system.
- Run accurate reports stating which results have been acknowledged and which results have not.
- Have a safety net or second person identified for each consultant in the event that an alert has not been acknowledged within the set timeframe.
- Increase the frequency of alerts/reminders for critical and significant findings.
- Forward, within the digital system Communicator, an alert to the correct consultant / Specialty and Associate Specialty (SAS) doctor when the patient the alert refers to someone that is no longer in their care or has been transferred.
- Remove no concern or low-level concern result reminders as this made searching for serious concerns difficult.

Red Flags

A red flag group, led by the Deputy Medical Director and the Divisional Director for Quality and Nursing (DDQN) for the Diagnostics and Specialties Division, was convened to progress the issues for improvement. A detailed action plan is in place, for all the issues identified, and the implementation of solutions is coordinated and monitored by the group.

- We have made improvements to the Codes requiring acknowledgement, removing clinically unimportant addenda from requiring a response and moving to current Royal College of Radiologist guidance – Now 2 codes require a response:
    - Urgent Unexpected Result
    - Alert Code Cancer
- Changes to the radiology results alerting frequency and escalation was implemented on 07 January 2025.
    - The system will now continue to alert the report requester nine times, every two days, unless it is acknowledged (this frequency was chosen as this covers off 2 weeks leave and still alerts on first days back from leave to ensure visibility).
    - After this time, it will be escalated to a designated individual or shared mailbox, highlighting that it remains outstanding.
- Creation of a Business Intelligence dashboard that enables clinicians to monitor their outstanding reports, is the first stage of managing the risk associated with failing to action critical radiology findings.
    - Ongoing work to create reports/alerts to go out to clinical leads/department leads for review/safety checks.
- Work is continuing in relation to cleansing the results alerting distribution lists and escalation routes.
    - To support specialties in describing or instating appropriate governance practices around the monitoring of results a Standard Operating Procedure template is being produced to be shared with specialties.
    - This will help to ensure that the work in progress is maintained and managed locally by specialties.
- A harm review of the data being captured and reported by the Business Intelligence dashboard, related to a sample of retrospective unacknowledged reports is now also underway as this data will be used to understand the status of historic unacknowledged radiology reports and support a proposal for any further retrospective review of outstanding cases.

Unacknowledged radiology alerts recorded on the Business Information (BI) Dashboard as of 2 April 2025

Note since changes were implemented in December 2024 - January 2025 to types of alerts and frequency of repeat alerts, the percentage of unacknowledged alerts has reduced significantly from April – November 2024 - range 26-32.8% to 8.9-10.8% January /February 2025. These dashboards can now be easily reviewed and dealt with by individuals/teams as the dashboard is more accurate and easier to interrogate.

Plans for Improvement in 2025-2026

The Red Flag Group will continue to improve and reduce the risk of unacknowledged radiology results alerts and each Division must have a process in place for monitoring the compliance within each speciality.

The plan will include:

- Having a clear pathway in place for monitoring and reviewing radiology alerts that remain unacknowledged outside of the Trust agreed time frame for acknowledgment and that exceptions are acted on.
- Reporting of monthly status reports of unacknowledged radiology alerts through Divisional quality governance structures and onwards to the Quality Delivery Group.
- Taking action to review and address radiology alerts that remain unacknowledged outside of the Trust agreed time frame for acknowledgment to ensure that every effort is made to maintain patient safety.
- Building oversight systems that are held by the Clinical Lead/Specialty Triumvirate, with reporting via Service Line reviews to the Division senior leadership team.

7. Quality Priority: Clinical Vision of Flow (admission and discharge)

Background

In the NHS, “flow” generally refers to the movement of patients in a smooth and efficient manner. It is about optimising the patient’s journey from initial contact to discharge, ensuring timely care and reducing delays. Flow specifically refers to the way patients move through the different stages of care; such as emergency department to ward, from a doctor’s appointment to specialist consultation, or from hospital to home. Improving flow can lead to better patient outcomes, increased hospital capacity and improved satisfaction for staff and patients.

Clinical Vision of Flow Improvement Programme

The overarching goal of the Clinical Vision of Flow improvement programme is to make sure that every patient's journey is efficient, seamless, and centred on what’s right for them. We are committed to swiftly connecting our patients with the right clinical team and ensuring admission only when truly essential.

How have we performed in 2024-2025

Our Clinical Vision of Flow programme includes four clinically-led workstreams in the:

- Emergency Department,
- Assessment and short stay areas,
- General/ specialty areas, and
- Frailty Service.

Our ambitions will be to make the following improvements:

Workstream 1: Emergency Departments

- No ambulance handover more than 40 minutes in line with national standards.

Workstream 2: Short stay

- No patients in short-stay units for more than two nights. This includes the Acute Medical Units and the Surgical Assessment Unit.

- No patient in Same Day Emergency Care for more than eight hours.

Workstream 3: Specialty wards

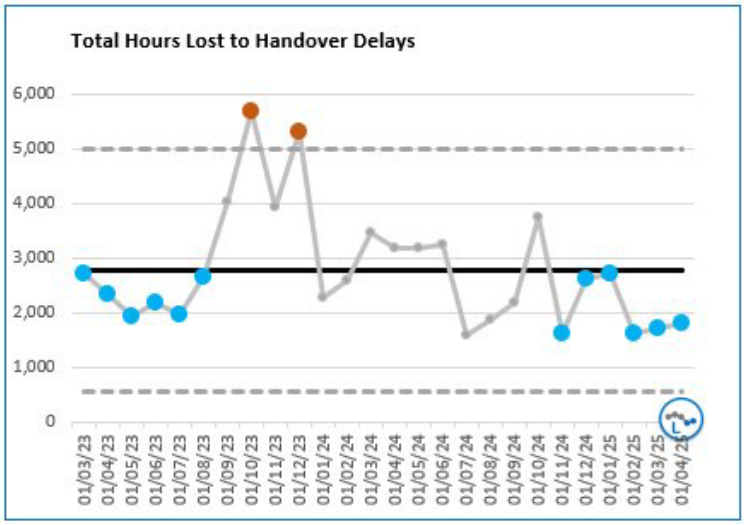
- No outliers e.g. no medical patients in surgical beds
- No boarded patients in corridors
- 80% of patients being discharged through the discharge lounge at Gloucestershire Royal Hospital.

Workstream 4: Frailty

- No escalation beds open within our Same Day Emergency Care services or frailty assessment areas

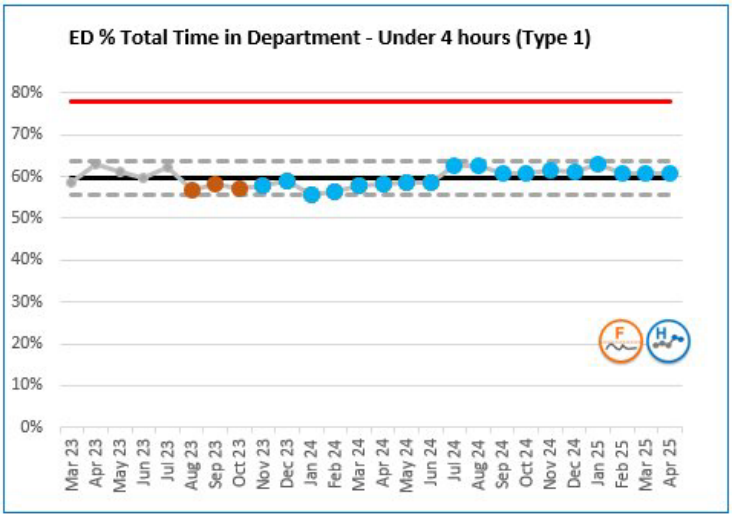
The below tables demonstrate our journey so far with the Emergency Department metrics/measures. The first shows the sustained reduction in the hours lost to ambulance handover delays, from 3200 per month in April 2024 to less than 2000 per month in March 2025.

Table: Total hours lost to handover delays



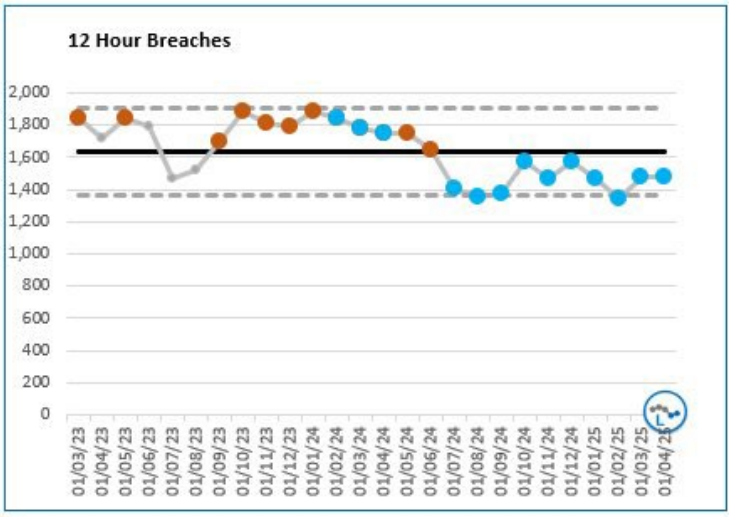
The next table demonstrates the sustained increase in the percentage of patients who are treated and discharged from the emergency department in under 4 hours.

Table: Percentage of Patients who were in the emergency department for under 4 hours



The next table demonstrates a sustained improved position in the reduction of 12-hour breaches.

Table: 12-hour breaches.



Emergency Department initiatives

We have:

- Introduced minor injury and illness walk-in patient streaming and rapid assessment, with refined protocols and action cards.
- Introduced a new and successful emergency department handover processes involving operation manager, site managers, and Community Assessment and Treatment Service attendance to facilitate escalations and referrals.

- Reviewed the long-established Pitstop process, for rapid assessment of patients with major illness and injury, including those who walk in. We have also reviewed the location of Pitstop to improve, safety and privacy and improve flow.

Assessment/short stay workstream initiatives

We have:

- Improved patient flow through rapid assessment processes and optimised short stay bed utilisation.
- Introduced a trial of multiple quality improvement projects, like the Advanced Care Practitioner-led Rapid Assessment and Patient Initiated Follow Up, which have been recognised for external presentation.
- Ongoing PDSA (Plan, Do, Study Act) cycles/trials that highlight continuous improvement, such as those for the Same Day Emergency Care initiatives and the new discharge models. These include nurse-led discharge, one-stop ward rounds and the rapid renal assessment and procedure unit.

Specialty workstream initiatives

We have:

- Illustrated how structured quality improvement projects across different wards have engaged multidisciplinary teams, incorporating training sessions, board rounds, and revamped discharge pathways.
- Improved emphasis on deconditioning initiatives to decrease patients' length of stay and enhance clinical outcomes.

Frailty workstream initiatives

We have:

- Provided optimal care through fewer patient moves and getting patients to the right place efficiently.
- Focused on the successful pilot of the Long-Term Services Supports for patients with chronic illness and the Frailty Assessment Unit, the launch of the Emergency Department Referral List on the Electronic Patient Records, and the accompanying updates (like the refreshed Frailty Dashboard).

These initiatives have resulted in significant operational benefits (e.g., saving bed days) and that future plans include a Direct Admission Bay and Frailty Same Day Emergency Care.

Plans for improvement for 2025-2026

- Each workstream has established clear milestones and actions. For instance, rolling out the new minors streaming process, finalising the Pitstop rapid review assessment protocol, scheduling and refining Emergency Department huddles, and expanding discharge models.
- Ongoing staff engagement and training efforts are required to sustain these improvements, ensuring everyone is up to date with the new pathways and protocols.
- Sustained improvement will be measured across all the programme metrics.

8. Quality Priority: Communication (Martha's Rule)

Background

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha, aged 13, would probably have survived had she been moved to intensive care earlier.

In response to this, and other cases related to the management of deterioration, the then Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's Rule' – a patient safety initiative as part of a wider NHS strategy to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.

Martha's Rule is an NHS England patient safety initiative designed to enhance the ability of patients and their families to escalate/communicate their concerns regarding clinical deterioration.

The 3 components of Martha's Rule are as follows:

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

In May 2024 NHS England announced the implementation of Martha's Rule across 143 pilot sites across the country, with plans to expand to all providers, including community and mental health, in the coming years, as appropriate and subject to government funding. This is part of a wider programme of work to improve the management of deterioration, incorporating work to improve prevention, identification, escalation and response to acute deterioration. **Our Trust is one of the pilot Trusts.**

How have we performed 2024-2025

The Martha's Rule Implementation Group was established to oversee the delivery of this initiative.

The Martha's Rule Implementation Group is responsible for:

- Monitoring implementation progress and reporting to NHS England.
- Ensuring adherence to NHS clinical guidelines.
- Reporting progress, risks and issues to the Quality Delivery Group.

The project follows a phased delivery plan, covering different timeframes from October 2024 to April 2026.

Table: Implementation plan for Martha's Rule

Phase	Timeline	Status
Awareness and engagement	Oct - Jan 2024	Completed
Training and education	Jan - Mar 2025	In Progress
Pilot implementation	Feb - Apr 2025	Ongoing
Evaluation and refinement	Mar - Apr 2025	Planned
Full rollout and embedding	Apr 2025 Onwards	Planned

So far we have:

- Delivered teaching sessions and are conducting training in pilot areas to support staff in implementation of the 3 components of Martha's Rule.
- Assessed staff awareness and confidence and then will evaluate staff understanding, confidence, and use of patient wellness questions within the adult national early warning score.
- Enhanced patient awareness by distributing leaflets to increase patients' and families' awareness about the process.
- Mapped processes so that all Divisions can be fully compliant in staff having 24 hours a day escalation process.
- Enabled, in acute adult in-patient areas, for patient and carers to be able to escalate to the Acute Care Response Team since April 2024.
- Enabled the processes to be delivered in Paediatrics since July 2024 and the patient wellness question is embedded in the Paediatric Early Warning Score nationally.
- Prepared to pilot the maternity patient escalation process in April 2025.
- Planned for the Maternity Early Warning Score updates on BadgerNet, which are in December 2025, to include the patient wellness question.
- Noted that Neonates are out of scope for Martha's Rule as they have fully integrated parental feedback systems in place.

Table: Our progress so far with the 3 Martha's Rule components

Component	Paediatrics	Adults	Maternity
Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.	Nov 2023 national paediatric early warning score charts launched (we have been part of pilots since 2018)	Implementation of fields on adult national early warning score charts	To launch with new maternity early warning score charts Dec 2025
All staff will be able, at any time, to ask for a review if they are concerned that a patient is deteriorating, and they are not being responded to.	Complete July 2024	Since launch of Acute Care Response Team in 2017	Pilot process to be launched April 2025
This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.	Complete July 2024	April 2024	Pilot process to be launched April 2025

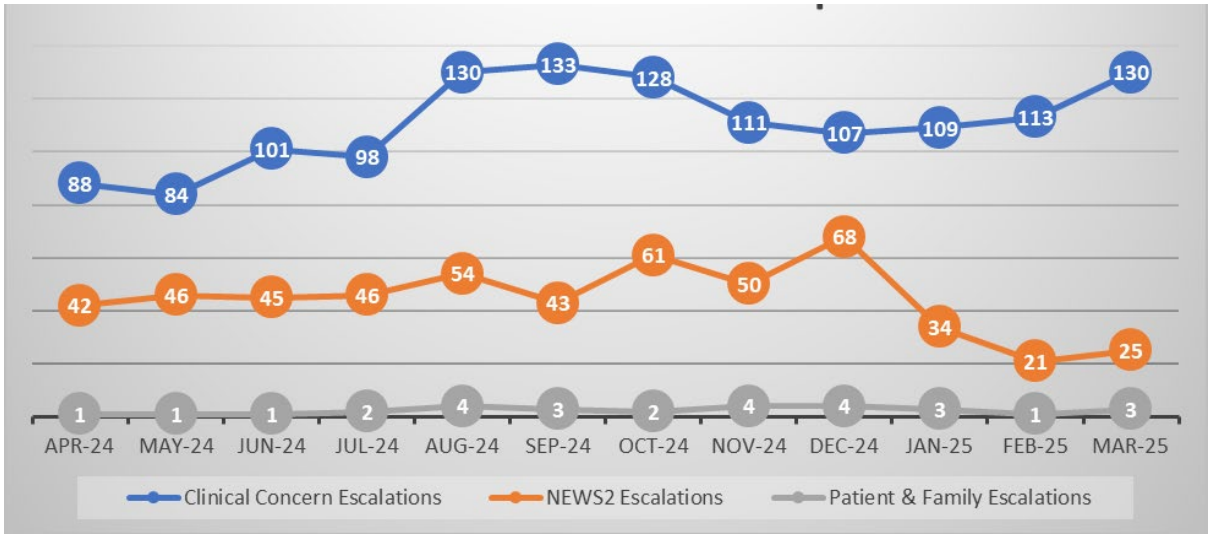
A deeper dive into adults, NEWS2 and Martha's Rule

Early warning scores are systems used in hospitals to identify patients at risk of deterioration, including sepsis, and to prompt timely intervention. In the adult areas we use a system called National Early Warning Score 2. Below are 2 charts that demonstrates Martha's Rule in action at our 2 main hospital sites Gloucestershire Royal Hospital and Cheltenham General Hospital.

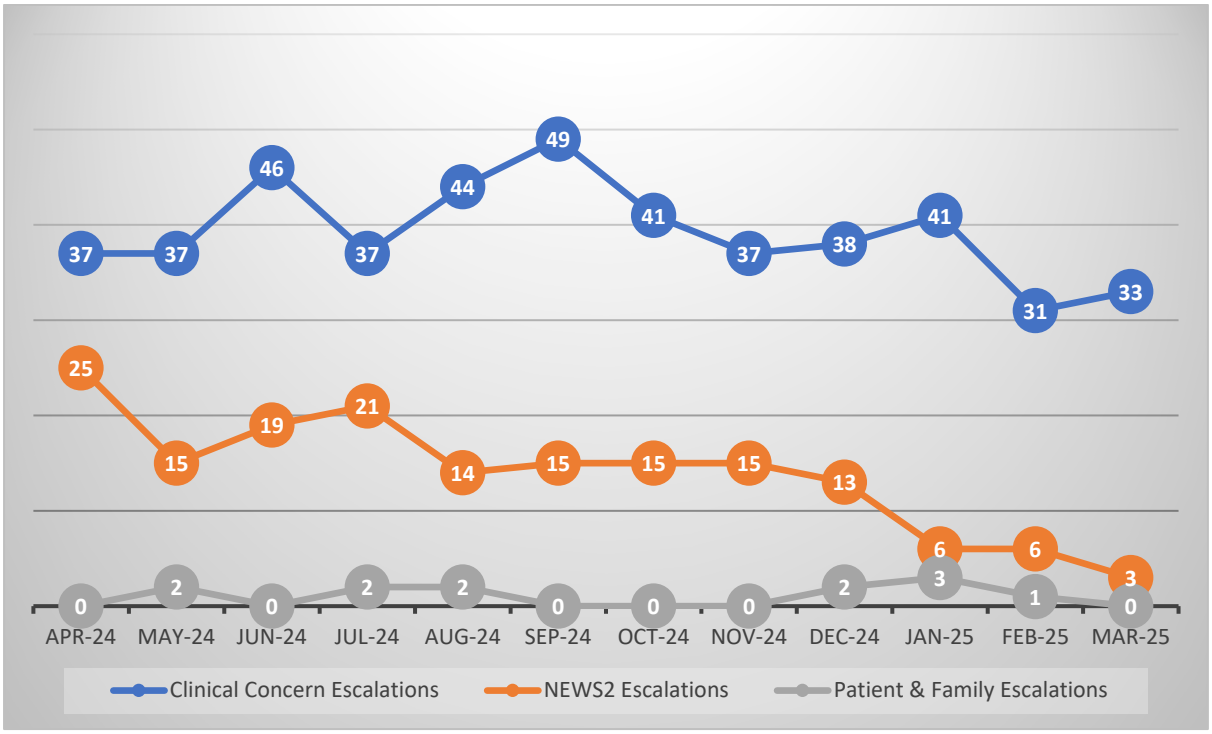
Clinical deterioration is detected by clinical staff every day, using their own skills and knowledge as well as our early warning scores. Each month we have approximately 110 staff escalations of concern from the Gloucester hospital and 40 staff escalations of concern from the Cheltenham hospital to the Acute Care Response Team due staff recognising the need for urgent clinical review and action. The Acute Care Response Team review the patient and make a plan of care for the next steps. Also, early warning scores may alert the clinician to calling the Acute Care Response Team and over the year the scores triggered staff to call the team about 45 times a month at Gloucester and 14 times a month at Cheltenham. Lastly, we have captured data for our patient/family/carer escalations and we have approximately 2/3 calls from Gloucester hospital and 1 call from Cheltenham directly from patients a month to the

Acute Care Response Team as part of the “Martha’s Rule” programme we have been running.

Graph: Escalations of care due to concerns of clinical deterioration by early warning scores, staff concerns and patients/families/carers at Gloucestershire Royal Hospital



Graph: Escalations of care due to concerns of clinical deterioration by early warning scores, staff concerns and patients/families/carers at Cheltenham General Hospital



Learning to date:
Patients and carers are experts in their own clinical condition and often notice signs of deterioration before clinical observations change.

Examples of escalations:

- A family member identified “soft signs” of type 2 respiratory failure prior to any change in NEWS2 score or clinical indication. The process was activated and the patient was reviewed and then admitted to a Critical Care bed.
- A family member identified new confusion in a frail patient with dementia, the patient did not recognise their son, a full review was carried out and with reassurance there was no need for a change in treatment plan.
- A parent challenged the discharge of their son in the emergency department as they had identified morbidity that had not yet established itself in clinical observations and the child was assessed and not discharged.

Plans for Improvement for 2025-2026

The following actions will be carried out to ensure continued progress and sustainability.
We will:

1. Expand training and awareness initiatives and integrate Martha’s Rule training into mandatory staff induction.
2. Enhance data reporting and develop a Business Intelligence (BI) dashboard to track compliance with escalations and outcomes.
3. Refine escalation pathways to address barriers identified through the pilot phase evaluations.
4. Formalise governance integration and embed Martha’s Rule oversight into existing patient safety structures.
5. Continue ongoing patient engagement and use patient stories to improve our communication materials.
6. Continue to feed our learning into the communication safety priority.
7. Collaborate with the Emergency Departments to establish if Martha’s Rule can be implemented safely there.

Part 2.2 Statements of Assurance from the Board

Health Services

The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. 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 2,512 registered nurses and midwives, 736 Healthcare Assistants and 1042 medical staff. 249 Healthcare Scientists and 474 Allied Health Professionals. In addition, our estates are looked after by 910 NHS Gloucestershire Managed Services staff, Further details, including our organisational chart can be found on our website.

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

Health Inequalities

Health inequalities are preventable, unfair and unjust differences in health across the population and between groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The conditions in which we are born, grow, live, work and age can impact health and wellbeing. These are sometimes referred to as the wider determinants of health. For example, people living in areas of high deprivation, with low educational attainment and in poor quality work would be at even greater risk of experiencing health inequalities.

Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare. NHS trusts play a crucial role in addressing health inequalities by focusing on providing equitable access to services and ensuring patients receive a consistent level of care. People living in more deprived areas are more likely to experience poor health, shorter life expectancy and less good access to health and care services due in part to poor housing, lower incomes, and lower health literacy (knowing how to understand and navigate the health and care system). Despite being a relatively affluent county, within Gloucestershire there are pockets of significant social deprivation with 12 neighbourhood areas that are within the 10% most deprived nationally.

Our population is ageing but those from more deprived neighbourhoods are spending increasingly more time in ill health and people are developing multiple long-term conditions at younger ages than before. Whilst there is a stark difference in life expectancy between the most and least disadvantaged men and women. In Gloucestershire, male life expectancy at birth is 79.8 years and female life expectancy at birth is 83.6 years. In 2018-2020, males born in the most deprived deciles of Gloucestershire could expect to live 7 years and 7 months less than those born in the most affluent areas. Females born in the most deprived areas could expect to live 7 years and 10 months less than those born in the most affluent areas.

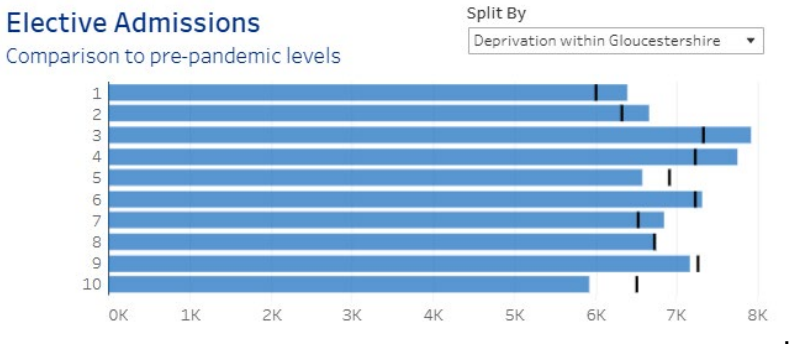
Gloucestershire is characterised by a comparatively small population of ethnic minorities (excluding white minorities). The 2021 Census showed the population of ethnic minorities (excluding white minorities) accounted for 44,765 people or 6.9% of the population; this was much lower than the England percentage of 19.0%. The population of Gloucestershire is, however, becoming increasingly diverse. The population of ethnic minorities (excluding white minorities) increased by 63.8% between 2011 and 2021, from 4.6% to 6.9% of the population. The number of people classed as ‘other white’, which includes migrants from Europe, increased by 55.1%, from 3.1% of the population in 2011 to 4.5% of the population in 2021.

NHS organisations have a legal duty to collect, analyse and publish information on health inequalities every year. NHS England’s Statement on Information on Health Inequalities sets out how organisations should exercise this duty and what information should be published. This includes a list of indicators which organisations should report against. The indicators are aligned to key health inequalities priorities for the NHS, which includes the five priority areas for addressing healthcare inequalities and the Core20PLUS5 approach to reducing inequalities for adults and children and young people.

Elective Recovery

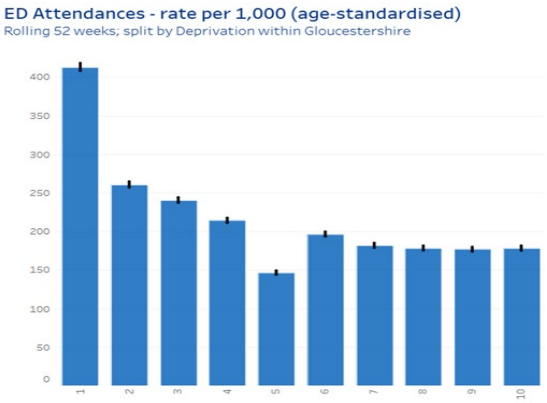
- Elective activity for children’s services is in-line with pre-pandemic levels
- Adult activity is below pre-pandemic levels by 7.4%
- No differences noted by gender or ethnicity

- However, we are carrying out more activity for patients living in the most deprived parts of the county, where we are delivering in excess of pre-pandemic levels.

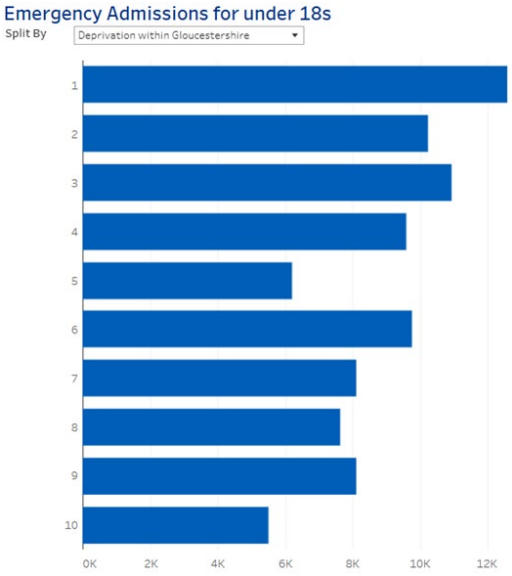


Urgent & Emergency Care

- There are consistent inequalities identified in urgent care. The 10% most deprived patients are significantly more likely to attend the Emergency Department.
    - IMD 1 (10% most deprived): 414 attendances per 1,000 population
    - IMD 10 (10% least deprived): 178 attendances per 1,000 population



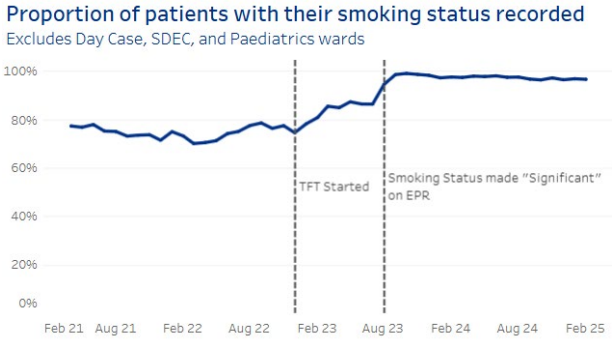
- Similar pattern of attendances by deprivation for children, although the difference between the most and least deprived is less stark.



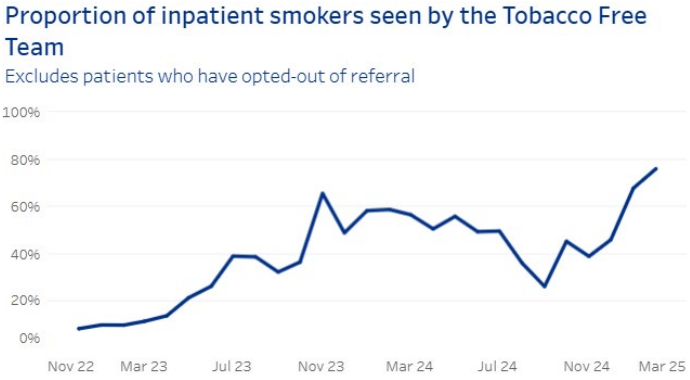
- No differences noted by gender or ethnicity

Smoking Cessation

- 97% of inpatients have their smoking status recorded on admission, compared to 74% prior to the introduction of the Tobacco Free Team

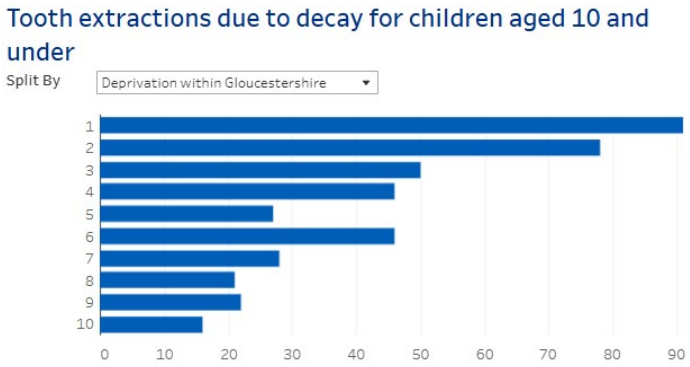


- Last month we saw a record number of patients. As of Feb 2025, 75% of inpatient smokers were offered support from the Tobacco Free Team

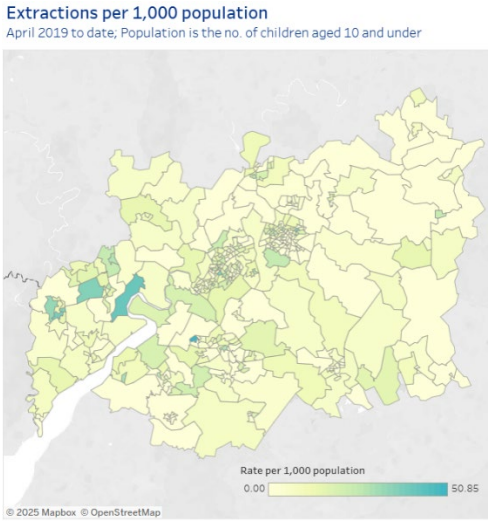


Children's Oral Health

- There is a stark difference in the rate of tooth extractions (due to tooth decay) being carried out between the most and least deprived parts of the county



- No differences noted by gender or ethnicity
- This is a more significant issue in certain parts of the county, in particular the Forest of Dean. Coleford, Cinderford & Newnham have the highest rates of tooth extractions in the county (around 40 extractions for every 1,000 children aged 10 and under)
- There are also pockets of inequalities in other areas:
    - Matson & Robinswood (Gloucester)
    - Oakley (Cheltenham)
    - Parts of Stonehouse (Stroud)



Health Inequalities Group

Over the past year, a Health Inequalities Working Group has been established, with the Executive Director for Improvement and Delivery taking strategic leadership to advance the Trust's commitment to addressing health inequalities. A comprehensive strategic approach and workplan are currently being developed, with collaboration from both internal and external stakeholders to drive meaningful progress in this critical area.

Information on Participation in Clinical Audit

From 1 April 2024 to 31 March 2025, 61 national clinical audits and 6 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides. During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 97% 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 2024/25 are as follows:

Audit Title	Eligible	Participated	Status
BAUS Data & Audit Programme: a) BAUS Penile Fracture Audit	Y	Y	Completed
BAUS Data & Audit Programme: b) BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Y	Y	Completed
BAUS Data & Audit Programme c) Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Y	Y	Completed
Breast and Cosmetic Implant Registry	Y	Y	Ongoing
Case Mix Programme (CMP)	Y	Y	Ongoing
Child Health Clinical Outcome Review Programme (NCEPOD)	Y	Y	Ongoing
Cleft Registry and Audit NEtwork (CRANE) Database *	N	Y	Ongoing
Emergency Medicine QIPs:b) Care of Older People	Y	N	N/A
Emergency Medicine QIPs:c) Time Critical Medications	Y	Y	N/A
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP): a) Fracture Liaison Service Database (FLS-DB)	Y	Y	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP): b) National Audit of Inpatient Falls (NAIF)	Y	Y	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP): c) National Hip Fracture Database (NHFD)	Y	Y	Ongoing
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Y	Y	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK)	Y	Y	Ongoing
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Y	Y	Ongoing
National Adult Diabetes Audit (NDA): a) National Diabetes Core Audit. Includes: Care Processes and Treatment Targets, Complications & Mortality, Type 1 Diabetes, Learning Disability and Mental Health, Structured Education, Prisons and Secure Mental Health Settings	Y	Y	Ongoing
National Adult Diabetes Audit (NDA): d) National Diabetes Inpatient Safety Audit (NDISA)	Y	Y	Ongoing
National Adult Diabetes Audit (NDA): e) National Pregnancy in Diabetes Audit (NPID)	Y	Y	Ongoing
National Adult Diabetes Audit (NDA): g) Gestational Diabetes Audit	Y	Y	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	Ongoing
National Audit of Dementia (NAD)	Y	Y	Ongoing
National Bariatric Surgery Registry	Y	Y	Ongoing
National Audit of Metastatic Breast Cancer (NAoMe)	Y	Y	Ongoing
National Audit of Primary Breast Cancer (NAoPri)	Y	Y	Ongoing
National Bowel Cancer Audit (NBOCA)	Y	Y	Ongoing

Audit Title	Eligible	Participated	Status
National Kidney Cancer Audit (NKCA)	Y	Y	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Ongoing
National Non-Hodgkin Lymphoma Audit (NNHLA)	Y	Y	Ongoing
National Ovarian Cancer Audit (NOCA)	Y	Y	Ongoing
National Pancreatic Cancer Audit (NPaCA)	Y	Y	Ongoing
National Prostate Cancer Audit (NPCA)	Y	Y	Ongoing
National Cardiac Arrest Audit (NCAA)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): c) National Heart Failure Audit (NHFA)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): d) National Audit of Cardiac Rhythm Management (CRM)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): e) Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP): f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Y	Y	Ongoing
National Child Mortality Database (NCMD)	Y	Y	Ongoing
National Comparative Audit of Blood Transfusion: a) National Comparative Audit of NICE Quality Standard QS138	Y	Y	Ongoing
b) National Comparative Audit of Bedside Transfusion Practice	Y	Y	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	Ongoing
National Joint Registry	Y	Y	Ongoing
National Major Trauma Registry [Note: Previously TARN)	Y	Y	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	Ongoing
National Neonatal Audit Programme (NNAP)	Y	Y	Ongoing
National Obesity Audit (NOA)	Y	Y	Ongoing
National Ophthalmology Database (NOD): a) Age-related Macular Degeneration Audit	Y	Y	Ongoing
National Ophthalmology Database (NOD): b) Cataract Audit	Y	Y	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	Ongoing
National Perinatal Mortality Review Tool	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP) a) COPD Secondary Care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP) c) Adult Asthma Secondary Care	Y	Y	Ongoing
National Respiratory Audit Programme (NRAP) d) Children and Young People's Asthma Secondary Care	Y	Y	Ongoing
National Vascular Registry (NVR)	Y	Y	Ongoing
Perioperative Quality Improvement Programme	Y	Y	Ongoing
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	Ongoing
Serious Hazards of Transfusion (SHOT): UK National Hemovigilance Scheme	Y	Y	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA) **	Y	N	PTP
UK Cystic Fibrosis Registry	Y	Y	Ongoing
UK Renal Registry Chronic Kidney Disease Audit	Y	Y	Ongoing
UK Renal Registry National Acute Kidney Injury Audit	Y	Y	Ongoing

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

* This work is carried out in a clinic in Bristol.
** Unable to participate in 2024/25 due to centralisation of the acute take from Cheltenham to Gloucester hospital.

The reports of the above national clinical audits were reviewed (or will be reviewed once available) by the provider in 2024/25.

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?**
British Association of Urological Surgeons (BAUS) Data & Audit Programme: a) BAUS Penile Fracture Audit	This audit will collect data on all patients undergoing surgical repair for penile fracture between 1 April 2022 and 31 March 2024. Data submission will take place from 1 March to 31 March 2025 inclusive. Data submitted and awaiting results.
BAUS Data & Audit Programme: b) BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Launched in early 2024. The audit collected data on all patients undergoing Radical Nephroureterectomy for suspected Upper Tract Urothelial Cancer between 1 July 2022 and 31 July 2023, and subsequent follow-up data including the number of patients who had post-Radical Nephroureterectomy bladder Mitomycin-C and the number of patients receiving adjuvant chemotherapy for T2 or higher disease. Data submission took place between 1 April and 21 May 2024. Results presented and discussed at the team QI meeting in November 24.
BAUS Data & Audit Programme c) Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Audit will take place during 2024/25. Data for this audit will be collected on all patients undergoing transurethral resection of bladder tumour (TURBT) for a new diagnosis of bladder cancer, for whom TURBT was performed between 1 April and 31 May 2024 inclusive. Data submission will take place from 1 November to 13 December 2024 inclusive. Data submitted Dec 24 and we are waiting results.
Breast and Cosmetic Implant Registry	The Breast and Cosmetic Implant Registry (BCIR) was opened on 10/10/2016. It captures the details of all breast implant procedures completed in England, Scotland and Northern Ireland by both the NHS and private providers. Individual surgeons' access National Database for data entry, and have access to individualised feedback on request.
Case Mix Programme (CMP)	The Case Mix Programme (CMP), launched in 1994, is the national clinical audit of patient outcomes from adult critical care. Data are available to review via a public facing webpage, and the most recent comparative unit public report (2023/24) showed the Trust was in line with expected results
Cleft Registry and Audit NEtwork (CRANE) Database CRANE Database 2024 Annual Report	CRANE is a national registry and clinical audit. It evaluates and reports on the delivery of cleft services to children born with a cleft lip and/or palate in England, Wales, Northern Ireland and Scotland. Registry information is presented for children born in 2021-2023 and audit outcomes at 5 years of age are presented for children born in 2015-2017. Report posted: 12 December 2024 The Trust does not run a cleft service, any required details are sent to the Bristol cleft team for submission
Emergency Medicine Quality Improvement Projects (QIPs): Care of Older People	The Trust is not participating in this QIP at present due to departmental priorities. Other Care of the Elderly QIPS are ongoing including improving documentation of Clinical Frailty Scores.
Emergency Medicine QIPs: Time Critical Medications	In the Emergency Department (ED), a time-critical scheduled medication is essentially a medicine that the patient is already on, all doses of which will need to be prescribed and administered in the ED throughout their stay. Data will be collected nationally for people living with Parkinson's who

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	take oral levodopa medication and for patients living with Diabetes Mellitus on insulin.
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy 12 has published a new report based on the first year of care for children and young people after a first paediatric assessment between 1 December 2021 and 30 November 2022 in England and Wales. This report contains a number of key findings relating to the involvement of appropriate professionals, mental health, appropriate assessment and care planning. The Trust continues to participate in the audit.
Falls and Fragility Fracture Audit Programme (FFFAP): a) Fracture Liaison Service Database (FLS-DB)	The Trust has recognised Falls as a Patient Safety priority through the Patient Safety Incident Response Framework (PSIRF) process, and as such has set up an annual Falls Quality Summit process to bring together all relevant audit data and other metrics to support improvement initiatives. Currently improvement work is being undertaken looking at the electronic documentation, suitable areas available to complete 'hot debriefs' following falls and the recording of information of these hot debriefs in order to pull together any learning associated with the incident occurring, whether harm was present or not. The Trust continues to participate in the audit.
Falls and Fragility Fracture Audit Programme (FFFAP): b) National Audit of Inpatient Falls (NAIF)	NAIF audits the delivery and quality of care for patients over 65 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. As of January 2025, this will remain at people aged 65 and over, but include all fractures and Intracranial Head Injuries. The 2024 National Audit of Inpatient Falls (NAIF) report states that falls prevention activity should not focus solely on older people's wards, finding that nearly half of all inpatient femoral fractures (IFFs) occur on general medical wards (almost twice the proportion of IFFs that happen in older people's wards). To address the potential for harm caused by hospital-acquired deconditioning, this report presents a new approach to risk factor assessment that focuses on promoting activity to ensure each patient is fit to move as safely as possible. 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. This includes management of post-fall checks and prevention of deconditioning. Initiatives are underway to improve the process and documentation of 4AT assessments, by the Admiral Nurse.
Falls and Fragility Fracture Audit Programme (FFFAP): c) 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.

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	NHFD provides 3 monthly update reports allowing us to benchmark our Trust against other hospitals, these reports are also discussed at governance meetings
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	The Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) programme, aims to improve healthcare for people with a learning disability and autistic people. LeDeR 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. LeDeR summarises the lives and deaths of people with a learning disability and autistic people who died in England in annual reports. The Trust continues to participate and reviews national recommendations to identify quality improvements.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK)	MBRRACE-UK conducts national surveillance and investigation of the deaths of women and babies who die during pregnancy or shortly after pregnancy in the UK. By investigating these deaths, MBRRACE-UK hopes to prevent similar deaths or serious complications in the future, to support the delivery of safe, equitable, high-quality and patient-centred maternal, newborn and infant health services. *This year themed reports have been published on;* • Enquiries into Maternal Deaths from thrombosis and thromboembolism, malignancy and ectopic pregnancy 2020-2022, and morbidity findings for recent migrants with language difficulties. • The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death The Trust reviews MBRRACE UK recommendations 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.
National Adult Diabetes Audit (NDA): a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings	The NDA helps improve the quality of diabetes care by enabling participating NHS services and organisations to: • assess local practice against National Institute for Health and Care Excellence (NICE) guidelines • compare their care and outcomes with similar services and organisations • identify gaps or shortfalls that are priorities for improvement • identify and share best practice • provide comprehensive national pictures of diabetes care and outcomes in England and Wales Through participation in the audit, local services are able to benchmark their performance, identify where they are

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	performing well, and improve the quality of treatment and care they provide. 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.
National Adult Diabetes Audit (NDA): d) National Diabetes Inpatient Safety Audit (NDISA)	NDISA records the details of any adult who has one of four avoidable complications which can occur in inpatients with diabetes; Severe inpatient hypoglycaemia, Diabetic **Ketoacidosis** (DKA), Hyperglycaemic Hyperosmolar State (HHS) and Diabetic foot ulcer. Linking with other health datasets allows the identification of high-risk demographics which enables the development of proactive processes to reduce the occurrence. The Trust continues to submit to NDSIA Harms on harms that are reported, errors are discussed by the Diabetes Team.
National Adult Diabetes Audit (NDA): e) National Pregnancy in Diabetes Audit (NPID)	NPID is part of the NDA and measures the quality of pre-gestational diabetes care against NICE guidelines and the outcomes of pre-gestational diabetic pregnancy. The audit will answer the following three key questions: • were women with diabetes adequately prepared for pregnancy? • were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother? • did any adverse outcomes occur? 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): g) National Gestational Diabetes Mellitus (GDM) Audit	The National GDM Audit is a 3-year programme, part of the NDA. The focus on the first and second year was to raise awareness of the audit and to engage with maternity services to encourage improved completion of the data items required in the MSDS. Data that is routinely collected for maternity services nationally via the Maternity Services Data Set (MSDS) and linkage with other existing NHS datasets, is being utilised. In 2025 a dashboard will be available for services to see their performance in the key metrics relating to GDM. In the future there will be a national report.
National Audit of Care at the End of Life (NACEL)	The National Audit of Care at the End of Life (NACEL) has published its latest report. Based on 7,620 case note reviews, 3,600 quality survey responses and 11,143 completed staff reported measures in England and Wales, this report sets out the findings of the fourth round of NACEL, which took place in 2022. The NACEL action plan has been updated based on the 22/23 audit results and following presentation at the Hospital

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	Mortality Group, Grand Round & the End of Life (EOL) 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. A report on *Care in General Hospitals 2023-2024*, underscores the need for a continued strong focus on governance, monitoring and oversight of dementia care. Trust QIs in progress include; • Working with expert by experience groups on transformation work on Guiting Ward. Two activity coordinators have been recruited to help with cognitive stimulation, we are in the process of recruiting enhanced care support workers too • Improved Datix reporting of falls, pressure ulcers, violence and aggression, complaints and the ability to highlight dementia, delirium or another vulnerability • A 'bespoke training package for staff • Ongoing work on ensuring Trust hospitals are Dementia Friendly environments, including current transformation work on Guiting Ward.
National Bariatric Surgery Registry	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.
National Audit of Metastatic Breast Cancer (NAoMe)	The NAoMe aims to report on all patients diagnosed with metastatic breast cancer in NHS hospitals in England and Wales. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NAoMe webpage for review. The current focus of the audit is on improving the completeness of key data items
National Audit of Primary Breast Cancer (NAoPri)	The purpose of the National Audit of Primary Breast Cancer (NAoPri) is to evaluate the patterns of care and outcomes for people diagnosed with primary breast cancer in England and Wales, and to support services to improve the quality of care for these people. As above, data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NAoPri webpage for review. Indicators suggest that GHT is performing better than the nation average for patients receiving breast cancer surgery within 12 months of diagnosis and patients who were recorded as having contact with a Clinical Nurse Specialist (CNS)

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National Bowel Cancer Audit (NBOCA)	Tim Cook and Jonathan Cutting listed as leads. Participation is confirmed, however the quality of the data uploaded from the Trust is in question. The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for people diagnosed for the first time with bowel cancer in NHS hospitals in England and Wales, to be able to improve the quality of the care that people receive. NBOCA has been a mandatory national audit since 2010.
National Kidney Cancer Audit (NKCA)	The purpose of the National Kidney Cancer Audit (NKCA) is to evaluate the patterns of care and outcomes for people diagnosed with kidney cancer in England and Wales and to support services to improve the quality of care for these patients. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NKCA webpage on a quarterly basis. All indicators have been found to be within control limits when compared with national data
National Lung Cancer Audit (NLCA)	The NLCA supports NHS lung cancer services in England and Wales to improve the quality of care for people diagnosed with lung cancer by providing information on patterns of care and patient outcomes. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NLCA webpage on a quarterly basis. All indicators have been found to be better than the national average, or within control limits
National Non-Hodgkin Lymphoma Audit (NNHLA)	The purpose of the National non-Hodgkin lymphoma Audit (NNHLA) is to evaluate the patterns of care and outcomes for people diagnosed with non-Hodgkin lymphoma (NHL) in England and Wales, and to support services to improve the quality of their care. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NNHLA webpage. Although not all indicators can be viewed for GHT due to low case volumes, where available each indicator is above the national average, or within the 95% confidence level.
National Ovarian Cancer Audit (NOCA)	More than 7,000 women in the UK are diagnosed with ovarian cancer every year, but we know that outcomes vary considerably across the country. This new audit, drawing on the work of a feasibility pilot audit which began in 2019, will produce granular information on diagnosis, treatment and surgery, to allow us to assess how we can improve care in England and Wales, and create better results.
National Pancreatic Cancer Audit (NPaCA)	The audit will be a really important tool, helping us to accelerate national efforts to improve the care and treatment of patients diagnosed with pancreatic cancer.

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	It will gather real world information from databases across England and Wales, allowing better comparisons to be made, and revealing where shortfalls need to be addressed. Pancreatic cancer is one the least survivable cancers, with virtually no improvement seen in survival rates in the UK over 40 years from the 1970s. Data are uploaded via the cancer outcomes and services data set (COSD) and data completeness and selected indicators are presented at a trust level via the NPaCA webpage and available for regular review, though care should be taken in regards to the low case numbers.
National Prostate Cancer Audit (NPCA)	The National Prostate Cancer Audit (NPCA), which is part of the National Cancer Audit Collaborating Centre (NATCAN), has published a report on care received by men diagnosed with prostate cancer in England and Wales from 1 January 2019 to 31 December 2023. Published: 09 Jan 2025 and discussed at the team monthly QI meeting March 25
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. 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 CPR attempts are highlighted and reviewed, and if appropriate, simulated to help focus teaching and lessons learned.
National Cardiac Audit Programme (NCAP): c) National Heart Failure Audit (NHFA)	NHFA collects data on patients with an unscheduled admission to hospital in England and Wales who are discharged with a primary diagnosis of heart failure. The audit aims to drive up the quality of the diagnosis, treatment and management of heart failure, to improve mortality and morbidity outcomes for heart failure patients. The specialist input for the annual report April '23- March '24 is 61.5% The recent initiatives include: Establishment of a nurse-led inpatient heart failure service in GRH (February '24)

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	Establishment of a 'virtual ward' to manage ambulatory heart failure patients within a virtual environment at home rather than in hospital. The new service enabled an increase in hours available for auditing. Current data shows the specialist input since the nurse lead service started is now 88.6% thus achieving BPT.
National Cardiac Audit Programme (NCAP): d) National Audit of Cardiac Rhythm Management (NACRM)	NACRM collects information about all implanted cardiac devices and all patients receiving interventional procedures for the management of cardiac rhythm disorders in the UK. The audit aims to improve the care of patients who undergo pacemaker, implantable cardioverter-defibrillator (ICD), cardiac resynchronization therapy (CRT) and cardiac ablation procedures. Trust reports are reviewed at the Arrythmia 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): e) Myocardial Ischaemia National Audit Project (MINAP)	MINAP contains information about the care provided to patients who are admitted to hospital with acute coronary syndromes. Quality of care is assessed against a set of quality improvement metrics derived from national and/ or international standards and guidelines. We are attaining the new data entry submission targets. This annual report covers April 23- March '24 Includes data from CGH before the department move to GRH in Feb '24 We met the target of over 70% of STEMI patients DTB. We align with the National level of 51% of eligible NSTEMI patients undergo angiography with 72 hours We met the target of 90% of patients receiving an in-patient echo and achieved the target for secondary prevention medication.
National Cardiac Audit Programme (NCAP): f) National Audit of Percutaneous Coronary Intervention (NAPCI)	NCAP collects data on all activity carried out in NHS hospitals and a selection of private hospitals throughout the UK. This provides an overview of the delivery of PCI services in the UK including activity and trends, and reporting on several specific quality improvement metrics, derived from national and/or international standards and guidelines. The Trust currently meets recommendations, 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. NICE recommended antiplatelet drug use in STEMI cases is higher at 76.8% than national average of 40%. 30-day mortality at 1.71% is lower than national average for matched activity/volume over the last reporting period.
National Child Mortality Database (NCMD)	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

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	childhood. Over the past 12 months this has included thematic reports on; - Learning from deaths of children with a learning disability and autistic children - Child deaths due to asthma or anaphylaxis The Trust continues to participate in the NCDM and reviews local data at Perinatal and Paediatric Clinical Governance meetings. Action plans are in progress for both of this year's reports. The Trust works closely with the ICB in these respects.
National Comparative Audit of Blood Transfusion: a) National Comparative Audit of NICE Quality Standard QS138	Report published at the end of March – review completed and ongoing dissemination to the team Key objectives • Provide the opportunity to evaluate local evidence of progress towards compliance with the four quality statements in the NICE Quality Standard for Blood Transfusion since the 2021 audit • Provide data to hospital teams to allow their understanding of what steps they can take to implement PBM and to measure their effectiveness in improving patient car • Allow the transfusion community, including the National Blood Transfusion Committee, to benchmark the progress of PBM and its effect on improving patient outcomes
b) 2024 National Comparative Audit of Bedside Transfusion Practice (re-audit)	Key objectives • The key aim of this re-audit is to determine whether the current British Society of Haematology guideline 'Administration of Blood Components' (2017) is being followed and to determine if there has been any improvement in compliance compared to previous audit cycles. It also looks to assess whether any specially developed documentation or technologies used to support bedside transfusion practice have a beneficial effect. The audit seeks to understand the reasons for any areas for non-compliance, to help identify the barriers and facilitators of good practice. Action Plan • Blood transfusion Champions to meet, discuss & plan to improve practice. • SL to meet with Senior managers & discuss Action Plans. • Re-audit in next 12 months. • Waiting for the outcome of audit on National Guidance on improving practice.
National Early Inflammatory Arthritis Audit (NEIAA)	The NEIAA aims to improve the quality of care for people living with rheumatic diseases by collecting demographic and care quality data on all eligible newly diagnosed patients over the age of 16 in rheumatology departments across England and Wales. Data collected and assessed includes waiting times, time to treatment, clinical response to treatment, and patient-

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	reported outcomes. Performance is measured against NICE quality standards (QS). Last year The Trust was a negative outlier for QS2 and QS3. Improvements in data collection and data accuracy are in progress, with a system for a new staff member entering the information on the NEIAA website for any newly diagnosed EIA. This will be reviewed with the upcoming NEIAA data report due in the Spring.
National Emergency Laparotomy Audit (NELA)	The latest NELA report was published in October 24. Data continues to be uploaded to the NELA website, with quarterly joint surgical and anaesthetic NELA meetings to review results.
National Joint Registry National Major Trauma Registry [Note: Previously TARN)	A new portal has been developed following the national outage of the previous version. The data backlog is currently being entered both retrospectively and prospectively.
National Maternity and Perinatal Audit (NMPA)	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. In 2024 a report was published on 'Evaluating hospital and crisis care for perinatal mental health'. 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 consistently high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care and supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes. The audit reports 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 actions are in progress to improve data recording of intraventricular haemorrhage (IVH) and an audit project underway which has led to the introduction of continuous temperature monitoring from delivery to admission into the neonatal unit (NICU).
National Obesity Audit (NOA)	This audit looks primarily at obesity outcomes, treatment and access to weight management services and uses hospital episode statistics data alongside GP information to create a picture of obesity across the country. Dashboards are updated on a quarterly basis for review.
National Ophthalmology Database (NOD): a) Age-related Macular Degeneration Audit	The most recent AMD report was published in 2023
National Ophthalmology Database (NOD): b) Cataract Audit	The NOD webpage provides information on posterior capsular rupture (PCR) which is the most common complication during cataract surgery. Data is from the FY 22/23 and outcomes for GHT are within expected limits.

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National Paediatric Diabetes Audit (NPDA)	The NPDA collects information on the care and diabetes outcomes of all children and young people receiving care from paediatric diabetes teams in England, Wales and Jersey. The sole aim is to provide information that leads to an improved quality of care for those children and young people living with diabetes. Reports and recommendations are reviewed by the Trust Paediatric Diabetes Team Since 2021/22 data was submitted, there has been changes to the process; NPDA platform now enables live data capture, this means data is now input at the time of practice by clinicians. Twinkle has been approved and will be implemented next year, which will improve data validity. At the end of each quarter, checks are done to ensure that patients have had their health checks completed on time and any patient who hasn't had their checks will be followed up. It is expected that this will be reflected in next year's audit results.
National Perinatal Mortality Review Tool (PMRT)	PMRT aims to support objective, robust and standardised local reviews of care when babies die. This is to provide answers for bereaved parents and their families about whether the care that they and their baby received was appropriately safe and personalised or whether different care may have changed the outcome. The second aim is to ensure local and national learning results from review findings to improve care, reduce safety-related adverse events, and prevent future baby deaths. The PMRT is designed to support the review of baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths, and neonatal deaths. For about 90% of parents, the PMRT review process is likely to be the only hospital review of their baby's death that will take place The Trust participates 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. National reports are disseminated at Maternity Clinical Governance meetings. Local PMRT summary reports are completed and shared with the Maternity Delivery Group/Trust Board. Actions are reviewed at monthly PMRT meetings.
National Respiratory Audit Programme (NRAP) a) COPD Secondary Care	NRAP's COPD secondary care workstream 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. A QI is underway in offering smart phone apps to COPD patients to help them self-manage their condition. The business intelligence spreadsheets tracking

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	admissions is continuing to support the identification of patients with COPD.
National Respiratory Audit Programme (NRAP) c) Adult Asthma Secondary Care	NRAP's adult asthma secondary care workstream 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) d) Children and Young People's (CYP) Asthma Secondary Care	NRAP's children and young people's asthma secondary care workstream 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 Vascular Registry (NVR)	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 specialty meetings
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.
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.

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?
	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. 3. Reduction in vacancies in therapy for Physio, OT, SALT and psychology 4. Activity coordinator roles on Woodmancote ward to improve wellbeing and rehab of ward patients 5. Community Neuro Rehab team now embedded to increase community therapy offer and improve access to stroke Early Supported Discharge team 6. Work with ward nurses to improve training and management of continence and low mood/anxiety 7. Move of HASU into a dedicated ward (Hatherley) with therapy room and co-located ambulatory area for SDEC reviews (January 2025) 8. Ongoing work with the ICB/ICS reviewing the system pathway and resource 9. Business cases drafted for additional resource to provide 7-day therapy cover and ACPs
Serious Hazards of Transfusion (SHOT): UK National Hemovigilance 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. Where risks and problems are identified, SHOT produces recommendations to improve patient safety. The recommendations are put into its annual report which is then circulated to all the relevant organisations including all of the reporting hospitals. Reports reviewed and actioned, but difficulties have been highlighted due to the infected blood inquiry report stating that NHS trusts should have a method of monitoring / evidencing the SHOT recommendations and if / how they are implemented. These recommendations are for the Transfusion Practitioner to review and implement, which is impossible given the very high-level nature and content of what SHOT are asking for. This has been fed back to SHOT, and a gap analysis is in progress for escalation at Quality Delivery Group due unfeasibility of the recommendations
Society for Acute Medicine Benchmarking Audit (SAMBA)	SAMBA is a national audit of acute medical care. The aim is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and progress at seven days after admission and to provide a benchmark for each Trust with the national average. The last audit took place on 20th June 2024. The Trust was unable to participate due to it occurring at around the time of

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?
	the centralisation the acute take from CGH to GRH, and being understaffed to do the audit. The aim is to ensure a full audit for 2025. Ongoing actions following last year's SAMBA include; - Further increase in AMU consultant body by 2.55 as of this month. - Amending job roles (Cinapsis consultant now doing 2 hours PTWR in ED) to reduce time to PTWR for patients admitted out of hours - Good data from medical assessment zone in AMU showing this stream is working to reduce patients in ED, expanded from 8 beds to 12 in past year.
UK Cystic Fibrosis (CF) Registry	The purpose of the UK CF Registry is to improve the health of people with cystic fibrosis. This includes; - helping people with CF and their families understand CF - 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 out the best ways to treat cystic fibrosis The annual CF Registry Conference in October is attended by the Trust. The annual report provides regional feedback and highlights opportunity for quality initiatives.
UK Renal Registry Chronic Kidney Disease Audit	The UK Renal Registry (UKRR) collates data from kidney centres and hospital laboratories to improve the care of patients with kidney disease in the UK. Data collection includes cases of acute kidney injury (AKI) in primary and secondary care in England and cases of advanced CKD in secondary care, not on KRT, in England and Wales. Data is also collected about children on dialysis or with a kidney transplant. 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.
UK Renal Registry 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 UK Renal Registry (UKRR) collects data on approximately 500,000 people with an AKI each year. The objectives of the audit are; - 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

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?
	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.

Local audits and Quality Improvement Projects

In the Trust 207 local clinical audits and Quality Improvement projects were registered in 2024/25 and these are reviewed and actioned locally. In addition, 41 'Silver' quality improvement projects which graduated through the Gloucestershire Safety and Quality Improvement Academy during 2024/25.

Some examples of actions associated with audits and completed Quality Improvement projects are as follows:

Aim: To increase the number of discharge summaries sent from GHNHSFT to community pharmacies via PharmOutcomes to 500 by Oct 2024. Changes: Focus on Frailty sending DMS referrals for all patients on their ward due to COTE wards contributing to the largest proportion of discharges, sending DMS referrals via EPMA following launch, creating inclusion criteria for patients suitable for DMS referrals and sharing this with the pharmacy department, creating a SOP and sharing with department. Results: GHNHSFT have increased the average number of discharge summaries sent on Pharm Outcomes from 120/month in Sept 2022 to an average of 397/month, achieving the CQUIN target of >1.5%. Next steps: Statistics will be monitored, reminder emails to send DMS referrals if numbers begin to decline. Working with community pharmacies to improve their ability to complete the DMS referral in primary care.
Aim: to improve trainee self-development time uptake to 80% (of recommended guidance) by April 2024 Changes: Afternoon SDT allocated by a Care of the Elderly (CotE) ward-based trainee to other trainees whenever ward staffing larger than minimum, new consultants to ward informed and educated about trainee SDTs, afternoon SDT allocated by CotE rota coordinators with department-wide senior approval Results: increase in trainee SDT uptake from 0.4 hours/trainee/week to 2.3 hours/trainee/week by the end of the third PDSA cycle Next steps: re-evaluate trainee SDT uptake on a regularly basis to see if any further changes are necessary and disseminate our work to other departments across the country
Aim: to reduce use of single use cups by 50% in 3 months in ED Changes: staff education and raising awareness: green initiatives day, staff mug secret Santa, reusable cups introduced Results: disposable cup numbers reduced by average of 75%, monthly spending on cups reduced by 44% (incl. purchasing disposable as well as replacing lost reusable cups) Next steps: to remove all reusable cups from ED, consider viability of domestic housekeeper to reduce workload for nursing team
Aim: complete a frailty score assessment for 10% of Myelofibrosis patients who are over the age of 65 years, over a five-week period. Changes: staff training, extra appointments scheduled, Rockwood scoring tool added to Infoflex – score >4 requiring a further follow up appointment at 12 weeks. Results: 30% of MF patients with frailty score recorded consistently, exceeding target of 10%. Implementation of all patients attending clinic face to face to have weight recorded on monthly basis. Next steps: roll out frailty score assessment for Myelodysplastic and AML patients. Search for frailty scoring tool that can be used on patients <65 years

Aim: To reduce the monthly rate of postpartum haemorrhage>500mls from 41% to below the national average PPH rate of 25% of births and major obstetric haemorrhage >1500mls in Gloucestershire Royal Hospitals NHS Foundation Trust from 5% to 3% in 6 months

Changes: compliance with completion of antenatal risk assessment at booking at 36 weeks on Badgernet, compliance with admission/ intrapartum risk assessment, compliance with emergency management proforma,
evidence of early identification of risks and distribution of learning through Comms lead and multi-disciplinary team talk, Postpartum Haemorrhage / Major Obstetric Haemorrhage audit

Results: Major Obstetric Haemorrhage rates now below national target (5% to 2.9%) Postpartum Haemorrhage rate 33%.

Next steps: business case for blood product management submitted, weekly audit of Postpartum Haemorrhage, focus on reduction in PPH, and reduction of loss during instrumental deliveries, introduction of oxytocin infusion for 1000mls and ongoing bleeding regardless of cause, ongoing clearing of backlog with Microsoft forms.

Participation in Clinical Research

Research and Innovation 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 2024/25 the Research and Innovation team has recruited to 80 open National Institute for Health and Social Care portfolio studies. This is a slight drop from 2023/24 where the team supported 100 open studies, but this is not a concerning drop, as activity is following national trends across the portfolio.

Of these studies, 15 (19%) are commercially sponsored trials, another slight drop from the 21% in 2023/24. However, this is not concerning considering the slight reduction in open, recruiting studies.

Despite this drop in the number of open portfolio studies, the Research and Innovation team has recruited 1,850 participants to these open studies which is a slight increase on the year-end total of 1,736 for 23/24. The total for 2024/25 may increase slightly over the next few weeks following this report as some central uploading of recruitment figures by sponsors can be delayed.

We are regularly approached to act as a site for commercially sponsored studies and continue to express an interest in all studies that the Research and Innovation team and Clinical Teams are able to support. Not all studies are suitable for the Trust's population and we are facing some issues opening studies with the current pressure on the Pharmacy Manufacturing unit, but we are monitoring these pressures and meeting regularly with Pharmacy to work on solutions. This activity has been achieved against a backdrop of a major reorganisation and staffing issues in the team, including a complete change in the senior management structure within Research and Innovation.

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. The Research and Innovation Team have successfully bid for and secured funding to evaluate an AI Tool designed to review prostate scans to reduce the need for invasive biopsies, as well as NHS England "Net-Zero" bids to evaluate projects designed to improve and reduce the carbon footprint in the areas of hand-surgery and midwifery. Although these projects are at an early stage, we anticipate being able to report outcomes for these studies in the next 12 months.

We continue to explore all opportunities to submit funding/grant bids for innovation and research and the team is currently waiting for the outcome of a first stage Decarbonisation project application worth several million pounds.

Care Quality Commission

The Trust continues to be registered with Care Quality Commission and the overall Trust rating remains at 'Requires Improvement'. Care Quality Commission last undertook a well-led inspection in 2022 (12-13 April and 14-16 June) and the overall rating for the Trust did not change in 2024/2025.

Enforcement notice - maternity

The Care Quality Commission inspected Maternity Services at the Gloucestershire Royal Hospital's site in March 2024. On 9 May 2024, the Trust was notified of Care Quality Commission's decision to serve an enforcement notice under section 31 of the Health and Social Care Act. The Care Quality Commission imposed conditions on our registration in respect of the maternity service and they took this action as they believed a person will or may be exposed to the risk of harm if they did not do so. Eight conditions were imposed, and the Trust have provided the Care Quality Commission with the required monthly update reports with the maternity service dashboard (data). Significant progress has been made with 2 out of the 8 conditions now fully met and 6 conditions nearing completion to be fully met. The findings of the Care Quality Commission inspection were of significant concern to the Trust board and the Executive Lead for Maternity Services. Support has been provided to the service and regular briefings on progress have been provided by the service leads at every public board session since the notice was received.

Inspection reports published

After significant delays, on the Care Quality Commission's behalf, the final maternity service inspection report from the March 2024 inspection was published in January 2025. The Maternity service retained an inadequate rating received in 2022. Also in January 2025, the Care Quality Commission published the Emergency Department report from an unannounced inspection in December 2023 and the service retained a "requires improvement" rating.

Inspection activity

There has been only one Care Quality Commission inspection in medicine and oncology services at the Cheltenham General site in July 2024 and the Trust are still awaiting the publication of the final report (it is likely that the service will be rated as "good" overall as this was the rating in the final draft of the report).

Information Governance Incidents

Information Commissioner's Office reportable IG incidents.

There have been three incidents reported to the Information Commissioner's Office since Apr 2024

ICO & Datix ref	Date reported to ICO	Incident	ICO action
37242 INC1939	24/05/2024	Personal identifiable data shared in error, in response to a FOI request. A request was processed through whatdotheyknow.com. The information was provided to whatdotheyknow.com by an attached spreadsheet. The information that was intended to be shared was included on a displayed worksheet tab. A hidden sheet included a pivot table and access to additional patient level data that had been used to create the high-level aggregated data in the displayed sheet. The FOI team where not aware of this hidden data and attached the spreadsheet in its entirety.	Information Commissioner's Office acknowledgement ref: IC-0235-2024 Follow-up questionnaire sent to Information Commissioner's Office in Aug 2024. Information Commissioner's Office confirmed no further action in Sep 2024.
38033 INC5491	16/07/2024	A member of staff took photo of email of referral on his phone in order to facilitate taking bloods listed in email. Blood tests include HIV and hepatitis screening. Patient identifiers thought to have been excluded, but name and local hospital identifier were captured. After work accidently posted on Facebook	Information Commissioner's Office acknowledgement ref: IC-320567-T5G2 No further contact since.
38618 INC8402	10/08/2024	Member of staff with extensive access to the electronic staff record system ESR found to have accessed a number of their managers and colleagues home addresses. Motive for	Information Commissioner's Office acknowledgement ref: IC-324998-D6S6 Follow-up questionnaire sent to Information Commissioner's Office in Aug 2024.

		access has been raised as a safeguarding concern as the staff in question is currently the subject of a disciplinary investigation, members of staff whose address has been accessed include line management, and the appointed lead investigator and witnesses involved in the disciplinary investigation	No further contact since.

Non-Information Commissioner's Office reportable Information Governance incidents.

The following have been submitted as Data Security & Protection (Information Governance) incidents to Datix since Apr 2024.

Classification	**Number**
Confidentiality	146
Integrity	31
Availability	7

Learning from Deaths in the NHS

Background

Learning from deaths, especially in healthcare, is crucial for improving patient care, preventing future avoidable deaths and supporting bereaved families.

- All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners.

- Any deaths that demonstrate identified triggers have a structured judgment reviews (SJR) which is a detailed examination of the circumstances surrounding the death, aiming to identify any issues in care and areas for improvement.

- All mortality reviews are reported through Specialty Mortality and Morbidity meetings and all specialties receive individual monthly data on SJR performance

- There are national requirements for reviews for identified groups of patients. Learning Disability Reviews, Child Death Reviews, Perinatal Deaths, and associated learning reports and national audits are conducted.

How have we performed during 2024-2025

- Hospital mortality rate for elective admissions is 0.5%, with the national average at 0.6%.

- Hospital mortality rate for non-elective admissions is 3.1%, with the national average at 3.4%.

- The current SHMI (Summary Hospital-level Mortality Indicator) is 1.15, with 2855 observed deaths and 2485 expected deaths.

- All serious incidents have action plans based on identified learning.

Family Feedback

- Positive feedback is consistently high regarding the care provided.

- Negative feedback trends relate to communication of next steps.

Plans for Improvement in 2025-2026

- Continuous improvement processes will monitor the mortality data and feedback from families and staff.

- National Campaigns such as ‘Dying Matters Week’ will be utilised for a Trust wide focus on what matters to patients and their families.

- Leads from the End-of-Life Improvement Group will attend the Trust wide Morbidity and Mortality meetings in order to implement areas for improvement in real time.

- Data quality work will be undertaken with the clinical coding for patients' co-morbidities to ensure an accurate for hospital mortality rates.

Statement from NHS doctors in Training Rota Gaps

Context and Background

Rota gaps remain a significant challenge for both doctors in training and the wider NHS workforce, with direct impacts on trainee wellbeing, morale, and patient safety. These gaps often result in longer hours, increased workload intensity, and additional responsibilities for those in post, while also risking the quality of care delivered to patients. Within our Trust, the prevalence and duration of rota gaps continue to vary by specialty, with medicine and acute care areas experiencing the largest and most persistent shortages.

The national context reflects a similar picture: recent surveys and reports highlight that rota gaps of 15–20% are now common in key specialties, with many gaps lasting three to six months or longer. The General Medical Council and Health Education England have both increased their focus on rota gap monitoring, with new questions in the National Training Survey to better capture the impact of rota design and workload on education, training, and patient care.

Monitoring, Delivery, and Assurance

The Guardian of Safe Working continues to provide quarterly reports to the Trust Board, highlighting the scale and impact of rota gaps and exception reporting across all specialties. These reports, combined with annual Quality Panel feedback from NHSE appointed trainees, offer valuable insights into the lived experience of doctors in training and the effectiveness of mitigation strategies.

The National Training Survey, now enhanced with specific questions on rota design and workload, provides a comprehensive nationwide overview, capturing feedback from both NHSE-appointed trainees and locally employed doctors. This data is critical for benchmarking our performance and identifying areas for improvement.

Rota Gap Mitigation Strategies for 2025/26

Building on last year's efforts, the Trust has expanded and refined its mitigation strategies to address rota gaps more sustainably:

- **Advanced Practice Roles:** Continued expansion of advanced clinical practice roles, including Advanced Care Practitioners, Physician Associates, and Advanced Nurse Practitioners, particularly in high-gap specialties, to support service delivery and reduce reliance on doctors in training.
- **International Medical Graduates:** Ongoing targeted recruitment of International Medical Graduates, with a focus on long-standing hard-to-fill gaps, supported by structured onboarding and mentorship.
- **Locally Employed Doctors:** Further integration of Locally Employed Doctors into the workforce, with pathways for permanent backfill in rotas with chronic vacancies.
- **Flexible Workforce Models:** Enhanced use of collaborative staff banks and digital workforce platforms to improve shift coverage and reduce agency reliance.

- **Workforce Planning:** Closer collaboration with NHSE Education & Training to ensure trainee numbers are matched to service demand, and to advocate for increased flexibility in training pathways.

Challenges for 2025/26

Despite these efforts, several challenges persist:

- **Rising Less Than Full Time Working:** The proportion of Rising Less Than Full Time trainees continues to increase, reducing available whole-time equivalents and complicating rota planning.
- **High Maternity and Parental Leave Rates:** Ongoing high rates of maternity leave and other statutory absences further reduce workforce availability.
- **Trainee Amendments:** Growing numbers of trainees requiring amended duties or being removed from on-call rotas for health or personal reasons.
- **Data and Communication Issues:** Continued misallocation of doctors under incorrect cost codes, especially in medicine, and communication breakdowns between rota leads, medical staffing, and finance.
- **Community Placement Pressures:** Challenges in arranging community placements and GP supervision due to part-time working, practice mergers, and retirements.

Next Steps for 2025/26

- **Permanent Backfill:** Assess and build business cases for permanent International Medical Graduates / Locally Employed Doctors backfill in rotas with persistent gaps.
- **Integrated Workforce Planning:** Strengthen coordination between medical staffing, finance, rota leads, and Post-Graduate Medical Education to proactively address gaps and ensure accurate workforce data.
- **Role Expansion:** Continue expanding Advanced Clinical Practitioners, Physicians Associates, and Advanced Nursing Practitioner roles to move towards a self-sustaining workforce, particularly in critical departments.
- **Trainee Allocation:** Work with NHSE to ensure ongoing adjustment of trainee numbers and allocation to balance workload and service needs.
- **Digital Solutions:** Leverage digital rostering and workforce management platforms to improve transparency, compliance, and proactive gap identification.

Summary

In summary, the Trust is taking a comprehensive, multi-pronged approach to address training rota gaps, combining workforce innovation, targeted recruitment, and digital solutions. However, the increasing trend towards Less Than Full Time Trainees working and persistent workforce shortages highlight the need for urgent, coordinated, and sustainable workforce planning. Addressing these challenges is essential to maintain a safe, supportive training environment and ensure the delivery of high-quality patient care in 2025/2026 and beyond.

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.

Performance 2024/25

This year saw the beginning of a new model of Veteran Aware support for our patients. The Patient Advice and Liaison Service had two staff train specifically as Armed Forces Champions, through the Sussex NHS Armed Forces Network. They join a network of staff in the Trust who are Armed Forces Champions in the Human Resources department, Ward Clerk Lead, Improvements Lead, Head of Quality and Regulation Team. The Service Champions support the Armed Forces community by raising awareness of both the moral and contractual obligations under the Armed Forces Act 2021, the Armed Forces Covenant, the NHS Constitution and the Health and Social Care Act.

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 1563 veterans registered in the adult acute in-patient electronic records for the year 2024-2025. The capture rate of Armed Forces personnel in acute care remained steady at 86%, a 10% improvement on previous years. The average length of stay for Armed Forces patients at 7, 14 and 21 days was the same as for non-Armed Forces patients.

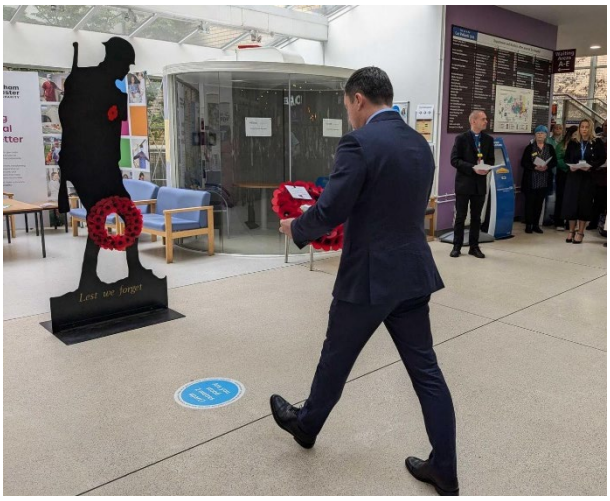
Trust induction training has been updated to advise that the Patient Advisory and Liaison Service team have been trained by the NHS Armed Forces Network, as Service Champions, and will be the first point of contact for a Veteran or Armed Forces patient need. NHS e-learning for Veteran Aware responsibilities 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 our new Chief Executive 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 achieved for 2024/2025

- The re-establishment of the Armed Forces Network enhances both staff and patient experience of Armed Forces and Veteran Aware work throughout the Trust
- The Step-Into-Health programme to actively encourage Armed Forces leavers into the NHS is in progress and the Armed Forces Lead organises informal visits and conversations for prospective Armed Forces applicants.
- 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
- Re-accreditation for the Employer Gold Employer Recognition Scheme id underway.



- 12 Armed Forces Consultant clinical placements are supported, as well as critical care nursing placements and emergency care placements for medics and combat medical technicians.

Plans for 2025/6

Significant outreach with Local Government, Integrate Care Board and Gloucestershire Health and Care Trust partners, already established through the Armed Forces Network.

Continued support of the Armed Forces Charity Sector, through invites to the Armed Forces Network.

Build up our own Armed Forces Champions forward liaison and engagement through the Armed Forces Network

Continued support through the LGBT Inclusion Network for our Armed Forces Staff and Patients who may have experienced disadvantage by Armed Forces inclusion policies prior to 2000, where Armed Forces law prevented inclusion of LGBT colleagues.

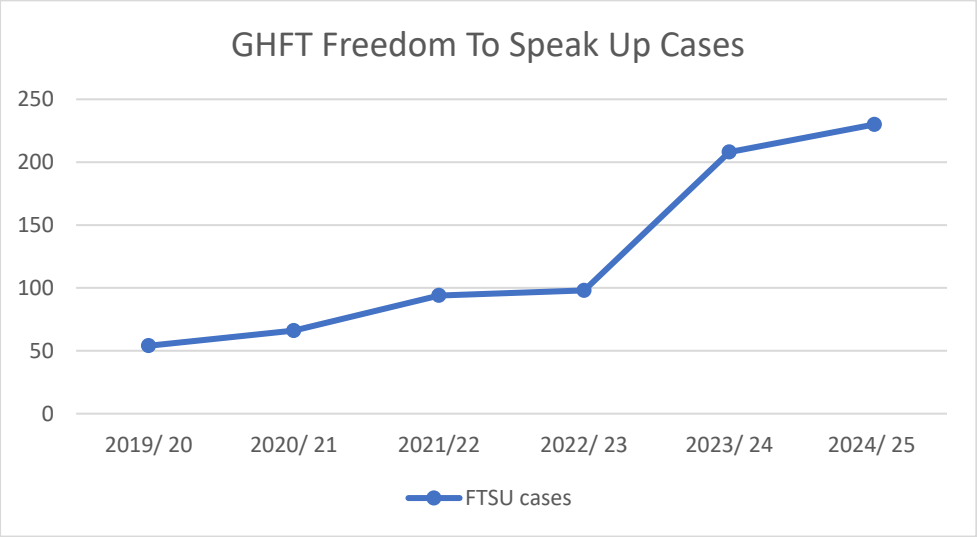
Freedom to Speak Up Service

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.

Trust Data

In 2023- 24, 208 staff accessed the Freedom to Speak Up service to raise concerns, more than doubling the activity of the previous year. At the end of last year, it was expected that cases would continue to rise, and 230 cases have been raised in 2024/25. Staff accessing the Freedom to Speak Up service this year are voicing barriers, indicating that the correct cases are now reaching the service.

Graph: Total number of cases per year

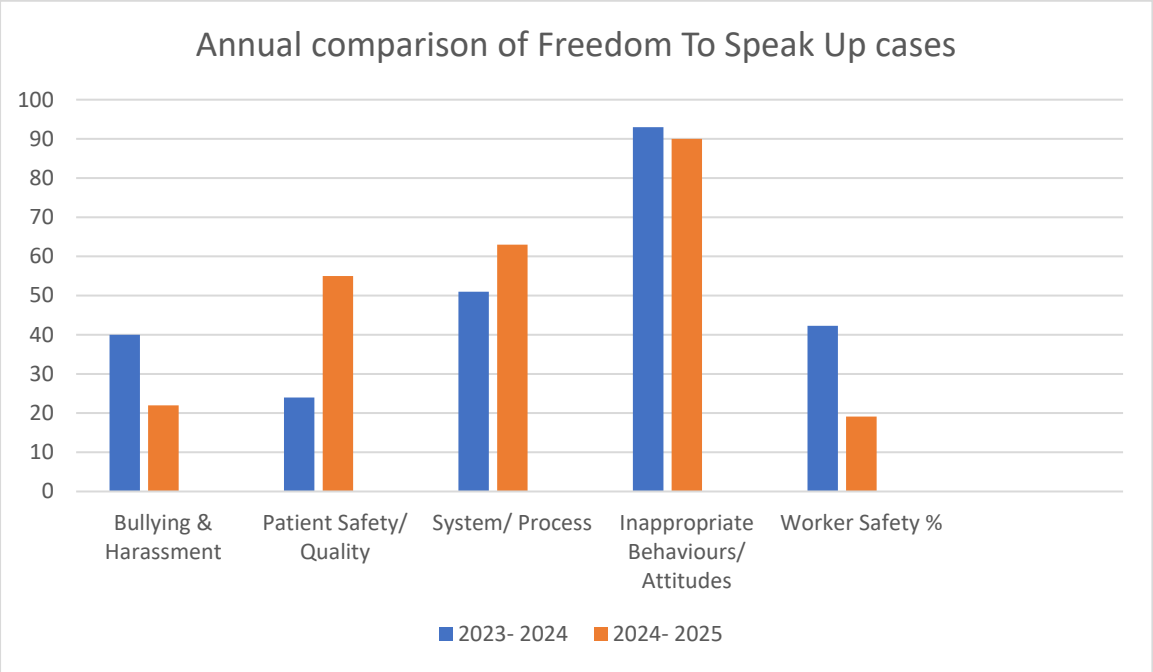


Staff have spoken up about a variety of concerns but inappropriate attitudes or behaviours remain the organisations highest reason for contacting the Freedom to Speak Up service. Themes have been captured in the service as voicing concerns about speaking up due to staff experience; poor experience connected to a process; poor behaviours witnessed or experienced in the organisation.

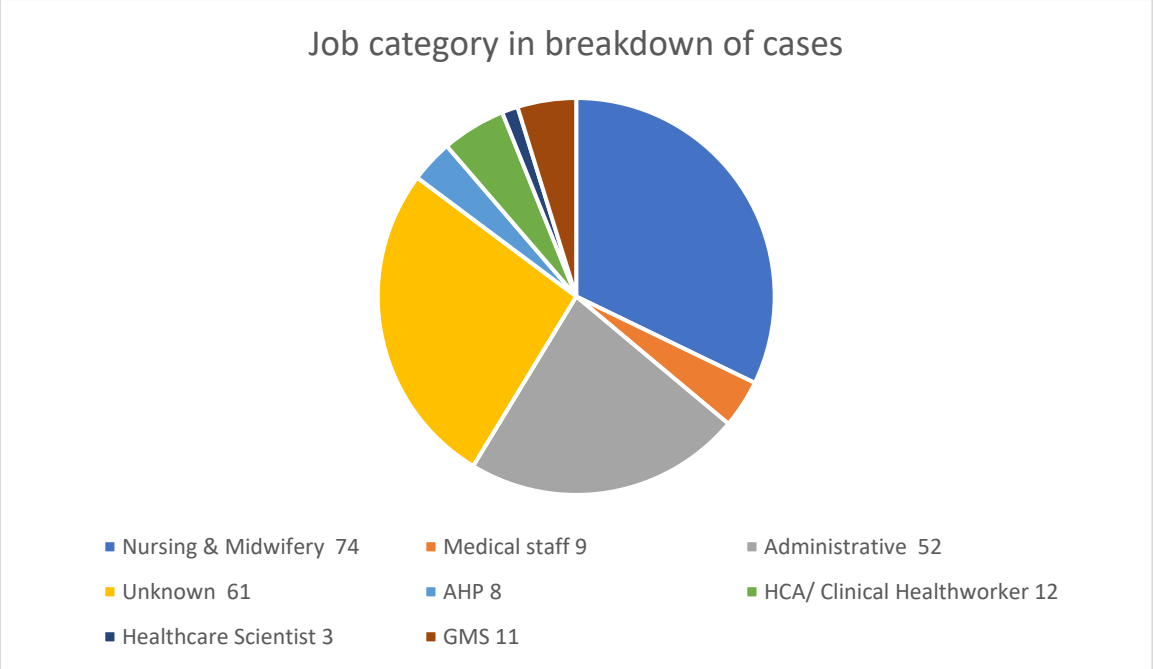
The Freedom to Speak Up service has implemented weekly managerial drop-in sessions to respond to the 151 out of 230 cases where staff reported their line manager as a barrier to

speaking up. Reasons for those barriers are themed as; actual detriment or discouragement to speak up; perceived favourable relationships with other managers; lack of trust; fear of detriment; unsatisfactory experience of speaking up and occasions where staff have seen their manager upset over other speaking up issues which leads them to avoid approaching their line manager.

Graph: Annual comparison of themes within Freedom to Speak Up Guardian cases



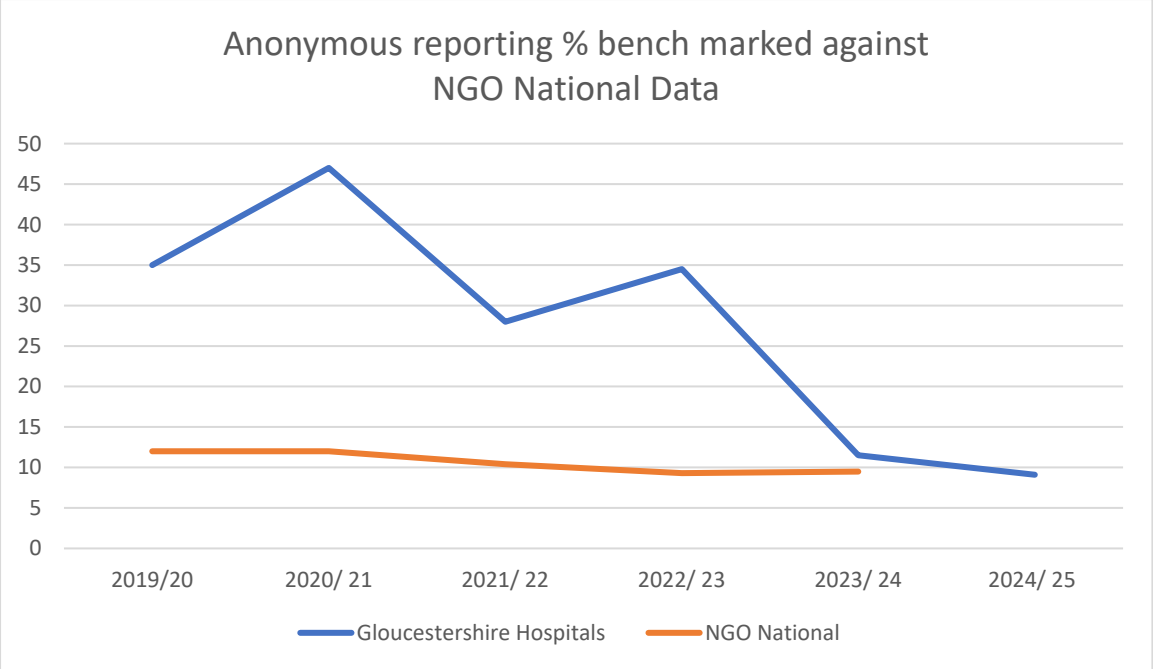
The types of cases that staff raise remain broad with staff accessing the service from all staff groups as can be seen in the graph below. It is reassuring that the reach of the service continues to be established in the organisation.



A stark change in the Freedom to Speak Up service has been the reduction of anonymous reporting. It was noted in the last report that anonymous reporting at Gloucestershire Hospitals has been higher than the national average peaking in 2020/21 at 47%.

Anonymous reporting is highlighted by the National Guardians Office as an indicator of staff potentially feeling a lack of trust and fear of detriment. As expected, the stability of a Lead Guardian and the Freedom to Speak Up service team has decreased anonymous reporting to more open concerns and less anonymised concerns.

The graph below shows the anonymous reporting trends bench marked with National Data over the last 5 years showing the reduction to 9.1%



The recruitment of the additional 0.4 whole time equivalent Band 7 the Freedom to Speak Up Guardian has improved the service function and supported important work such as building the Champion network and aligning the Freedom to Speak Up element of education into the Trust.

The champion network is a growing network of 20+ champions who are supporting speaking up matters in the organisation. Champions are supported in monthly meetings, where visiting speakers promote speaking up matters.

The Freedom to Speak Up function is designed to support staff to have a voice in the organisation where there are barriers to speaking up. The service continues to focus on case management and restorative support to provide staff with an excellent speaking up experience, challenge the organisation and ensure speak up, listen up and follow up is supported by the organisation.

Despite some of the challenges that staff express around speaking up, there is evidence to suggest trust has been gained in the service and the organisation is being increasingly trusted by staff to respond to their concerns.

Over the next year, the Freedom to Speak Up service will continue to capture data on the barriers staff are experiencing in relation to speaking up and commits to widening the data collected to support a deeper dive into discrimination and the learning that can be shared Trust wide as a result.

There is genuine support from senior leaders to respond to cases and support staff speaking up, the Service is committed to seeing this multiplied across all levels of leadership. Looking ahead, the Freedom to Speak Up service will engage with all divisions every quarter to support this approach.

The service has an ambition to operate restoratively, and develop into a trusted service that improves organisational speak up culture, impacting patient safety/ quality by supporting the speaking up concerns of all staff who meet barriers.

Data Quality

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

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

High quality information is: -

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

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

- Identification, review and resolution of potential duplication of patient records
- Monitoring of day case activity and regular attenders
- Gathering of user feedback
- All existing reports have been reviewed and revised
- Routine Data Quality reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence Hub
- We regularly send data submissions to the secondary users service and via these submissions we receive Data Quality reports back. Based on these reports we action all red and amber items highlighted in report to improve data quality.
- In data published for the period April 2024 to March 2025, the percentage of records which included a valid patient NHS number was:
    - 99.9% for admitted patient care (national average: 99.7%)
    - 100% for outpatient care (national average: 99.7%)
    - 99.4% for accident and emergency care (national average: 98.9%)
- The percentage of published data which included the patient's valid GP practice code was:
    - 100% for admitted patient care (national average: 99.4%)
    - 100% for outpatient care (national average: 99.3%)
    - 100% for accident and emergency care (national average: 99.8%)

- A comprehensive suite of data quality reports covering the Trust's main patient administration system (TrakCare) and electronic patient records (Sunrise ePR) is available and acted upon. These are run on a daily, weekly and monthly basis.
- These reports and are now available through the Trust's BI Hub. These include areas such as but not limited to: -
    - 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
    - Emergency Department 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 a 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. The Data Quality team now present at the Doctors Induction.

Part 2.3 Reporting against core indications

Domain	Indicator	Years	Trust
Domain 1 – Preventing people from dying prematurely	Most recent value of the Summary Hospital Level Indicator SHMI for trust	2024/25	1.115
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	2024/25	13.15%
Domain 4 – Ensuring people have a positive experience of care.	Staff who would recommend the trust to their family or friends	2024/25	49%
	Patients who rate the quality of their care as positive or extremely positive	2024/25	91.89%
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	2024/25	77.34%
	Rate of C.difficile infection	2024/25	39.2
	Patient safety incidents and the percentage that resulted in severe harm or death	2024/25	43

Patient Reported Outcomes

Below is from the national website for period April 23 – March 24 (Most up to data finalised data).

	EQ-5D		EQ VAS		Oxford Score	
	Trust %	*England %*	*Trust %*	*England %*	*Trust %*	*England %*
Total Hip	87.50%	88.80%	77.20%	68.60%	98.60%	97.10%
Total Knee	85.50%	80.90%	68.70%	58.90%	96.60%	93.90%

Patient Experience

National Cancer Patient Experience Survey

This cancer patient experience survey is mandated for all hospital Trusts in England to provide data and make comparisons and improvement against Trusts, Integrated Care Boards and Cancer Alliances. The National Cancer Patient Experience Survey data is from 2023 and published in 2024. The data for 2024 will be published in July 2025. The survey includes all patients over the age of 16 affected by cancer who had an in-patient or day case stay. Our Trust had 273 responses out of a total of 440 patients, with the majority responding to a paper survey rather than on-line. No patients used the translation service to respond and the majority of patients falling outside of the most deprived groups. Patients who have purely outpatient treatment are not included in this survey. Our Trust is seeking to learn from their experience separately.

There were some pleasing results where the Trust scored much higher than the national average illustrated in the table below. There are also some areas where the Trust scored lower than national average, which provide areas for improvement.

Questions above expected range

	Case mix adjusted scores			National score
	2023 score	Lower expected range	Upper expected range	
Q3. Referral for diagnosis was explained in a way the patient could completely understand	**75%**	60%	73%	**67%**
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	**65%**	43%	62%	**52%**
Q53. After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	**47%**	21%	44%	**32%**
Q56. The whole care team worked well together	**94%**	86%	94%	**90%**

Questions below expected range

	Case mix adjusted scores			National score
	2023 score	Lower expected range	Upper expected range	
Q5. Patient received all the information needed about the diagnostic test in advance	**88%**	89%	96%	**92%**
Q41_3. Beforehand patient completely had enough understandable information about radiotherapy	**81%**	83%	95%	**89%**
Q42_3. Patient completely had enough understandable information about their response to radiotherapy	**74%**	78%	92%	**85%**

There were some encouraging comments from patients too:

- *The entire staff I have encountered have been extremely supportive, helpful and caring. They all work hard to keep the wards working efficiently which means multi-tasking and still have the time to care for your needs and spend time with you.*

- *I have nothing but praise & admiration for everyone of the staff that I have encountered during my cancer journey! The support that I have had, has been outstanding all along the way, - from volunteers to consultants. I*

Improvements made in response to survey results in 2024/5

Staff have been trained not just to introduce themselves by name, which they usually do, but also their role and where they will support in the patient's recovery.

More cancer specific treatment summaries are being given to patients following their treatment to give them information about support services post treatment and information about possible recurrence and concerns that need medical intervention.

More Cancer Nurse Specialists are being trained to deliver Nurse Led Breaking Bad News clinics to reduce the time patients wait for their results.

Improvements planned for 2025/6

Cancer Clinical Nurse Specialists will analyse the survey data according to the site on the body the patient experienced their cancer, to identify specific improvements required. Leads for those cancer sites will action the identified improvements.

The cancer specific patient public voice group will join the improvement work to co-produce an action plan.

The Trust will design a bespoke survey for outpatient led cancer patient experience.

Local Indicators within the Trust's Integrated Performance Report

The Integrated Performance Report reports on operational performance, quality and safety metrics, use of resources and workforce monthly through quality and performance meetings to the Trust Board. The quality and safety metrics reported on monthly include the following:

Friends and Family Test

Friends and Family Test results below illustrates patients' response whether they would positively recommend the Trust to their friend and family.

Patient Advice and Liaison Service

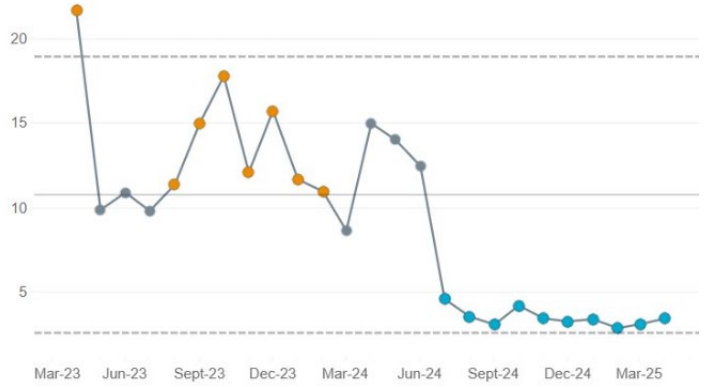
The performance of the Patient Advice and Liaison Service where the target is to complete all patient reports of concern and advise signposting within 5 days is illustrated below.

Mixed Sex Accommodation Breaches

Mixed Sex Breaches are reported below where patients of the opposite sex have to share bays or facilities. This occurs infrequently, but can happen in times of pressure on flow into and out of the hospital, and while patients are waiting for a ward bed from Critical Care.

Boarding of patients in non-designated bed spaces

The daily average of boarded patients below reports where patients have had to wait or sleep in a corridor in the Acute Medical areas or the emergency department. This happens infrequently at times of increased pressure on flow into and out of the hospital.

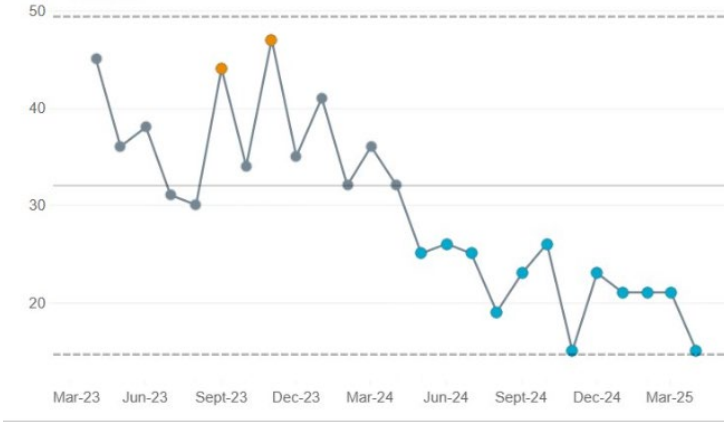


C. difficile infections

The infection rate of the infection C. difficile below is set by the NHS per 100,000 bed days. The Trust reports the rate monthly. The incidences are monitored closely and the Infection Improvement Group oversee targeted actions on preventing hospital acquired infection.

Pressure Ulcers

The incidences of Category 2 below and Category 3 pressure ulcers are reported monthly.

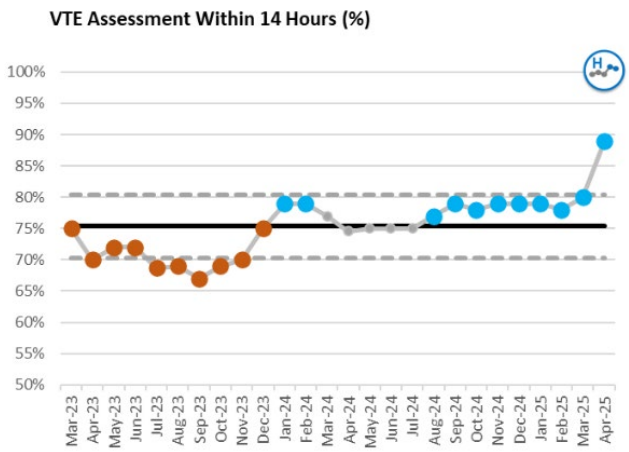


Falls

The incidents of the number of patient falls per 1000 bed days are reported. The Falls Prevention Improvement Group is leading quality improvements in recording falls to facilitate better analysis of the data, developing the electronic patient records and implementing post-fall hot debriefs for staff learning.

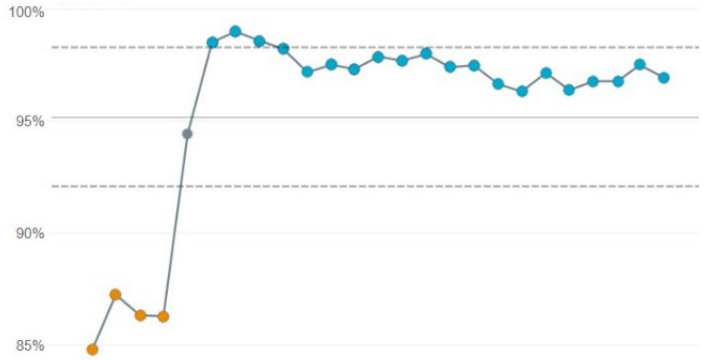
Venous Thromboembolism (VTE) risk assessment

The rates of Venous Thromboembolism risk assessment for preventing blood clots are reported below as a safety measure and performance is reviewed at the monthly Venous Thromboembolism committee. Improvements in data measurements and practice have seen Venous Thromboembolism assessment rates improve.



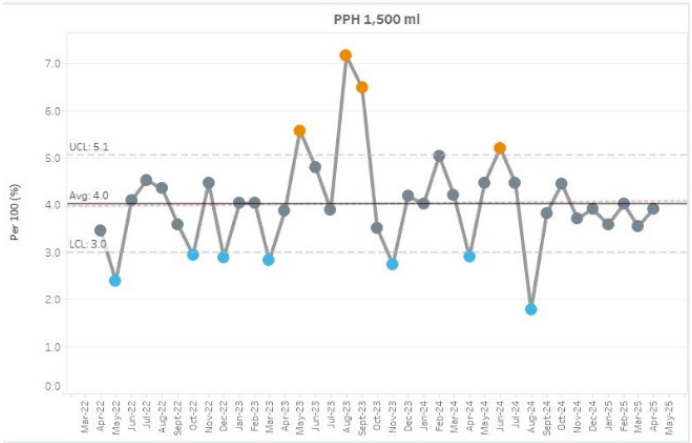
Smoking cessation

Smoking cessation compliance below asks all in-patients about their smoking history and offering nicotine replacement therapy is reported monthly as below.



Postpartum haemorrhage

Rates of maternity care postpartum (post birth) haemorrhages of over 1500mls are reported to monitor this obstetric emergency complication that occurs in between 1-10% of all deliveries.

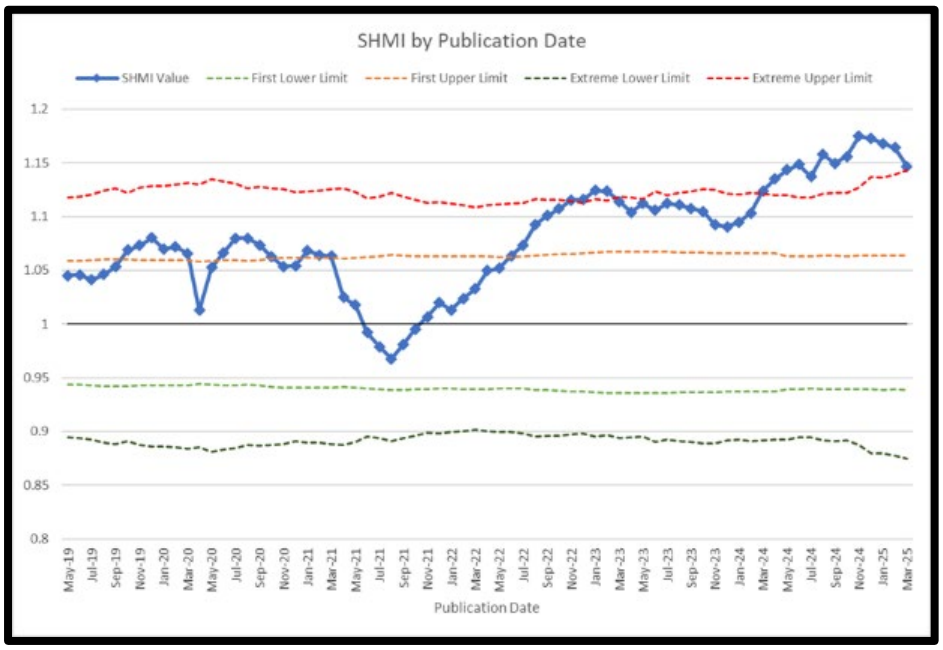


Summarised Hospital Mortality Index (SHMI)

The Summarised Hospital Mortality Index (SHMI) is a metric used to assess hospital mortality rates in England. SHMI is calculated using several patient characteristics, including the patient's primary diagnosis and their co-morbidities.

The table below demonstrates the increases in the SHMI, indicating higher than average expected deaths starting from 2021, which correlates with the time the electronic patient record system was introduced.

Table: Gloucester Hospitals SHMI data compared to the expected levels



Improvement Aim: A Quality Improvement project has facilitated better understanding and recording of Gloucestershire patient co-morbidities within the Trust and wider healthcare system.

Specific change ideas included:

- Strengthening clinician-coder collaboration.
- Implementing co-morbidity-specific Quality Improvement initiatives for patients with chronic illness such as kidney disease and diabetes.
- Developing educational programs for various specialties and staff.
- Optimising Electronic Patient Record systems to support accurate coding.
- Targeting remediation coding efforts based on age groups and diagnosis impact.

Measurements:

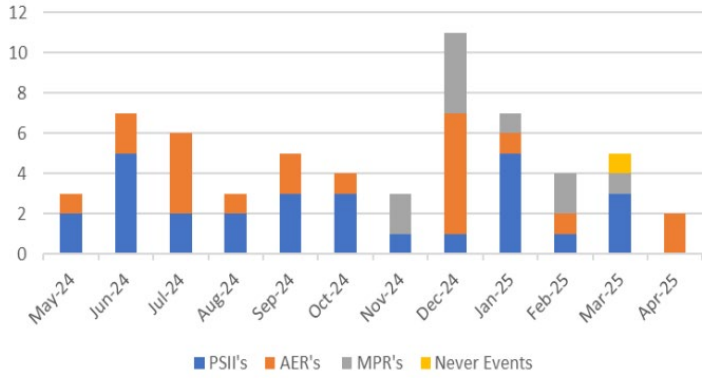
- **Outcome Measures:** Charlson score which identifies co-morbidities.
- **Process Measures:** Charlson score by age, specialty, and admission type.
- **Balancing Measures:** Trust SHMI and expected deaths rate.

Next Steps:

- Scale remediation coding efforts.
- Integrate coding into consultant job plans.
- Leverage financial benefits, with a more accurate Charlson score representing the general health of Gloucestershire patients, the Trust is likely to see its funding increase.
- Transition from retrospective re-coding to accurate coding from the outset.
- Strengthen collaboration with system partners across Gloucestershire.

PSIRF

The implementation of our Patient Safety Incident Response Framework (PSIRF) reports each of the 4 responses to patient safety incidents. Each response focuses on different aspects of investigation, learning, multi-professional consideration and system wide change.



Part THREE: Other Information

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

Statement from Healthwatch Gloucestershire 12.06.2025

Thank you for sharing the Quality Accounts for Gloucestershire Hospitals NHS Foundation Trust for 24/25.

Healthwatch Gloucestershire congratulate the Trust on their achievements last year including the opening of the Hyper-Acute Stroke Unit at Cheltenham General and the new Alstone Urology clinic. We also acknowledge the introduction of the Patient Portal and the potential for this to improve accessibility of information for many people.

We recognise the actions being taken in response to the CQC inspection into Maternity care and improvements made. We are pleased to see how the application of PSIRF has led to improvements in quality across the 8 local safety priorities through encouraging learning by involving patients and the empowerment of frontline teams to implement change.

We understand that shifts in organisational culture take time to embed but it is promising to see that this starting to show through staff feeling more secure about raising concerns in the staff survey. We note the recognition given to the Trust's dedicated staff and the invaluable services provided by volunteers by the CEO Kevin McNamara.

We are also pleased that the clinical vision of flow and ensuring the best possible outcomes for patients remains a priority as this aligns with one of our priorities this year, focussing on understanding people's experiences of being an inpatient at Gloucestershire Royal Hospital. We hope to explore communication between patients, carers and professionals and how people's care and support is made personal to ensure that a person can be discharged as early and safely as possible.

Healthwatch Gloucestershire values the strong connections we have with the Trust and look forward to working closely with the Trust this year to ensure that patient voices are at the heart of service delivery and improvement.

Statement from the Integrated Care Board 19.06.2025

NHS Gloucestershire ICB welcomes the opportunity to comment on Gloucestershire NHS Foundation Trust quality account. We recognise the continued efforts of the trust in delivering high-quality care during another challenging year, especially in the context of ongoing system pressures and the continued recovery from the COVID-19 pandemic.

We note the Quality account demonstrates a clear commitment to improving patient safety, clinical effectiveness, and patient experience.

We acknowledge the progress made against 2023/24 improvement priorities. It is pleasing to see that the Pressure Ulcer risk assessment rate for in-patients improved by 25% in 12 months. Although PSIRF is still a relatively new, it is good to see the shift in how the trust is managing patient safety incidents related to hospital acquired pressure ulcers and the potential learning to enable pressure ulcer prevention.

The trust has made enormous progress in nursing vacancies on inpatient wards and the positive impact of the international recruitment campaign with colleagues joining the workforce from so many countries. Rightly the focus is now on retention planning and its good to see a key priority is increasing support for staff in post.

The ICB encourages the trust to continue to address areas where they have faced challenges. We acknowledge the hard work from dedicated staff following the Care Quality Commission report on maternity services. The ICB has worked closely with the Trust and other stakeholders to ensure continued improvement to provide safe, high-quality maternity care.

The ICB notes the high compliance from Gloucestershire Hospitals NHS Foundation Trust of national clinical audits and national confidential enquiries. The Trust also participated in 207 local clinical audits, Quality Improvement projects and 41 ‘Silver’ quality improvement projects graduated through their Gloucestershire Safety and Quality Improvement Academy, demonstrating the dedication and commitment of staff to continuously improving the quality of healthcare provided.

The trust has successfully rolled out their PSIRF policy with a structured approach to respond to patient safety incidents, focusing on learning and improvement. The ICB will work with the Trust to continue this approach to further ensure embedding of learning It is pleasing to see that for the following year the trust has chosen to continue the focus on their Patient Safety Incident Response Plan.

The proposed priorities for 2025/26 align well with wider ICS objectives, the ICB will fully support the delivery and oversight in order to continually drive forward high quality, safe services.

The ICB values the strong partnership working and we look forward to working together to support further improvement across the local health and care system.

Marie Crofts,

Chief Nursing Officer, NHS Glos ICB

Statement from the Overview Scrutiny Committee To be received

Annex 2: Statement of Director's Responsibility 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 2024/25 and supporting guidance.
- detailed requirements for quality reports 2023/2.
- requirements as set by the Gloucestershire Integrated Care Board.

The content of the quality report is consistent with internal and external sources of information including:

- board minutes and papers for the period April 2024 to March 2025 (link)
- papers relating to quality reported to the board over the period April 2024 to March 2025
- feedback from Gloucestershire Integrated Care System dated 19 June 2025
- feedback from Healthwatch Gloucestershire dated 12 June 2025
- the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2023/24 (Link to latest published report) (next report due July 2025)
- the 2024 National Patient Surveys published by CQC in 2024/2025 (Link)
- the 2024 national staff survey published Jan 2025 (Benchmark report Link)
- Current 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 England's reporting requirements 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

Trust Chair	Chief Executive
Deborah Evans	Kevin McNamara