NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality Account

2020/21

the Best Care for Everyone
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Our Quality Account 2020/21

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.

Contents

Part 1

Statement on quality from the Chief Executive

I am pleased to introduce the 2020/21 Quality Account which sets out how the Trust has performed against the quality standards and priorities set both nationally by Government and locally by the Trust Board, in partnership with the One Gloucestershire Integrated Care System (ICS). This is an opportunity to recognise our achievements in the last year, to describe what we have learnt and how these insights will improve the experience of our patients, their families and our staff. However, this year, it is an Account with a difference; a report that reflects a year like no other. As I penned last year's message, we had just seen our first few cases of coronavirus and could not have imagined the year that lay ahead.

The Year Just Gone

For decades to come, 2020/21 will be marked by the pandemic that affected every corner of the globe, every sector of society and billions of individuals. As at 1 July 2021, the global death toll stands at almost four million and over 900 people in Gloucestershire have lost their lives to COVID-19, with the ripples of these deaths reaching far and wide. Sadly, the legacy of this pandemic will cast a long shadow for many years to come; a reach that goes far beyond health care to the determinants of future good health and prosperity – education, employment, environment, wellbeing and opportunity. Of considerable concern, is the apparent "discriminatory" nature of the virus; it has not affected us all equally with ethnic minorities being disproportionately affected; those with a learning disability have had poorer outcomes and those in older age groups, particularly those living in care homes, have been especially impacted. One phrase summed up this picture of inequity, for me "we have all been in the same storm, but we were not all in the same boat".

As a Board, at the outset of the pandemic we set ourselves three guiding principles and these have served us very well throughout the year

- Preserve life
- Protect staff
- Prevent spread

Highlights

First and foremost I am immensely proud of the care my colleagues gave our patients and their families; outstanding care in the face of great adversity and gladly going above and beyond for each other. Teams faced a new disease, where there was no "rule book" and yet the sickest patients in our care had outcomes better than the national picture and very positively this included those most at risk such as patients from ethnic minorities and those with a learning disability, who have also fared better under our care than nationally – I'd like to take this opportunity to reiterate my thanks to my dedicated and talented colleagues. At times, our team working in critical care had the very difficult job of caring for their close colleagues; I can say, without hesitation, that I would not have wanted their lives in any others hands and count my blessings every day that I was not one of the Chief Executives that had to announced the tragic and untimely death of a colleague.

However, whilst there is much to mourn, in my mind this year will also be characterised as the year in which the NHS Gloucestershire family rose to their greatest ever challenge and shone. Compassion and care for each other flourished; going the extra mile for our patients and their families became the norm; new leaders emerged; innovation became the solution to intractable problems and we took some bold decisions that served us well at the time and will continue to do so.

One of the characteristics of the year was the pace and agility with which the organisation, services, teams and individuals responded to the unknown. Within days of the pandemic being declared and the national lockdown proposed, our digital teams had enabled hundreds of staff to work from home through deployment of a virtual desktop which not only enabled administrative staff to continue working from their own homes, with secure access all of the Trust's systems, but it enabled our clinicians to consult with patients, albeit virtually, and thus continue to deliver essential care through the rapid deployment of a platform that wasn't intended to be launched until 2022. Clinical colleagues supported by their managers and enabled by our digital experts delivered the impossible including delivering more than 95% of urgent cancer appointments throughout the year within two weeks of referral and 2020 being the year in which, for the first time since 2014, the Trust delivered all eight national cancer waiting standards.

Many of the innovations and approaches we pioneered in the last year were recognised nationally with two initiatives in particular, standing out in my mind. Firstly, the development of our "yellow lanyards" team; our respiratory specialist doctors, nurses and therapists who within days of Government declaring a pandemic, had developed an e-learning resource and "roaming" team of experts to up-skill those about to be central to the care of hundreds of patients with a hitherto unknown but serious respiratory condition. This model of care and the educational tools were shared with Trusts throughout England – the team went on to win the Nursing Times Clinical Team of the Year. Similarly, the work of our Infection Prevention and Control (IPC) Team, including input to national specialist bodies from Trust IPC experts became nationally respected and the PPE Safety Officer role was an innovation adopted by many other Trusts.

A new disease brought to the fore the

importance of research and evaluation and by the second wave of the pandemic we were already improving outcomes through the use of existing drugs such as dexamethasone, as a result of evaluation in the first wave. Our research team and investigators changed tack almost overnight and Gloucestershire was quickly at the forefront of recruiting patients and staff into a number of urgent public health studies. I made my own small contribution to building the evidence base for the future by participating in the SIREN Study for the last nine months.

Through a series of temporary service changes we were able to redesign the way we delivered care to ensure that patients were managed in as safe a way as possible and that the risks to staff were kept to an absolute minimum. This required staff to work in different ways, on different sites and even in different services and everyone rallied around a common cause. Surgeons who couldn't operate supported ward teams, administrative staff stepped in to support our incident management team and help ward staff freeing them up to spend more time with sick, often anxious patients who were unable to receive visitors – a particular highlight came from a student dental nurse who took to Twitter with pride having spent a shift on one of our COVID wards helping patients and their loved ones connect using iPads, provided by the Trust charity, to help loved ones stay in touch through "virtual visiting".

I have already described the number of people whose lives were irrevocably changed during the pandemic, by the death of someone close to them. Whilst the vast majority of these deaths were attributed to COVID, others lost loved ones too and all of these people were impacted by the necessary constraints on visiting and the

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(often cruel) impact of social distancing. One of the things I am most proud of is the way in which we rose to this new challenge. Every Name A Person captured our pledge to ensure that nobody who died during the pandemic, would be seen as a statistic. We pledged to recognise that every person we treat in our hospitals and in our communities has a story; whilst we may have had little time to get to know each person, we committed to learn something about them that mattered the most, to provide comfort throughout their final days and endeavour to ensure they were not alone in their final moments. This pledge was brought to life through the symbolism of a dandelion – one placed with the patient and one given to their loved one; this theme will be a central part of our commemorations this year.

Every name is a person – Every person a life lived – Every life a story behind it

Unsurprisingly, the focus on the health and wellbeing of our staff has been at the forefront of our minds throughout the pandemic. Our communities were truly phenomenal in stepping up to both recognise and support NHS staff and other key workers, from Claps For Carers on a Thursday evening to the mountains of "goodies" which local

business and individuals bestowed upon us. I cannot overstate the positive impact that this recognition and support had on the wellbeing of all of us, whether it was access to a hot meal at the end of a long shift or an inspiring message of support via social media.

As well as the support of our communities, our own 2020 Staff Support and Advice Hub came into its own, offering guidance, support or signposting to more than 10,300 staff. The small team moved to operate seven days a week during the peak of the pandemic, running late into every evening ensuring that staff knew how to navigate practical hurdles such as access to COVID testing, childcare or accommodation so they could be close to the hospital should they be needed. In addition to this, the Hub was able to signpost colleagues to specialist psychological support, as well as being a regular touchstone for those staff who were absent from work due to COVID or shielding from the risks. Our Psychological Link Workers became the envy of many Trusts as we redeployed our highly skilled clinical psychologists to work alongside those working on the front line providing them with coping strategies or helping them surmount new challenges such as breaking bad news to a family member via the telephone.

However, this year hasn't just been about surviving a pandemic and, as such, I am especially proud of the progress we have made on many of our strategic objectives – as a Board this was something that we were determined to achieve. For example;

More than a decade on from the first discussions about the configuration of services across our two hospital sites, we developed a vision that embraces our two hospitals as an opportunity to be

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seized rather than a problem to manage. We launched our vision of two Centres of Excellence – one for planned care at Cheltenham General Hospital and one for emergency care at Gloucestershire Royal. Six months of public and staff engagement enabled us to better understand what matters to local people and colleagues; these views considerably shaped the final proposals considered and supported by the Trust Board and our commissioner Gloucestershire Clinical Commissioning Group, in March 2021.

In March 2020 as the pandemic landed, we held our nerve and proceeded with our plans to implement our electronic patient record. This decision not only served us well in the short term through our ability to continually monitor, in real time, the sickest patients on our general wards but was subsequently seen as central to the case we made nationally to expedite our digital journey and which went on to secure an additional £3m of investment in our digital programme over the next three years.

Whilst this year has very much been centred on our people and their phenomenal contribution and personal resilience, it has also shone a light on the shortcomings of some of our buildings as we've strived to deliver "COVID secure care". To this end, in partnership with Gloucestershire Managed Services, Trust colleagues have continued to progress our strategic site

development scheme and in February 2020 the Board approved the Full Business Case (FBC) for the investment of £44m in our two sites to modernise and extend areas of our estate supporting planned care at Cheltenham General and urgent care at Gloucestershire Royal.

There was no place where the shortcomings of our estate shone out so brightly, as they did in our oncology centre. Throughout the pandemic, the oncology team were determined to continue to offer chemotherapy and radiotherapy care to all those who needed it but to do this in a way that didn't expose patients or staff to the risks of coronavirus; as a result, they had to completely change the way they worked and the location of many of their services. However, whilst they rose to the challenge superbly, it was a year that affirmed the importance of our plans to develop the Gloucestershire Cancer Institute and within that the development of the Oncology Centre on the Cheltenham site. With this ambition at the forefront of our minds, we embarked upon the development of a case and fundraising appeal to raise £11m to complete phase one of the transformation of the centre to one where the quality of the environment is befitting of the quality of care delivered within it, by our outstanding cancer teams.

We have continued our commitment to being an organisation characterised by an inclusive culture and compassionate behaviours towards each other, our patients and their families. In Autumn last year, we commenced a partnership with an external party to better understand why some groups of staff report a less good experience of working in the Trust than others; we are well advanced in our understanding of the areas where we need to make further improvements and work "Board to ward" is underway to ensure we are an organisation that embraces the diversity of its workforce, and those it serves, and one that is truly inclusive of that diversity. This will remain one of the organisations highest priorities in the coming year.

The Year Ahead

In December 2020, the day we had all been waiting for dawned with the announcement that the medicines regulator had approved the first COVID-19 vaccine. This was great news for us all not just for the lives it would save but also because it signalled the start of our journey towards the lives many of us had missed so much. Our Trust was the lead organisation for this programme in Gloucestershire and for members of the vaccination team within the Trust, this date in December was preceded by two months of incredibly hard work. Under the superb leadership of Chief Nurse, Professor Steve Hams as Senior Responsible Officer for the programme, the team organised the biggest public health and vaccination programme that Gloucestershire had ever seen. Steve inspired and motivated the team here at the Trust, as well as colleagues from partner organisations who made up the wider vaccination programme team across the county. This was partnership working in its best sense, so thank you to everyone who played their part in putting together the local vaccination teams who delivered the county's unique and highly successful programme. The Gloucestershire programme has been widely acclaimed both on the national stage and by countless grateful recipients who have benefited from it so far. We continue to receive fantastic feedback about the organisation of this life-changing programme and I am tremendously proud that we led this from the front.

We enter 2021 with many positives in our sights. Community cases of COVID are falling, and the numbers of COVID patients in our beds and our critical care departments is in single figures. The national vaccination programme has been an unprecedented success and I am especially proud that Gloucestershire has remained at the forefront of this success with more than xx% of the adult population now vaccinated. We know that this is not over yet, but we have much to celebrate from the last year, and much we can learn from as we take on future challenges.

It is clear that the world has been altered by this pandemic, with much chat about finding a "new normal" and never was this sentiment more relevant than in the NHS. We will start the year with commemorating all that we have lost, as well as what we have found, during this most unprecedented year and start the journey towards defining the "new normal" for Gloucestershire Hospitals. We are committed to embracing all that we have learnt, embracing the innovation and new, agile ways of working that not only served us well during the pandemic but will continue to do so in the years ahead. The Board has reviewed our ten strategic objectives, in the light of the impact and legacy of the last year, and confirmed they remain as relevant going forward as when they were established in 2019. The "golden threads" of compassion, inclusion and excellence will remain the things that guide all that we do.

As we move through this current year, the success of the vaccination programme continues to serve us well and we are slowly easing the restrictions that have been placed on all of us. I am especially proud that Gloucestershire has remained at the forefront of this success with more than xx% of the adult population now vaccinated. Unfortunately, the advent of a variant virus, known as the Delta variant, is now driving an increase in the number of community cases of COVID-19. However, again, the impact of the vaccination programme means that the numbers of people becoming seriously ill and requiring hospitalisation is small compared to previous waves.

It is clear that the world has been altered by this pandemic, with much chat about finding a "new normal" and never was this sentiment more relevant than in the NHS. We will start the year with commemorating all that we have lost, as well as what we have found, during this most unprecedented year and start the journey towards defining the "new normal" for Gloucestershire Hospitals. We are committed to embracing all that we have learnt, embracing the innovation and new, agile ways of working that not only served us well during the pandemic but will continue to do so in the years ahead. The Board has reviewed our ten strategic objectives, in the light of the impact and legacy of the last year, and confirmed they remain as relevant going forward as when they were established in 2019. The "golden threads" of compassion, inclusion and excellence will remain the things that guide all that we do.

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 Trust member, a partner, a patient or interested member of the public. We have risen to challenges that couldn't even have been imagined a year

ago, let alone conquered them. It has been the greatest privilege of my career to lead the Trust during these times and whilst, undoubtedly, the shadow on COVID will be long and lasting, I have every confidence that we will continue to support and serve each other with the compassion, competence, dedication and humility that has characterised 2020.

I thank each and every one of you, from the bottom of my heart, for what you have done but equally what you will do for us in the year to come.

Formal bit

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

Deborah Lee
Chief Executive Officer

Part 2 and 3

Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following 2 sections are divided into four parts:

- **Part 2**
  - **Part 2.1**
    - **What our priorities for 2021/22 are:** explains why these priorities have been identified and how we intend to meet our targets in the year ahead.
    - **How well we have done in 2020/21:** looks at what our priorities were and whether we achieved the goals we set ourselves. Where performance was below what was expected, we explain what went wrong and what we are doing to improve
  - **Part 2.2:** Statements of assurance from the Board
  - **Part 2.3:** Reporting against core indicators.
- **Part 3:** The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

Part 2.1

Our priorities

Our priorities for improving quality 2021/22

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

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

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

Our consultation process

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

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

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

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

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

The Quality Delivery Group is responsible for monitoring the progress of the organisation against our quality improvement priorities. The Group meets every month and reviews a series of measures which give us a picture of how well we are doing.

This will allow appropriate scrutiny against the progress being made with these quality improvement initiatives, and also provides an opportunity for escalation of issues. This will ensure that improvement against each priority remains a focus for the year and will give us the best chance of achievement.

Our priorities for improving quality 2021/22

WELL LED: Continuous improvement

Priority quality indicator goals 2021/22	Why we have chosen this indicator
Our COVID response	▸ We need to continue to embed learning from our response to Covid and focus on how we can continue to support and treat patients who have experienced delays due to Covid, as well as focus on the health and wellbeing of colleagues

EXPERIENCE: Enhancing the way staff and patient feedback is used to influence care and service development

Priority quality indicator goals 2021/22	Why we have chosen this indicator
To improve children and young people's experience of transition	▸ The Women and Children's division are developing a Children and Young People's Strategy, which is being co-designed with colleagues across the division and young people using our services. One of our priorities in this strategy is to deliver a programme to transform outdated processes and pathways, which will incorporate transition into adults services. ▸ The new transition service for young adults with diabetes will be launched in 2021/22, with recruitment for new posts underway. This service is a 12 month pilot, and a key aim of this work is that the clinical care provided will follow structures set out within Best Practice Tariff with an aim of the service being income-generating longer term to help promote longevity of the service.
To improve maternity experience through delivery of the Continuity of Care programme	▸ Maternity services are developing a divisional strategy, and improving the experience of women accessing our services will be a key priority area. ▸ Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016). ▸ Our focus will be to implement this programme, aiming to put in place the building blocks by March 2022 so that continuity of carer is the default model of care offered to all women by March 2023

EXPERIENCE: Enhancing the way staff and patient feedback is used to influence care and service development

Priority quality indicator goals 2021/22	Why we have chosen this indicator
To improve Urgent and Emergency Care (ED) experience	▸ We know from the experiences that our patients share through our Friends and Family Test that we don't always get it right, with 18% of patients reporting a poor experience of care ▸ A number of priority actions are ongoing in the patient experience improvement plan. The Trust is currently reviewing the recent National Urgent and Emergency Care Survey results, which will be used to review and update the improvement plan
To improve Adult Inpatient Experience	▸ We know that communication has been an issue for many inpatients, as well as management of patient property, and so this will be our focus, alongside receiving the results for the National Inpatient Survey (anticipated Summer/Autumn 2021)

Our priorities for improving quality (cont.)

SAFETY: lessons are learnt and improvements are made

Priority quality indicator goals 2021/22	Why we have chosen this indicator
To enhance and improve our safety culture	▸ This work was delayed due to the pandemic in 2020/21 ▸ The SCORE programme will be re-started in 2021-2022, beginning with a review of the data previously collected to understand any changes due to the passage of time. Once completed the next step of the process will be to develop a multi-disciplinary quality improvement collaborative using the data and feedback collected.
To improve our prevention of pressure ulcers	▸ The implementation of the Electronic Patient Record has enabled us to have better oversight of pressure ulcer risk assessments and prevention plans that are being put in place for our patients. ▸ The focus for 2021/22 will be to continue to develop the data we have available, develop a shared decision making council and to engage wards and specialties around their data and undertaking learning
To prevent hospital falls with injurious harm	▸ We have seen an increase in the number of falls reported during 2020/21, due to a number of factors including the impact of the pandemic ▸ The Trust improvement plan will continue, working with divisions to develop improvement plans focussed on the reduction of falls for our inpatients

CLINICAL EFFECTIVENESS / RESPONSIVENESS

Priority quality indicator goals 2021/22	Why we have chosen this indicator
To improve how we meet the NHSI learning disability and autism standards	▸ We know that our data capture and management remains a significant challenge for the teams. ▸ The improvement plan for 2021/22 focusses on the disaggregation of data about people with Learning Disabilities and/or Autism from our general data, including the creation of an autism flag in our electronic systems, and creating daily Business Intelligence reports on our Learning Disability inpatients across both sites, so we can better identify and supporting patients with a learning disability or autism who are in our care
To improve our care of patients whose condition deteriorates	▸ Our data shows that we still need to improve our compliance with recording observations in the system, to best identify and care for patients whose conditions deterioriates ▸ There is an improvement plan in place with strong engagement from divisional and digital teams
To improve mental health care for our patients coming to our acute hospital	▸ Healthwatch Gloucestershire published a report which included a number of recommendations on how we can improve the mental health care we provide to our patients. ▸ Our Mental Health Working Group has recruited Experts by Experience to co-design this improvement work

Our priorities for improving quality (cont.)

CLINICAL EFFECTIVENESS / RESPONSIVENESS

Priority quality indicator goals 2021/22	Why we have chosen this indicator
To improve our care for patients with diabetes	▸ This work will continue as a Trust priority. It is now well documented that there is an increased risk of patients with diabetes becoming acutely unwell if they contract Coronavirus and in fact patients developing Diabetes following COVID infection due to the treatment required. The organisation is therefore prioritising recruitment and retention of Diabetes Nurses within the Inpatient team to focus on direct patient interventions and increased remote monitoring. ▸ A trust wide rollout of education across both Cheltenham and Gloucester sites that start with wards experiencing the highest rate of incident will also be a focus for 2021/22, including: ▹ 1:1 and Group teaching live on the ward. ▹ Provision of teaching and learning aids on the wards. ▹ Development of an eLearning module for all clinical staff. ▹ Review of the documentation we use to streamline and simplify where possible.
To improve our care of patients with dementia	▸ Our data shows that there is still work to do on improving the number of dementia screenings completed within 24 hours of admission, and the team have access to ward level data to target engagement and education on this, in partnership with divisional leads ▸ Work will continue to improve the data available in ESR, and on a number of quality improvement projects led by the Admiral Nurse and clinical teams
Delivering the 10 Standards for seven day services (7DS)	▸ Our audits show that we are not currently meeting clinical standards two and eight ▸ The Medical Review Project has identified a number of recommendations that can be embedded to support compliance with the standards

Part 2.1

How well have we done in 2020/21?

Priority quality indicator goals 2020/2021

Our COVID response

How have we performed in 2020/21?	Plans for 2021/22:
▸ Designed and developed a 'Covid dashboard' which won an award for Best Use of Data in the HTN 2020 Awards ▸ Introduced PPE Safety Officer role, shortlisted for Nursing Times Award and recognised as best practice nationally and internationally in supporting staff with PPE ▸ Developed the 'yellow lanyard' service which won the Nursing Times Award, supporting colleagues to develop respiratory skills to support our patients during the pandemic ▸ During 2020/21, the 2020 Hub was used as the central point of contact to support colleagues, and they had over 9,600 individual contacts with colleagues during this time ▸ Introducing Psychology Link worker roles to support teams ▸ Developing infographic so that colleagues had access to full range of health and wellbeing services available to them	▸ Continue as a Quality Indicator for 2021/22 ▸ Embed the learning from our response to Covid, and continue to develop our health and wellbeing offer to staff, as well as support our recovery plans for patient care

To improve how we meet the NHSI learning disability and autism standards.

How have we performed in 2020/21?	Plans for 2021/22:
▸ The NHSI Benchmarking Learning Disability Standards audit has been completed for the last three years and improvement plans written as a result of the first two audits have focused on the audit standards, without addressing wider issues relating to people with learning disabilities and/or autism. ▸ This year, the improvement plan has been written to encapsulate the changes needed to drive forward improvement in our standards of care for people with learning disabilities and/or autism, using as evidence the results of the NHSI audit, LeDeR reviews and Serious Adult Reviews (SARs). ▸ A number of actions have already been progressed against this plan, including the creation of a Learning Disability inbox, shared drive and workload tracker, to improve our systems and processes in identifying and supporting patients with a learning disability in our hospital, and the development of a vulnerabilities framework to provide easy access for colleagues across the Trust to information and guidance on patients with a variety of vulnerabilities, including Learning Disabilities	▸ Continue as a Quality Indicator for 2021/22 with a focus on improving data capture and management, as this remains a significant challenge for the teams. ▸ The priority workstreams include the disaggregation of data about people with Learning Disabilities and/or Autism from our general data, including the creation of an autism flag in our electronic systems; Revising our Reasonable Adjustments policy so that it explicitly includes autistic people and installing Changing Places Facilities at Cheltenham and Gloucester hospitals in 2021/22, following delays due to Covid ▸ The team plan to undertake a patient survey and focus group to better understand the experience of being an inpatient, outpatient and day case patient, which will inform our improvement work

To improve the numbers safeguarding assessments completed on our Electronic Patient Record (EPR).

How have we performed in 2020/21?	Plans for 2021/22:
▸ In 2020, a Safeguarding Risk Assessment was developed and embedded as part of our Nursing Admission documents within the Electronic Patient Record (EPR) for use on adult inpatient wards. Completion rates can be measured by monitoring percentage completion rates of Nursing Admission within 24 hours of admission. ▸ The data shows an average across the year of 80% completion across the Trust, but this figure varies across our wards and sites. Completion rates are very high (up to 94%) for areas of high turnover such as AMU and the 5th floor at GRH, but less good for areas with lower numbers of direct admissions.	▸ Our EPR data is used by teams to identify areas for further engagement and education, supported by divisional teams and the Safeguarding team. Our aspiration is to get compliance with our risk assessments in EPR to 100% ▸ The Safeguarding Lead is developing an improvement plan for ongoing work in 2021/22, which will be monitored through the Safeguarding Operational level Governance groups and the Trust's Quality Delivery Group. ▸ The Safeguarding team will continue to work closely with the Digital teams on the future plans for our EPR roll out to wider areas across the Trust, particularly looking at refining our safeguarding risk assessments in Unscheduled Care, so that Paediatrics are included

To improve cancer patient experience

How have we performed in 2020/21?	Plans for 2021/22:
▸ The latest Cancer Patient Experience Survey 2019 scores were published in September 2020; The Trust results are the best results since the survey started with 39 out of 52 questions scoring equal or greater to national average, and our patients on average rated their care as 8.9 out of 10. This result is the highest score we have had since the survey started and above national average (8.8) ▸ The Trust signed up to a national Quality Improvement project in September 2020 focusing on using data from NCPES, Cancer Wait Times, internal surveys and local public health reports to understand our demographics and communities that experience health inequalities. ▸ The Trust continues to work on the patient experience improvement plan, which has been co-designed with cancer patients;	▸ Work will continue into 2021/22 on the patient experience improvement action plan, including further engagement with patients to update and review this work, to ensure we continue to focus on priority areas (such as communication and estates/facilities) ▸ This work will monitored through cancer services and updated reports through to our Quality Delivery Group

To improve children and young people's experience of transition to adult services

How have we performed in 2020/21?	Plans for 2021/22:
▸ Work on this area was delayed due to the pandemic ▸ In September 2020 we applied for a Roald Dahl Transition Nurse Specialist Post, to support our transition workstream. Unfortunately we were unsuccessful in securing the funding on this occasion. ▸ Although our transition programme has been delayed in some areas, there has been significant progress in developing a transition service for adolescents and young adults living with type one diabetes. The team have received funding for a 12 month pilot, to introduce a transition service to provide better outcomes and experience for young adults living with type one diabetes. ▸ The team have collaborated with other organisations who have transition services in place to identify best practice, and have been undertaking patient and staff engagement, as well as developing dashboards to support the ongoing monitoring and evaluation of this service.	▸ Continue as a Quality Indicator for 2021/22 ▸ The Women and Children's division are developing a Children and Young People's Strategy, which is being co-designed with colleagues across the division and young people using our services. One of our priorities in this strategy is to deliver a programme to transform outdated processes and pathways, which will incorporate transition into adults services. ▸ The new transition service for young adults with diabetes will be launched in 2021/22, with recruitment for new posts underway. This service is a 12 month pilot, and a key aim of this work is that the clinical care provided will follow structures set out within Best Practice Tariff with an aim of the service being income-generating longer term to help promote longevity of the service.

To improve maternity experience

How have we performed in 2020/21?	Plans for 2021/22:
▸ Although nationally we were not required to capture Friends and Family Test data this year due to Covid, as a Trust we took the decision to continue with this to ensure that we could capture the experience of women in our care, and understand the quality of service we were providing to our patients during our response to the pandemic. ▸ Our FFT data shows that in 2020/21, patients reported a more positive experience at the height of wave one, which decreased in the middle of the year as the visiting restrictions were introduced. As a Trust, we tried to ensure that the impact of these restrictions on the experience of mothers and partners was as low as possible, but the feedback shows that it was the restrictions in place that mainly impacted the women's experience of our services, and caused the decrease in positive score. ▸ As a Trust, we took part in the voluntary National New Mothers Experience of Care Survey; we ranked 3rd out of a total of 12 Trusts who took part in the survey. With a higher than average response rate of 32% (132 responses out of 408), our overall positive score was 90.96%. ▸ A number of areas were identified in the survey where we had improved or were above the national average, as well as areas where further improvement was needed. This work is being coordinated alongside our response to recommendations from the Ockendon Report	▸ This will continue as a Quality Indicator for 2021/22 ▸ Maternity services are developing a divisional strategy, and improving the experience of women accessing our services will be a key priority area, with a focus on embedding the Continuity of Care Programme, aiming to put in place the building blocks by March 2022 so that continuity of carer is the default model of care offered to all women by March 2023 ▸ A co-designed patient experience improvement workshop will be delivered, led by the Head of Midwifery in Autumn 2021, incorporating experience data from a range of sources, which will lead to a quality improvement collaborative supported by GSQIA ▸ Maternity services are working with the Maternity Voices Partnership and the Local Maternity and Neonatal System (LMNS) to develop a range of opportunities for engagement, to ensure the voices of women and staff are heard in our service developments ▸ There will be a particular focus on how we engage with and support our ethnic minority communities in the development of our services

To improve Urgent and Emergency Care (ED) experience

How have we performed in 2020/21?	Plans for 2021/22:
▸ Patients reported a variable experience of our ED department through our FFT surveys, and thematic reviews of these comments was undertaken, from August 2020 to February 2021 ▸ This review highlighted a number of themes emerging from the feedback, which has been used by teams to develop a patient experience improvement plan addressing these areas, with a number of actions already in progress. Work on this will continue into 2021/22. ▸ This work is being monitored through the division and also through the Trust's Quality Delivery Group	▸ This work will continue as a Quality Indicator for 2021/22, as there are a number of priority actions that are ongoing in the patient experience improvement plan. The Trust is currently reviewing the recent National Urgent and Emergency Care Survey results, which will be used to review and update the improvement plan. The key focus areas for 2021/22 include: ▹ Setting up a Patient Experience Group for the department and recruiting experts by experience to be involved in identifying and prioritizing areas for improvement. This group will meet regularly to monitor delivery and review of the plan ▹ Introducing a Patient Guardian role into the department ▹ A focus on improving the care we provide for patients with mental health illness in the department, through the Mental Health Working Group which has experts by experience involvement ▹ Reviewing all signage in the department to improve accessibility ▹ Reviewing patient information leaflets ▹ Ensuring patient representation on working groups is diverse and representative of our communities

To improve Adult Inpatient experience

How have we performed in 2020/21?	Plans for 2021/22:
▸ One of the major impacts from the pandemic on inpatient experience was the restriction on visiting, which was particularly distressing for our patients and their relatives ▸ In response, our Patient Experience Team set up the Patient Support Service, who were available 7 days a week to support relatives and patients keeping in touch. The service supported concerns and queries, delivering letters, photos and messages to patients from their relatives, and our team of volunteers took in belongings from relatives unable to visit our patients. ▸ Since the service was set up on 3 April, we have taken 6800 calls, delivered over 1100 messages, letters and photos to patients on our wards, and collected over 4500 belongings from relatives unable to visit our patients. The belongings service has been staffed by volunteers at both sites, and has proved extremely popular and was available 7 days a week.	▸ Improving our inpatient experience will continue as a Quality Indicator for 2021/22 ▸ The key themes that have emerged through PALS and our Patient Support Service this year as areas for improvement have been looking at communication, and management of property. Our work for 2021/22 will therefore include: ▹ Introducing volunteer roles that work closely with PALS and divisional teams to focus on improving communication and experience for our inpatients ▹ Working closely with divisional and corporate teams to review and improve our property management and how we minimize lost property in our hospitals ▹ Working with teams across the hospital to look at how we can continue to develop our offer to carers of patients in our hospital ▹ Reviewing the National Inpatient Survey 2020 (which is expected in Summer 2021) to identify priority areas for improvement

To enhance and improve our safety culture

How have we performed in 2020/21?	Plans for 2021/22:
▸ Work on the Safety, Communication, Operational Reliability & Engagement (SCORE) surveys with theatres teams was put on hold due to the pandemic, as focus groups with teams were not possible during this time	▸ This work will continue as a Quality Indicator for 2021/22 ▸ The SCORE programme will be re-started in 2021-2022, beginning with a review of the data previously collected to understand any changes due to the passage of time. Once completed the next step of the process will be to develop a multi-disciplinary improvement collaborative using the data and feedback collected. ▸ This will utilise Quality Improvement methods and with the support of the Gloucestershire Safety & Quality Improvement Academy (GSQIA) involve the staff in developing and testing improvements in the identified areas. The SCORE survey will then be repeated to determine the impact of the interventions undertaken.

To improve our prevention of pressure ulcers

How have we performed in 2020/21?	Plans for 2021/22:
▸ Following our initial pressure ulcer summit, we had developed a pressure ulcer prevention quality improvement plan which was be led by the Tissue Viability Team. Our first programme of work was to complete in depth diagnostic work of our data to turn this into insights so we could prioritise our improvement work. ▸ The implementation of the Electronic Patient Record has enabled us to have better oversight of pressure ulcer risk assessments and prevention plans that are being put in place for our patients. ▸ Our SPC data shows a significant reduction in the rate of hospital acquired stage 2–4 and unstageable pressure ulcers in 2020/21 from 2019/20	▸ This work will continue as a Quality Indicator for 2021/22, with further work as identified in the improvement plan ▸ The focus for 2021/22 will include: ▹ Continued review of our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording. ▹ Establish a Shared decision making council to encourage that agreement about pressure ulcer prevention is reached in an inclusive and collaborative way. ▹ Mapping all our current data sources so that we can develop a single item quality report. ▹ Continue to develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues. ▹ Regularly monitor data and undertake learning to improve care – develop quick feedback loops. ▹ Work with wards to set measurable targets appropriate for their area. ▹ Continue to provide speciality level data for pressure ulcers. ▹ Include pressure ulcers data at Divisional level reports in SPC charts. ▹ Continue to map where the high-risk wards are and provide focused improvement work in these areas. ▹ Provide all clinical staff with educational resources for pressure ulcer prevention, and to continue to think outside the box on innovative ways to deliver. ▹ Ensure that all areas have access to equipment to facilitate pressure ulcer prevention, including exploring a managed equipment service. ▹ Continue to work with a network of tissue viability link nurses to support the trusts improvement plans

To prevent hospital falls with injurious harm

How have we performed in 2020/21?	Plans for 2021/22:
▸ Improvements set out in the Falls Prevention Improvement plan have been hampered by the COVID-19 crisis. ▸ Patient falls per 1000 bed days in 2020-21 averaged 7.8, compared with 6.3 (2019/20) an overall increase of 19%, despite having fewer beds in our hospitals. ▸ There were 2199 falls between April 2020 and March 2021. ▸ In relation to other hospitals around the Southwest, we are on a par and not standing out as an anomaly. ▸ There have been some improvements in 2020/21, including improved access to data on EPR, continued learning identified through the Preventing Harm Hub, and targeted engagement and support for areas identified as higher risk, including action plans	▸ This work will continue as a Quality Indicator for 2021/22, with a focus on: ▹ Identifying hotspots and work with wards and Divisions to reduce inpatient falls ▹ To have criteria around reducing the number of transfers a patient can have during one admission ▹ To monitor the data from EPR to improve on the completion of the falls documentation on EPR ▹ Providing trust wide falls prevention teaching ▹ Working with the falls links to improve falls prevention at ward level ▹ Learning from serious incidents via the Preventing Harm hub ▹ Identification of community dwelling people at risk of falls who are admitted to the acute to ensure preventative measures on place ▹ Recognition of ‘free from Days’ ▹ A Shared Decision Council for Falls and Pressure Ulcers has been commended so as to ensure ward level involvement for falls prevention.

To improve the learning from our investigations into our serious medication errors

How have we performed in 2020/21?	Plans for 2021/22:
▸ To achieve the required standards on the safe and secure handling of medicines set out with the Gloucestershire Hospitals NHS Foundation Trust Policy on Ordering, Prescribing and Administration of Medicines (POPAM), six standards are audited by pharmacy and reported monthly to senior nurses. ▸ Our overall compliance across the six standards Trust-wide is 93.8%, which exceeds the 90% target ▸ Standard Four (That there are NO drugs left out un-secured) has proved the most challenging for teams across the Trust during this year, particularly in Medicine and Surgery, where the overall compliance scores for the year were 83.8% and 86.6% respectively. ▸ Where we are below the 90% compliance, action is required by clinical area nurse managers, with an agreed escalation process	▸ The escalation process will be reviewed to ensure that where areas are identified as consistently not meeting the standards, we have appropriate support and review in place. Achievement of standard 4, that no medicines are left out unsecured, has been the most challenging issue for teams. The audit has identified issues include secure locations to leave medicine, transport bags and access to medicine cupboard keys. Further work in this area and to improve compliance with Standard Four will be a focus for work in 2021-22

To improve our infection prevention and control standards (reducing our Gram-negative blood stream infections by 50% by 2021)

How have we performed in 2020/21?	Plans for 2021/22:
▸ All episodes of Gram negative bacteraemia (E.coli, Klebsiella species and Pseudomonas aeruginosa) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements. The Trust has seen a reduction across all of these in 2020/21. ▸ Despite the challenges facing the team this year in responding to the Covid-19 pandemic, the Trust still participated in PreciSSion (Preventing Surgical Site Infection across a region), which is a collaborative project involving all hospitals in the West of England and the Academic Health Science Network (AHSN). ▸ PreciSSIon was implemented in Gloucestershire Royal Hospital in January 2020 we saw the colorectal elective SSI rate decrease from 14.6% to 8.5% (data collected until February 2021); this represents a 52.8% reduction in elective colorectal SSIs. PreciSSIon was also implemented in Cheltenham General Hospital in November 2019 we saw the colorectal elective SSI rate increase from 7.8 % to 8.6% (data collected until February 2021); this represents a 9.7% increase in elective colorectal SSIs.	▸ We aim to maintain a 3-5% reduction in hospital acquisition of Gram negative blood stream infections, as part of our 2021/22 infection prevention and control strategy ▸ The Trust will continue to deliver an evidence-based bundle to reduce colorectal surgical site infection but also explore implementation of evidence-based SSI prevention bundles for other surgical specialities including C. sections and Hip replacement surgery which will be supported by an enhanced Surgical Site Infection surveillance programme.

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

How have we performed in 2020/21?	Plans for 2021/22:
▸ In March 2020, the Trust decided to deploy the e-observations functionality within our Sunrise Electronic Patient Record, which enabled teams to record patient observations and escalate the management of deteriorating patients, all introduced amid the huge organisational change required to prepare for the pandemic ▸ The ability to record the NEWS2 electronically has led to huge improvements in accuracy of NEWS2 scores, numbers of sets of scores being recorded alongside greater availability and timeliness of data. The system generates list of patients with scores of 5 and over. ▸ Having e-observations in place within our electronic patient record has proved essential in managing our patients during the coronavirus pandemic. Our acute care response teams have been able to manage caseloads; senior nursing staff have used the data to manage staffing deployment; and teams have been able to track the numbers and locations of patients who are being supported by oxygen. The availability of data both at the bed side and remotely has improved visibility of the deteriorating patient. ▸ We audit the number of correctly calculated NEWS2 across various wards each month and these are reported on the Nursing Metrics and through our Insight reporting. Our data shows compliance ranged between 37% and 64% throughout the year, and further work is needed to embed this and improve recording	▸ Improving the care of patients who deteriorate will continue as a Quality Indicator for the Trust, and the priorities for 2021/22 include: ▹ Engagement with teams in divisions to understand and improve compliance with data being recorded in a timely manner ▹ Doctor's handover documents will be live on EPR from 12th May. ▹ Point of Care Testing and EPR: Plans to link blood gas machines to EPR. This will date stamp and put on the system all lactates, a key component of diagnosis of sepsis. ▹ Electronic prescribing will complete the chain of data from recognition of sepsis to time stamping all interventions including antibiotic prescribing and administration. ▹ Computer diagnosis of sepsis - Use of algorithms, based around vital signs and blood chemistry to diagnose early signs of sepsis July 2021. ▹ Medical Education: ongoing embedding of sepsis training for foundation doctors and clinical simulation, using sepsis as a basis of in-situ clinical simulation in addition to sessions run in the education centre. ▹ Referrals from the internal rapid response: looking into having a telephone number that relatives can call to talk to the acute care team.

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

How have we performed in 2020/21?	Plans for 2021/22:

▸ In 2020, Healthwatch Gloucestershire published their report into people's experiences of Mental Health Services in our emergency department. The report highlighted areas where care for our patients in Gloucestershire could be improved, and where partners across the system could work together more effectively
▸ In response to this report, the urgent care leadership team relaunched the Mental Health Working Group in the department, and reviewed their improvement plan to incorporate the recommendations and feedback from this report. The improvement plan has the following four key work programmes identified:
  ▹ Physical Estate and Signposting
  ▹ Patient flow and patient experience
  ▹ Skill mix and staff training
  ▹ Communication
▸ Progress made in 2020/21 against this plan includes:
  ▹ Engaged two Experts by experience to collaborate on the plan ahead
  ▹ Australian Triage Tool has commenced – early stages
  ▹ First draft complete of re-design of documentation and risk matrix
  ▹ Inclusion of Mental Health assessment in all ED documentation
  ▹ Funding approved for new furniture for Mental Health interview room
  ▹ Funding approved for Mural within Mental Health Interview room
	▸ This will continue as a Quality Account Indicator for 2021/22, with work continuing against the workstreams highlighted. This work will continue to be monitored through the Mental Health Working Group, with involvement of experts by experience, and through divisional board and Quality Delivery Group.

To improve our care for patients with diabetes

How have we performed in 2020/21?	Plans for 2021/22:
▸ As part of COVID-19 response the Diabetes Specialist Nurse team monitored and managed diabetes inpatients and responded to changes in blood glucose/ ketone levels. Patients across all inpatient wards were able to be monitored by the Diabetes team through a remote monitoring system whereby patient blood tests were uploaded into the system, analysed and the results sent electronically real time to the Diabetes team and Pathology service. Any patients who were outside of the expected control limit were automatically prioritised for nurse review and intervention which enabled harm to be reduced as a result. ▸ A Diabetes Inpatient Specialist Nurse commenced in post June 2020 and the highest proportion of reporting coincides with this appointment. This demonstrates the impact of dedicated inpatient nurse capacity to monitor and support the wards with recognising harm to patients with diabetes and the increased education is enabling staff to recognise gaps in patient management that may have been missed previously. ▸ The organisation had agreed to invest in more Diabetes Inpatient Specialist Nurse resource however we were unable to recruit into these key roles within year. To continue to improve insulin incident rates further in the future extra resource is a key enabler of our 2021/22 quality plan for Diabetes.	▸ This work will continue as a Quality Account Indicator for 2021/22, as a Trust priority. It is now well documented that there is an increased risk of patients with diabetes becoming acutely unwell if they contract Coronavirus and in fact patients developing Diabetes following COVID infection due to the treatment required. The organisation is therefore prioritising recruitment and retention of Diabetes Nurses within the Inpatient team to focus on direct patient interventions and increased remote monitoring. ▸ Education for wards is a large-scale endeavour that is required in addition to direct patient care. This takes the form of: ▹ 1:1 and Group teaching live on the ward. ▹ Provision of teaching and learning aids on the wards. ▹ Development of an eLearning module for all clinical staff. ▹ Review of the documentation we use to streamline and simplify where possible. ▸ A trust wide rollout of education across both Cheltenham and Gloucester sites that start with wards experiencing the highest rate of incident will also be a focus for 2021/22.

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

How have we performed in 2020/21?

- In June 2020, the Trust agreed to review our 2017 Dementia Strategy using the Trust's Quality Strategy framework of Diagnose Design Deliver to ensure a robust evaluation with an in depth analysis of research and data. This process helped to set out key priorities for dementia alongside measures that would show progress and improvement, and three key priority areas were identified as part of our improvement plan.
- Completion of dementia screening is now captured within the Nursing Admission documents in our EPR system. The metric reported shows the Dementia Screening assessments which were completed within 24 hours of admission on EPR and the patient was aged 75 or over (denominator), and counts those where it was documented that either the patient was too unwell to screen, or there was an answer to the question 'Has the patient got a clinical diagnosis of Dementia'.
- The current Trust average for compliance with the screening assessments in EPR is 71% across all sites
- The Trust's as recruited its first Admiral Nurse through a joint funding initiative with Dementia UK. The Admiral Nurse very quickly began leading face to face support for ward staff, patients and families. Links were established with the local Alzheimer's Society Dementia Advisors to continue support following discharge, and more recently testing ways to reduce the number of bed moves for patients with dementia
- The Admiral Nurse has also worked with Dieticians and Infection Control Teams to improve nutrition and hydration using a sequence of coloured water jugs as a visual way to alert staff to an individual's hydration status.

Plans for 2021/22:

- The Trust Dementia Improvement Plan work will continue as a Quality Indicator for 2021/22. The Trusts Admiral Nurse outlined the priorities for 2012/22:
  - Further Dementia data to be recorded in ESR and available on Insight, as well as embedded within our Quality and Performance Reporting.
  - Address DAR/FAIR issues if NHSE continues use as an indicator.
  - Dementia & delirium screening/ assessment/treatment to be recorded in the Electronic Patient Record; work is already underway to with the digital team to identify how to capture collate and compare data.
  - Work has commenced with ICS partners on a system-wide engagement with the delirium pathway.
  - The Trust's Admiral Nurse and Dementia UK are developing an activity report to capture the impact of investment and the scope of the Admiral Nurse role.
  - Trust Dementia Champions are being re launched as part of activity for May's Dementia Action Week.
  - To complete current Quality improvement work including minimising bed moves for dementia/ delirium patients, improving hydration and trails of whiteboards on wards 4a, 4b and 6b.

To improve outpatient care

How have we performed in 2020/21?	Plans for 2021/22:
▸ The Attend Anywhere pilot changed dramatically in March 2020 due to the pandemic and became an implementation of capability across the Trust for outpatient specialities 'at pace'. 56 specialities in the Trust rearranged clinics to embark on video consultations. ▸ The first challenge that we faced was to ensure that outpatient services continued and where it was deemed vital for a face to face these took place with special measures for Covid-19 in place. Other clinics were redesigned to ensure patients had either a telephone or video appointment across all disciplines. ▸ The second challenge was to ensure that equipment was made available for all those clinical areas that were to conduct video clinics. Across the nation the demand for equipment both for business and private use rose exponentially and support came directly from NHS England (NHSE). ▸ NHSE needed the Trust to perform at least 25% of our Outpatient appointments virtually (video or telephone) and the Trust has consistently met this goal and on data provided by NHS Improvement Model Hospital, the Trust has reached over 45% virtual outpatient appointments at the height of the second wave and continues to deliver at 40%.	▸ The significant upturn in the use of video appointments in response to the pandemic gave the Trust a valuable opportunity to embrace new technology. In 2021/22 the key focus is to increase use of video consultations and to understand where video consultations are both appropriate and effective. ▸ The Trust plans to continue to use Attend Anywhere for a further 12 months and review other platforms to get best value for money for the Trust. Currently there is funding in place from NHSE to finance the licence for Attend Anywhere for another year and in the meantime another platform Dr Doctor will be introduced and is expected to be in place within the next year. Dr Doctor will enable automated communication to patients direct from clinic software and enhance patient services further. ▸ Patient feedback to the offer of video appointments has been very positive, and the learning from this will be embedded as part of the ongoing Outpatient Services Transformation programme

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

How have we performed in 2020/21?	Plans for 2021/22:

▸ As part of an ongoing Trust commitment to improve medical review performance as well as a commitment to apply learning from the Trust's response to Covid, the Medical Director commissioned a review to:
  ▹ Compare performance against the 2019 assessment, with specific reference to Clinical Standard 2 and Clinical Standard 8
  ▹ Understand more fully how medical reviews are being carried out and learning from COVID
  ▹ Identify potential opportunities to improve Trust performance.
▸ For Clinical Standard Two: Time to Consultant Review, the April 2020 audit results showed that 70% of patients were seen by a consultant within 14 hours in the weekday, and 60% on the weekend
▸ For Clinical Standard Eight: Ongoing review, the April 2020 audit results showed that 84% of patients had a consultant led review in the weekday, and 85% at the weekend.
▸ For both clinical standards, we are still not meeting the 90% target. Alongside the audit, there were semi-structured interviews, and themes were identified that led to a number of recommendations for this work
	▸ This work will continue as a Quality Indicator for 2021/22
	▸ Review and embed recommendations from the Medical Review Project report, including incorporating the benchmarking information from other Trusts

How have we performed in 2020/21?	Plans for 2021/22:
▸ The project also reviewed the General Practitioner Assessment Unit (GPAU) project; the data shows that the creation of a separate area within ED, allocated specifically for GP referral patients, has significantly improved the time the patient is seen by a doctor, from arrival to the hospital. Pre-GPAU 52% of patients had their observations taken within 30 minutes of arrival to hospital and 65% were seen by a doctor within 4 hours of arrival, this increased to 84% of observations taken within 30mintes and 100% seen by a doctor within 4 hours of arrival once GPAU was implemented. ▸ Recommendations from the GPAU project have been incorporated into the overall recommendations from the review.	

Emergency Planning Response and Resilience: our COVID response

Background

On 11 March 2020 The World Health Organization (WHO) declared a COVID-19 Pandemic, with Gloucestershire's first cases being confirmed earlier in February 2020. The emergence of this novel infection has placed significant pressure on all NHS and care organisations.

At this time, we were in the midst of go-live planning for the next crucial part of our EPR jigsaw – implementing electronic observations across all adult inpatient wards in our two acute hospitals, so that we could identify our sickest and most vulnerable patients. We also had the biggest event of the year happening on our doorstep, with 180,000 people coming to Gloucestershire for the Cheltenham Festival.

This required an internal incident response involving staff from all parts of the hospital, to ensure we could monitor staffing levels, PPE kit levels, pathology turnaround times, oxygen status, bed occupancy, and all the other issues introduced by the crisis. This involved reporting twice a day to our own internal command centre on a trust-wide call, regular updates and involvement with our system partners, and managing the ever-changing reporting requirements for regional and national government.

Developing our systems

As a digitally immature Trust still developing its systems, the infrastructure required to manage and coordinate this response did not exist, so our digital teams built one – which won an award for Best Use of Data in the HTN 2020 Awards. What began as a web based dashboard showing COVID patients admitted to hospital; soon developed into a multi-layered information hub – used by operational staff to plan our response to the biggest pandemic in a lifetime.

We brought together data from existing systems; combined with data manually inputted into newly created web forms; into one place. Frequently updated (ranging from minutes to hourly depending on the requirements) it provided an essential snapshot for planning, reporting and managing our response.

Whilst we heard about shortage of PPE stocks across the country, the dashboard enabled us to manage and monitor stocks carefully, most importantly giving the executive team and senior clinicians oversight. Gloucestershire was hit early, with the highest case and admission numbers in the south west at the start of the pandemic. With no electronic stock management systems, the digital dashboard provided a way of monitoring our PPE levels, protecting our staff and patients and ensuring we never ran out or compromised safety.

At the height of the crisis the digital dashboard told us:

- Green and red bed capacity across two acute hospitals
- Closed wards and empty beds
- Number of COVID patients
- Number of swabs and results
- Staff testing numbers and results
- Actual staffing on every shift, broken down by role
- Intensive care bed space
- Oxygen supplies available and remaining
- Patients receiving oxygen and how

- Numbers on ventilation
- Gown stocks – disposable
- Gown stocks – re-usable laundered and waiting to be laundered
- Gown daily usage by ward and area
- Body bag stocks
- Hygiene product stocks (wipes, sanitiser)
- Mask stocks and usage
- COVID deaths
- Mortuary capacity

The dashboard also generated an automated daily sitrep, a downloadable high level report for sharing – sent to exec inboxes and used in bed management calls.

Access was managed centrally, providing secure access only to those operational and exec leads leading our response or participating in the twice daily sit rep calls.

Wider access to just the front screen – which provided high level case information on admissions, deaths and swabs - was given to partners in public health, and our county intelligence cell. Reducing the need for phone calls or delayed updates.

The success of the dashboard means that it is still used even after the initial crisis has passed. It provides real time information for our bed managers and chiefs of service, replacing a manual counting system (based on calls to ward staff six times per day) with an automated system loved by our bed management teams.

PPE safety officers

Alongside needing systems in place to coordinate our response, we knew that infection prevention and control would be key to saving lives and protecting our workforce. The COVID-19 pandemic brought infection control and prevention to the forefront of our work. It's something we've always focussed on, but with the introduction of specialist personal protective equipment (PPE) we needed a much bigger focus on its use. Our main priority was protecting our staff and instilling confidence in our workforce at the most challenging time in our careers.

Many nursing staff were unfamiliar with some of the equipment they were required to wear, causing anxiety and increased risk of exposure. Evidence from the Ebola outbreak demonstrated the importance of the doffing process in reducing risk of contamination and that correctly managing PPE would be crucial to keeping nurses safe.

Inspired by breathing apparatus expert roles embedded across the Fire Service, the Chief Nurse and team introduced PPE Safety Officers. These would be nurses from all levels and disciplines, trained to support colleagues with PPE. They would educate and support staff with the correct donning and doffing of PPE, provide dedicated FIT testing and on-demand support to colleagues across the hospital.

The main aims would be to reduce risk of infection and contamination, protect our staff and patients and ultimately save lives. We wanted to provide confidence and reassurance across our hospitals, for both clinical and non-clinical staff, that their safety was our priority.

The PPE Safety Officer role would be used to:

- support health care workers to safely use PPE required for contact with patients with suspected or confirmed COVID-19
- deliver ward based training to clinical and non-clinical health care workers on the correct and safe use of PPE for non-aerosol generating procedures, aerosol generating procedures and high risk areas
- answer questions and provide reassurance to staff to give confidence that their safety is of the highest priority.
- support staff in the safe donning and doffing of PPE to minimise the risks of self-contamination
- Deliver training on FFP3 respirator fit checking.
- Deliver training on hand hygiene
- Work with stock teams to ensure PPE is available to those who need it most, when it's needed
- Provide an on-call and out of hours service to be available to staff at all times

Although the initial idea came from the Chief Nurse and senior infection control nurses, the scheme itself was then developed entirely by junior nursing colleagues. We tested ideas amongst the infection control and ward teams and considered using 'doffing buddy' - but we needed the role to be taken seriously so created PPE Safety Officers. Visibility and awareness was essential for the role, with key activity to promote the work including:

- High viz jackets clearly badged with PPE Safety Officer
- Posters, leaflets and photo profiles of the team
- Developing an online training package
- Our own PPE demonstration materials to support our educational work, featuring nursing staff
- Online training sessions on PPE use, attended by hundreds of staff and shared widely on our intranet, internet and with other organisations
- Updated senior clinicians twice daily on the trust wide sitrep calls (run by the medical director)
- Monitored stock levels through an online dashboard, updated hourly
- Updates and information using a dedicated WhatsApp group
- Shared information quickly through social media

We know that ward staff feel much more reassured with PPE safety officers available and it boosted confidence and morale at a challenging time. The scheme has been shared with colleagues in the UK, US and Australia and we know of at least 20 NHS hospitals taking our idea and running similar programmes. Our main success outcomes are:

- None of our workforce have died as a result of COVID-19
- We did not run out of any PPE stocks, despite having the highest number of cases in the region for a sustained period of time
- We were able to get supplies to the clinical areas that needed them most
- We reduced nosocomial transmission through a strict approach to hand hygiene
- Highly visible communications campaign
- 1,000+ colleagues have viewed webinars and events

At a time when clinical staff were at their most exposed and vulnerable, we provided a heightened presence across the organisation so that colleagues felt supported and confident that their safety

is our priority. The teams were shortlisted for a Nursing Times Award for this initiative, and the PPE safety officer role is now embedded in our acute hospitals and we are refining it to ensure it stays relevant in a non-COVID world; and also ready to 'stand up' if another wave hits.

Launching the 'yellow brigade'

As the pandemic hit we were planning for 500 covid patients in our beds, but only had two wards with nurses used to dealing with complex respiratory patients.

We needed to ensure that all of our nursing, nursing associate and healthcare assistants felt confident, equipped and supported to provide good nursing care to respiratory patients.

To do this, we pulled together a team of more than 200 registered professionals with respiratory skills who were directed to provide support to nursing staff across our hospitals. The idea, which won the Nursing Times Award, came from our Associate Chief Nurse, who wanted to ensure that nurses and AHPs with respiratory expertise were highly visible, available and could be called upon for supervision and support. The 'yellow lanyard' or 'yellow brigade' specialists included RNs, Specialist nurses, ANPs, ACPs and physiotherapists. They would provide 24/7 on call respiratory support for:

- Setting up of NIV
- Setting up of CPAP
- Setting up of Hi-flow Oxygen
- Assist with assessment of unwell respiratory patients
- Supporting ward teams to care for sick patients
- Supporting ward teams to care for worried relatives and loved ones
- Ward based teaching relating to respiratory support including, humidified oxygen & venturi oxygen

As well as launching the 'yellow brigade', our respiratory nurses also helped develop an online learning package to support and educate our 4,000+ nurses, doctors, and healthcare professionals working on the frontline.

The challenge would be to embed the new responders within existing and new teams – and to ensure visibility and confidence amongst our teams. So we created a programme that would ensure the Respiratory Responder team would be present at Doctors ward rounds on Respiratory High Care; and available to support any nursing staff working with respiratory patients. This involved twice daily visits to wards, continuous training when needed and triage phone support.

Direct feedback from staff has been overwhelmingly positive, saying they felt supported, and the online training helped develop their skills and awareness. The package was shared and adapted with 52 NHS Trusts, and there has been more than 100,000 views of our online learning across 100 countries (including UK, Ireland, New Zealand, Australia, India and China)

Combined with our new EPR, we could identify the poorliest patients quickly and send in our respiratory experts. What began with a simple idea of a yellow lanyard, developed into something of which we are immensely proud and has boosted the number of staff with respiratory expertise. Our mobile team of nurses, supplemented with physios and doctors, could respond to areas where

there were COVID patients –providing specialist support to staff and patients.

Staff Health and Wellbeing: caring for those who care

The challenges that colleagues have faced in caring for our patients and communities over the last year have been huge, and we knew that we needed to ensure we put support systems in place to make sure we were also looking after our colleagues. 9.5 months after its launch in May 2019, the 2020 Staff Advice and Support Hub rapidly expanded its remit and scale to become the central point of contact, signposting and advice for colleagues for all COVID-19 related queries.

From 4 April 2020–26 March 2021 (12 months), there have been 9,677 separate points of contact to the 2020 Hub by colleagues who work across both Gloucestershire Hospitals NHS Foundation Trust (GHT) and Gloucestershire Managed Services (GMS). This compares with 631 separate points of contact in the first 9.5 months of the 2020 Hub opening (14 May 2020 – 1 March 2020). From 2 March – 3rd April 2020, during which the pandemic was officially announced and the UK went into its first national lockdown, the Hub received 3,207 contacts.

Since the Hub's launch it has responded to a total of 13,515 contacts.

In the previous 12 months, 77.4% of contacts to the Hub during this period were by phone call, with 22.6% as email contacts. Physical face-to-face visits to the 2020 Hub team are now negligible given the increased requirement for home working and physical distancing.

The table below shows the demand on the service on a monthly basis. We can observe that demand has mirrored the first and second/third waves of the COVID-19 pandemic.

The busiest months for contacts in the Hub in the last year were:

- April 2020: 1642 contacts
- November 2020: 1162 contacts
- December 2020: 1151 contacts
- January 2021: 1174 contacts

The quietest months were:

- July 2021: 450 contacts
- August 2021: 355 contacts
- February 2021: 527 contacts
- March 2021: 437 contacts

From 1 April 2020 – 31 March 2021, overall there have been 22,970 hits on the 2020 Hub webpages.

There has also been a dedicated wellbeing/support page on the COVID-19 section of the intranet which has received 25,488 hits since April 2020.

In October 2020 we launched a new Peer Support Network which is comprised of 20 volunteer colleagues who will provide confidential listening and support to colleagues who may be experiencing acute stress or distress. Peer Supporters will also be used to provide impartial pastoral support to colleagues who are involved in a safety or HR-related investigation. Since its launch, Peer Supporters have been accessed on 10 occasions by colleagues.

All Peer Supporters have undertaken training including: Psychological First

Figure 1: Total Staff Advice and Support Hub contacts Apr – Sep 2020

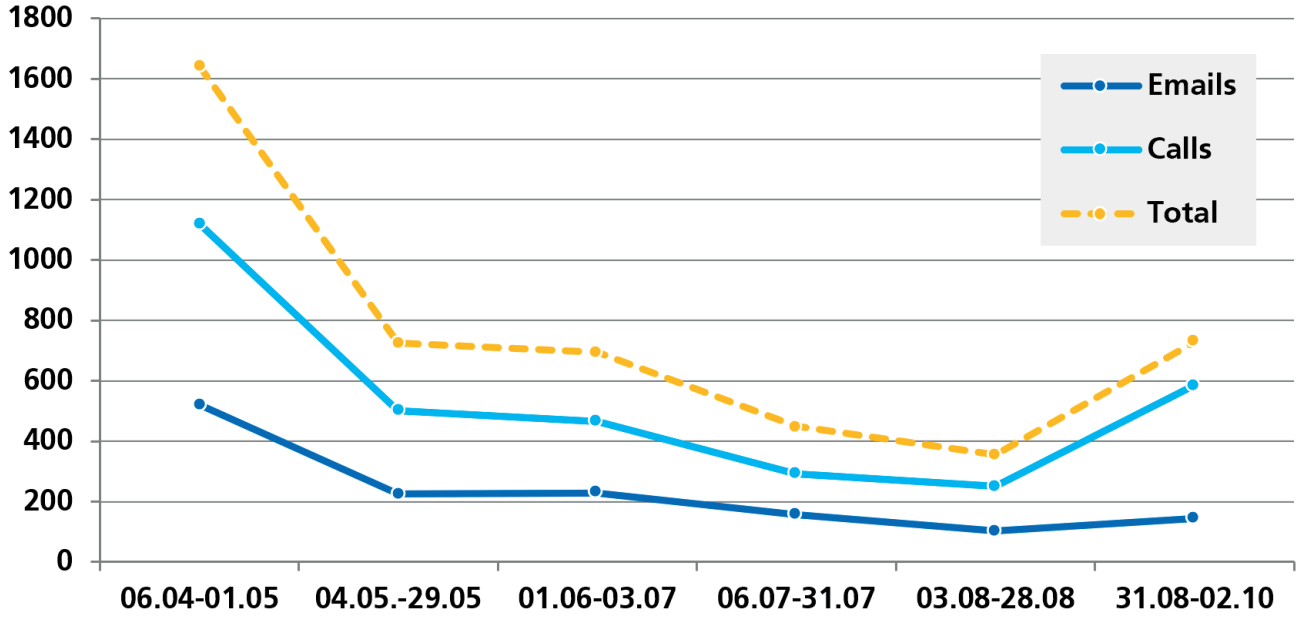
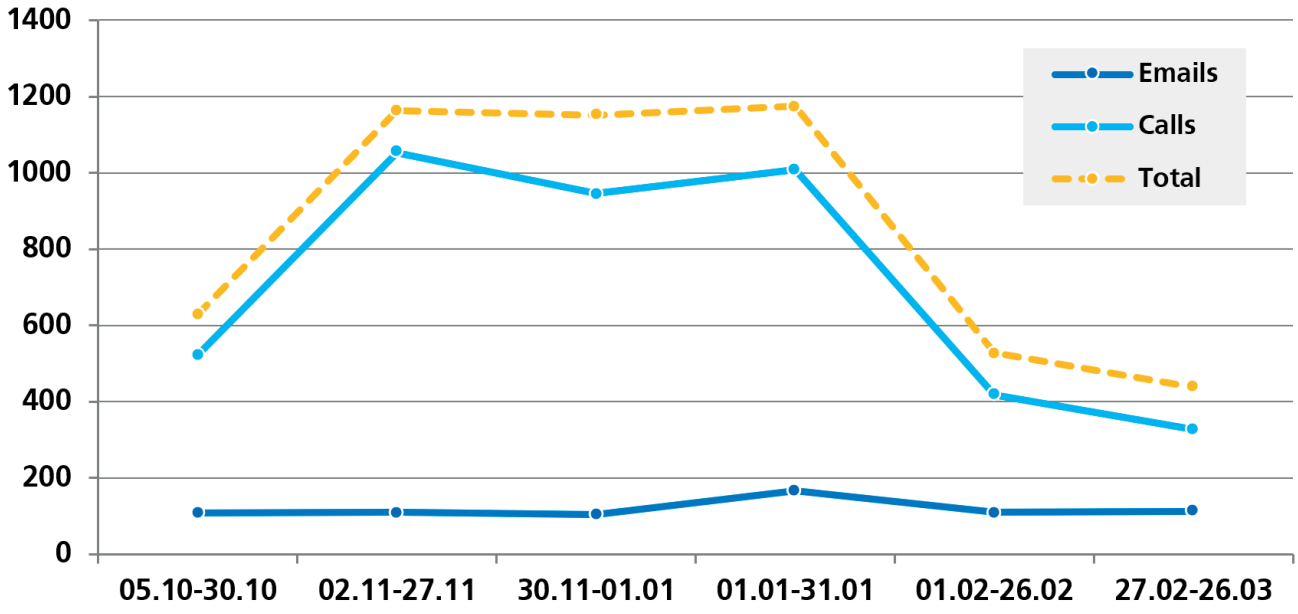


Figure 2: Total Staff Advice and Support Hub contacts Oct – Mar 2021



Aid training (online), Suicide Awareness Training (online) and participate in quarterly network events which include CPD. Due to the second/third waves of the pandemic, all Peer Supporters will be invited to undertake First Aid Mental Health Training in summer/autumn 2021.

Psychology Link Worker

During the first wave of the COVID-19 pandemic the Health Psychology team was deployed to act as Psychology Link Workers with departments and staff groups at the forefront of the pandemic response. Their support was appreciated by many and in a Trust-wide health-wellbeing survey we conducted during May/June this was one of the 'top 5' new additions to our health-wellbeing offer which colleagues wanted to continue having access to.

We employed a Psychologist on the Bank to do this role 2 days per week until October, who was then replaced by a Psychology Link Worker 0.4 WTE on a six-month contract until March 2021, using Charity funds.

The Psychology Link Worker role is to provide support to colleagues, managers and teams regarding any aspect of their psychological and emotional health and wellbeing, in the light of COVID-19 and how that might have impacted on their role and workplace. This role has been invaluable to colleagues across the Trust, and work will continue in 2021/22 to expand this resource.

Our COVID-19 Wellbeing Offer

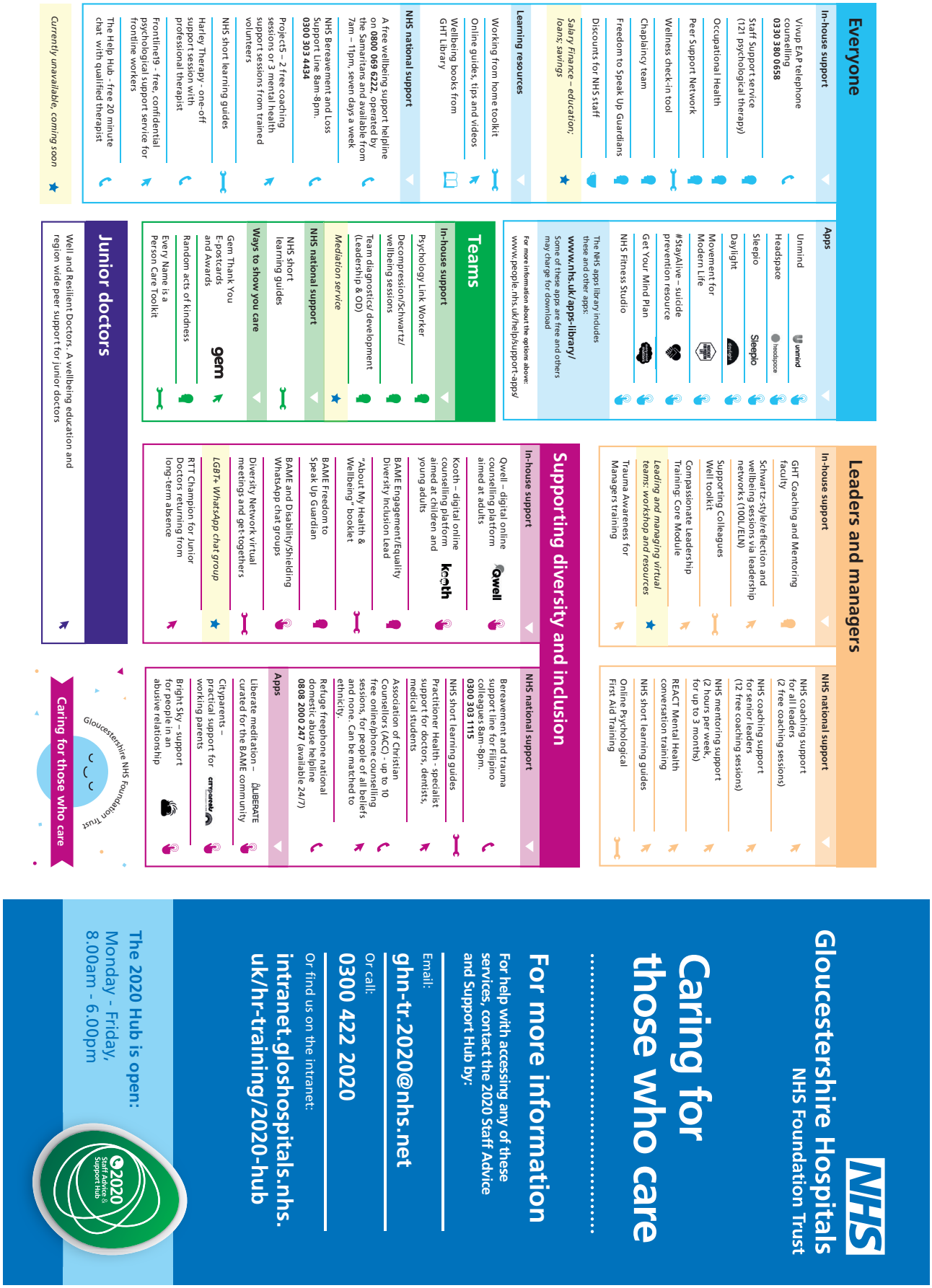
In April 2020 an infographic (Fig. 3) was developed for staff to highlight the range of health-wellbeing services which were available to colleagues. This was then updated and relaunched in October 2020, and has been updated once more in March 2021 to reflect the latest offers as we move into the recovery phase.

COVID-19 Recovery plan and next steps

To support the Trust's recovery from the impact of the COVID-19 pandemic, a number of resources and support have been organised for colleagues. These recognise both the immediate and longer-term impact that the pandemic may have on both individual and collective wellbeing and resilience.

- The Trust has supported individuals to take annual leave and appropriate rest, with appropriate phasing of restoration of services throughout the next 6 month period.
- The 2020 Hub team has grown from 2.0 WTE to 3.6 WTE to meet the increased demand for health-wellbeing support, and to administer/coordinate the increased range of services now offered (see below)
- Following the successful introduction of the Psychology Link Worker role during the first wave of the pandemic, this function is now well-established and the Colleague Wellbeing Psychologists are now embedded within the 2020 Hub function. Along with a substantive Colleague Wellbeing Psychology Lead role (0.6 WTE), using Charity and HEE CPD funds we have also appointed:
  - Psychology Link Workers x 2 (1.4 WTE 2 years fixed-term). These roles will expand and deepen the breadth of ground-level support offered to teams and leaders/managers
  - Psychologist Resilience and Wellbeing

Figure 3: Infographic detailing range of health-wellbeing services available



trainer (0.3 WTE 1 year fixed term). This role will deliver Wellbeing/Resilience workshops aimed at frontline clinical colleagues. Post holder is expected to commence in the summer.

- Clinical Psychologist (0.4 WTE substantive). This role will focus on providing 1-2-1 therapeutic counselling sessions for colleagues presenting with complex needs that cannot be met through the Vivup EAP telephone counselling service.

- We have established a TRiM model for the Trust (Trauma Risk Incident Management). TRiM is a trauma-focused peer support system which builds resilience by keeping employees functioning after traumatic events by providing support and education to those who require it. Forty colleagues are currently being trained as TRiM Practitioners who will be able to support, assess and signpost colleagues following a potentially traumatic incident, and/or are showing trauma-related symptoms in their behaviour. Eight of these Practitioners are also being trained as TRiM Managers (roughly one per division, including GMS) and they will coordinate the TRiM response Trust-wide with support from the 2020 Hub.
- Trauma Awareness training for Managers has been launched. These are half-day virtual workshops delivered by Trauma Specialists and are aimed at frontline clinical managers. There are 250 places available. The workshops help participants to:
  - Recognise post-traumatic symptoms
  - Understand the effects of trauma on human behaviour
  - Engage with potentially traumatised people to explore practical options
  - Identify clear routes to resolving workplace difficulties caused by trauma

Plans for improvement 2021/22

This will continue as a Quality Account Indicator for 2021/22, as the need to plan our recovery work continues as well as prepare for potential future waves. The Covid Dashboard, 'yellow lanyard' and PPE Safety Officer roles continue to be utilised, and will be developed further using learning from the last 12 months. The need to support our staff is a top priority for the Trust, and a number of measures are in place for 2021/22, including:

- The Team Support Group - comprised of OD, Quality and Safety, Health & Wellbeing, Freedom to Speak Guardians - meets on a monthly basis with divisional representatives. This group will support recovery by identifying trends, themes and teams/areas of the organisation which are healthy and those who need additional support post-COVID
- Throughout 2021/22 we will be expanding the numbers of volunteer colleagues who sign up as Peer Supporters. We aim to appoint an additional 12 volunteer colleagues to become a Peer Supporter – expanding the network by 50%
- We will be launching a Mediation Faculty in summer 2021/22 with trained, accredited Mediators in the Trust who will be able to provide support to colleagues who are experiencing communication and interpersonal challenges with fellow colleagues
- To support the recovery and restoration of medical colleagues, we will be partnering with Gloucestershire Health & Care NHS Foundation Trust to offer peer-to-peer decompression sessions and 121 support facilitated by Psychiatric Consultants.
- We will continue to deliver Compassionate

Leadership training to all leaders and managers in the Trust. This will support our vision to develop a compassionate and inclusive culture, which will become ever more important post-COVID.

Through our staff benefits provider, Vivup, in May 2021 we will be launching a range of financial wellbeing offers to support colleagues. Salary Finance will host access to four products: Borrow, Save, Help to Save, and Advance. A suite of financial education materials will also be available. As the furlough scheme ends and the longer-term impact of COVID on the economy is felt, these services can offer a source of support to colleagues who are adversely impacted financially, and/or need help to develop better ways of managing and saving their money.

To improve how we meet the NHSI learning disability and autism standards

Background

NHSE/I has developed standards to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism or both.

The standards have been developed with a number of outcomes created by people and families — which clearly state what they expect from the NHS.

The four standards concern:

- respecting and protecting rights
- inclusion and engagement
- workforce
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

The standards are intended to help organisations measure quality of service and ensure consistency across the NHS in how we approach and treat people with learning disabilities, autism or both.

They are prominent in the learning disability ambitions in the NHS Long Term Plan and included in the NHS standard contract 2019/20. The aim is to apply the standards to all NHS-funded care by 2023/24.

How we have performed 2020/21

The NHSI Benchmarking Learning Disability Standards audit has been completed for the last three years and improvement plans written as a result of the first two audits have focused on the audit standards, without addressing wider issues relating to people with learning disabilities and/or autism.

This year, the improvement plan has been written to encapsulate the changes needed to drive forward improvement in our standards of care for people with learning disabilities and/or autism, using as evidence the results of the NHSI audit, LeDeR reviews and Serious Adult Reviews (SARs).

The key themes that emerged from the triangulation of these different sources were:

- Data capture and management
- Patient experience
- Staff experience
- Family and carer experience

A number of actions have been progressed against each of these themes this year, including:

- Creation of a Learning Disability inbox, shared drive and workload tracker, to improve our systems and processes in identifying and supporting patients with a learning disability in our hospital
- Creation of a LeDeR tracker
- Collaborative working with wider nursing teams to introduce a vulnerabilities framework, to provide easy access for colleagues across the Trust to information and guidance on patients with a variety of vulnerabilities, including Learning Disabilities
- Reviewing the intranet pages for Learning Disabilities and Autism

- Prioritising the inclusion of Mental Capacity Assessment into our EPR documents

Plans for improvement 2021/22

This work will continue as a Quality Account Indicator for 2021/22, with a focus on improving data capture and management, as this remains a significant challenge for the teams.

The priority workstreams include:

- the disaggregation of data about people with Learning Disabilities and/ or Autism from our general data, including the creation of an autism flag in our electronic systems
- Creation of daily BI reports on our Learning Disability inpatients across both sites
- Revising our Reasonable Adjustments policy so that it explicitly includes autistic people
- Routinely asking and capturing information relevant to family/ next of kin as part our records
- Installing Changing Places Facilities at Cheltenham and Gloucester hospitals in 2021/22, following delays due to Covid
- Working with divisional and training teams to ensure a larger percentage of our workforce is trained in Learning Disabilities and Autism awareness.

To improve nursing safeguarding risk assessments process so that we identify our vulnerable patients

Background

All staff within health services have a responsibility for the safety and wellbeing of patients and colleagues. Safeguarding adults is about the safety and well-being of all patients but providing additional measures for those least able to protect themselves from harm or abuse. Safeguarding adults is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS, and routinely completing risk assessments will help to identify our vulnerable patients who need more support.

How we have performed 2020/21

In 2020, a Safeguarding Risk Assessment was developed and embedded as part of our Nursing Admission documents within the Electronic Patient Record (EPR) for use on adult inpatient wards. Completion rates can be measured by monitoring percentage completion rates of Nursing Admission within 24 hours of admission.

The graph below (Fig. 4) shows the number of Nursing Admission documents completed within 24 hours of admission on EPR (denominator), and counts those where the safeguarding risk assessment questions were answered (numerator).

The data shows an average across the year of 80% completion across the Trust, but this figure varies across our wards and sites. Completion rates are very high (up to 94%) for areas of high turnover such as AMU and the 5th floor at GRH, but less good for areas with lower numbers of direct admissions. This data is used by teams to identify areas for further engagement and education, supported by divisional teams and the Safeguarding team.

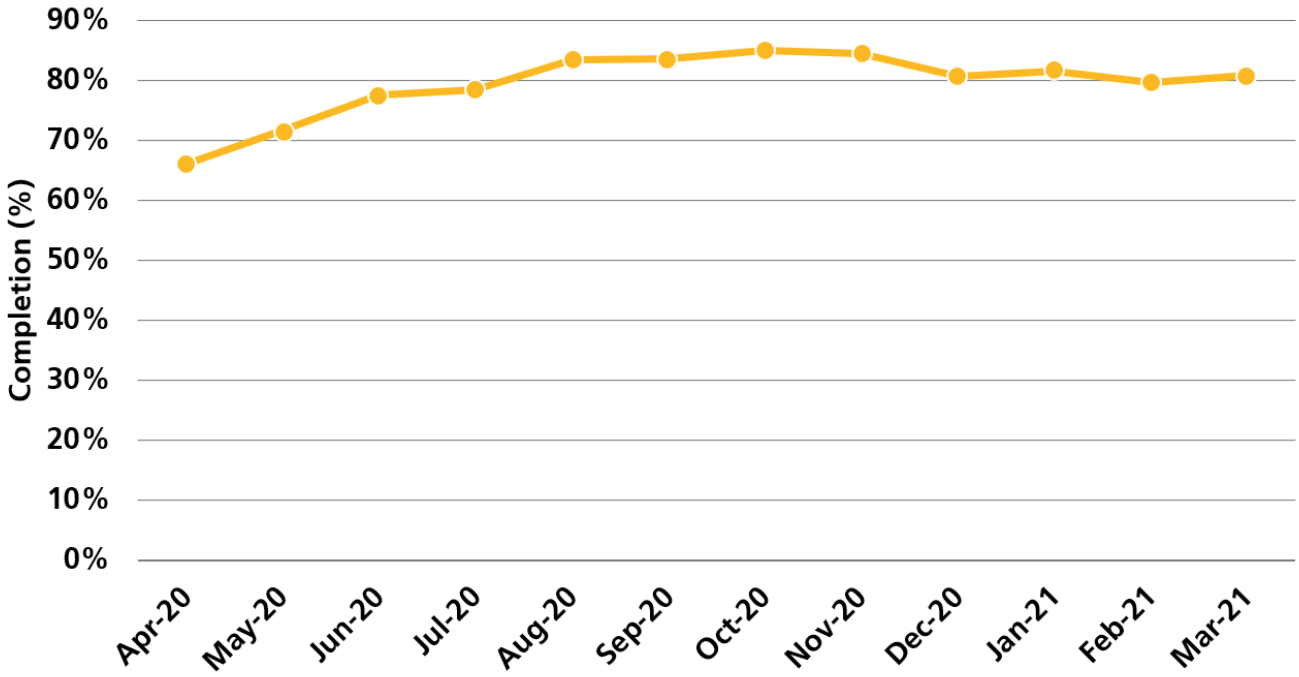
Plans for improvement 2021/22

The Safeguarding Lead is developing an improvement plan for ongoing work in 2021/22, which will be monitored through the Safeguarding Operational level Governance groups and the Trust's Quality Delivery Group.

The Safeguarding team will continue to work closely with the Digital teams on the future plans for our EPR roll out to wider areas across the Trust, particularly looking at refining our

safeguarding risk assessments in Unscheduled Care, so that Paediatrics are included. EPR gives us the ability to present only the age-appropriate assessment, which will remove one of the greatest risks, which is of older teenagers being assessed against adult criteria, instead of child criteria.

Figure 4: Safeguarding Risk Assessment Completion



To improve cancer patient experience

Background

The Cancer Patient Experience Survey has been designed to monitor national progress on cancer care, to provide information to drive local quality improvements. Cancer Patient Experience has been highlighted through the National Cancer Patient Experience Survey as an area of priority for the organisation, with the Trust having 9 'worse' than national average scores, and 3 'better' scores. In order to achieve an 'Outstanding' rating for Cancer Services we want to co-ordinate our improvement work with staff and patients to where it is most needed.

How we have performed 2020/21

We received the results for our NCPES 2019 Survey in September 2020, an overview of which can be seen on the next page.

The Trust received 486 responses to the survey with a response rate of 69% (7% greater than the national response rate).

- The Trust results are the best results since the survey started with 39 out of 52 questions scoring equal or greater to national average
- Our patients on average rated their care as 8.9 out of 10. This result is the highest score we have had since the survey started and above national average (8.8)
- 4 questions scored higher than 'upper expected range' which is an increase from last year
- 5 questions scored lower than 'lower expected range' which is a reduction from last year (9). Noting that question 5 and 54 would be considers a shared responsibility between primary care and secondary care. Whilst these 5 questions scored lower expected range, the scores were still an improvement from last year's report.

This year has clearly been a challenging year with the significant impacts on cancer care by the pandemic. Cancer Services are proud that despite the pandemic, diagnostics and treatment services kept running. Cancer Services core team as well as CNS's and Cancer Support Workers flexed to provide additional support to patients who were on our patient tracking lists throughout both waves of the pandemic. Due to this some of the patient experience actions were put on hold however there were also some significant improvements made.

The Trust signed up to a national Quality Improvement project in September 2020 focusing on using data from NCPES, Cancer Wait Times, internal surveys and local public health reports to understand our demographics and communities that experience health inequalities. Following analysis of data, it showed some interesting trends relating to patients not attending appointments. A project was set up to target additional support and understanding barriers to attending both 2ww and follow up clinics – specifically within gynaecological cancer and our local South Asian Community.

Further to this the Information hub number was also placed on all 2ww letters as a point of contact. 86 calls were received from Sept 20 to Jan 21. Themes were recorded and fed into Cancer Services team and specialties for pathway improvements.

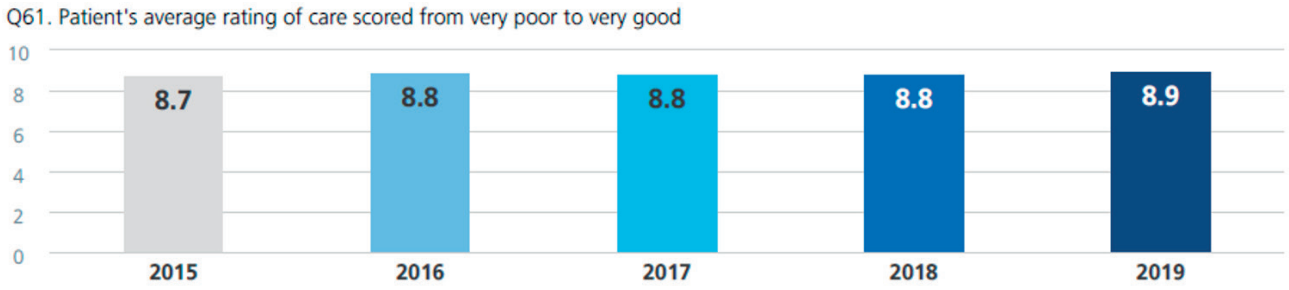
Figure 5: NCPES 2019 Survey response rate

	Sample size	Adjusted sample	Completed	Response rate
Trust	747	708	486	69%
National	119,855	111,366	67,858	61%

Figure 6: NCPES 2019 Survey Trust results

	2015	2016	2017	2018	2019
No. of scores better than national average	21	32	14	12	35
No. of scores the same as national average	2	2	8	12	4
No. of scores worse than national average	26	18	30	28	13

Figure 7: NCPES 2019 Survey average rating of care



Alongside the national Quality Improvement programme work, the Trust has developed a Patient Experience Improvement plan for cancer services, co-designed with cancer patients, which will continue into 2021/22. A number of actions identified as priorities by patients were progressed in 2020/21, including:

- Review of IT processes to ensure better communication between patients and their multidisciplinary around their diagnosis and treatment plan
- Developed end of treatment summaries for breast cancer, which was co-designed with breast cancer patients
- Reviewed public website for all specialities and placed under one cancer services page, to make it easier to navigate for patients and relatives
- Adapted the 2ww letter to include the information hub contact details so that patients have a consistent point of contact
- A directory of support services has been developed and is sent out with all 2ww letters to patients
- Target promotion to African-Caribbean patients around skin and prostate cancer through GFM local radio, with plans for further events.
- All Cancer Nurse Specialists have been given supervision, to support reflective and compassionate practice

Plans for improvement 2021/22

There are a number of priority areas for Patient Experience Improvement identified for 2021/22, including:

- Enhancing the personalised care agenda, in line with national guidance and the long term plan, including trialling the use of patient activation measures
- Engaging with patients, communities and colleagues about clinical trials and research that is available
- Continued work to improve the oncology environment
- Programme of work focussed on prehabilitation, working particularly with ethnic minority communities through focus groups to co-design new service model
- Planning a number of education and awareness events for ongoing monitoring and updating of improvement work

Whilst the NCPES was stood down for 2020, Trusts were informed that they could still take part on a voluntary basis. Due to the importance placed on getting it right for our patients the Trust decided to volunteer for participation in the 2020 survey. The data from this survey will be used to review and update the experience improvement plan in place for cancer services.

Figure 8: NCPES 2019 Survey: questions scored higher than 'upper expected range'

	Case Mix Adjusted Scores			National Score
	2019 Score	Lower Expected Range	Upper Expected Range	
Q11. Patient felt they were told sensitively that they had cancer	**90%**	83%	89%	**86%**
Q22. Hospital staff gave information about support or self-help groups for people with cancer	**93%**	84%	92%	**88%**
Q23. Hospital staff discussed or gave information about the impact cancer could have on day to day activities	**90%**	80%	88%	**84%**
Q35. All hospital staff asked patient what name they prefer to be called by	**80%**	63%	79%	**71%**

Figure 9: NCPES 2019 Survey: questions scoring lower than 'lower expected range'

	Case Mix Adjusted Scores			National Score
	2019 Score	Lower Expected Range	Upper Expected Range	
Q5. Received all the information needed about the test	**93%**	93%	97%	**95%**
Q25. Hospital staff told patient they could get free prescriptions	**76%**	76%	87%	**82%**
Q40. Patient given clear written information about what should or should not do after leaving hospital	**80%**	81%	90%	**86%**
Q54. GP given enough information about patient's condition and treatment	**91%**	93%	98%	**95%**
Q60. Someone discussed with patient whether they would like to take part in cancer research	**15%**	21%	40%	**30%**

To improve children and young people's experience of transition to adult services

Background

Following the CQUIN implementation of the Ready Steady Go programme, a gap in service provision was identified in how we support young people transitioning into adult services. A review was completed against NICE guidance in 2019/20, and a need for joint working was identified, in partnership with Trust and system Paediatric and Adult leads, as well as the Clinical Commissioning Group Lead for Transition, to develop the transition work within the Trust further whilst maintaining the progress achieved following the CQUIN implementation of the Ready Steady Go Hello pathway.

The pandemic has meant our progress around the transition agenda has been somewhat delayed during 2020/2021. We have taken this opportunity to forge links with the Regional Nurse Advisor for Young People's Healthcare Transition, and build relationships with Trusts both regionally and nationally to support us progressing our own agenda and services. Furthermore we attended the virtual south region transition network showcase event in January 2021, which gave us further opportunities to network and benchmark our progress against other organisations.

How we have performed 2020/21

In September 2020 we applied for a Roald Dahl Transition Nurse Specialist Post, to support our transition workstream. We were commended on our excellent application and business case but unfortunately we were unsuccessful in securing the funding on this occasion.

Although our transition programme has been delayed in some areas, there has been significant progress in developing a transition service for adolescents and young adults living with type one diabetes.

The paediatric diabetes service is an award-winning team that values social prescribing and has strong values around patient experience and patient-centred care. An area for improvement within diabetes highlighted in the recent Diabetes Peer Review (Summer 2020) and National Diabetes Transition Audit was around the transition age group. The recent GIRFT report in to diabetes highlights the necessity of a dedicated transition service to support young adults with their diabetes care with an aim of reducing hospital admissions, reducing rates of diabetes keto-acidosis and improving long-term clinical and mental-health outcomes. As a result of recent data and guidance, the team were successful in their application to the CCG for a 12 month focus-project dedicated to developing a transition service for children and young people with diabetes aged 16-19 years.

Following success of the funding bid, the team formed a working group across paediatric and adult services and agreed appropriate staffing for this to include additional paediatric and adult consultant time, nursing time, dietetic time, psychology time and an additional youth support worker and admin staff. The staffing and patient pathway that have been agreed are based on feedback and discussions with centres of excellence for transition in diabetes including Poole, Southampton

and Wrexham hospitals. The role of a youth support worker is an innovative one and the role will be tailored around feedback from youth ambassadors and how they perceive the role including a bridge between clinical care and real life and an accessible member of the team.

The proposed new diabetes transition service has been co-designed with patients, has a strong focus on both qualitative and quantitative data and colleagues have demonstrated strong networking skills with other centres in order to help deliver the best care for everyone. In 2020/21, key metrics for evaluating this new service have been agreed, including both qualitative and quantitative metrics alongside key health outcome measures for young people.

Patient surveys will be completed for both pre and post-transition and will be completed ahead of the project and 10 months in as well as part of the evaluation process. There will also be ongoing monitoring of the staff experience before and throughout the pilot, to ensure this does not have a negative impact on our staff experience in paediatric and adult services.

The team have worked with Business Intelligence colleagues to establish a dashboard to review Best Practice Tariff (BPT) parameters along with qualitative feedback from patient surveys and more in-depth patient experience interviews, hospital admissions and HbA1c (health check for diabetes).

The dashboard will be reviewed on a monthly basis, providing real-time data to monitor the service and its effectiveness. If overall the HbA1c improves, this will have significant cost savings for both the short and long term, along with reduced hospital admissions, which will be beneficial for the young adult. This will hopefully support an improved patient experience, and we hope the new service may lead to better self-efficacy and self-management of this chronic condition for the young people.

Plans for improvement 2021/22

This work will continue as a Quality Account Indicator in 2021/22. The Women and Children's division are developing a Children and Young People's Strategy, which is being co-designed with colleagues across the division and young people using our services. One of our priorities in this strategy is to deliver a programme to transform outdated processes and pathways, which will incorporate transition into adults services. Learning from the diabetes work can be used in other services.

The new transition service for young adults with diabetes will be launched in 2021/22, with recruitment for new posts underway. This service is a 12 month pilot, and a key aim of this work is that the clinical care provided will follow structures set out within Best Practice Tariff with an aim of the service being income-generating longer term to help promote longevity of the service. If the BPT parameters are met, this brings a value of approximately 3000 per patient per year, which will support developing a more permanent transition service in the Trust.

To improve maternity experience

Background

Patient experience feedback provides a clear measure of the quality of service we are providing for women in our care. As a Trust, we actively seek to hear from the women who use our services, to identify how we can continue to improve the quality of care we offer, and reach our goal of providing Outstanding Care.

How we have performed 2020/21

Although nationally we were not required to capture Friends and Family Test data this year due to Covid, as a Trust we took the decision to continue with this to ensure that we could capture the experience of women in our care, and understand the quality of service we were providing to our patients during our response to the pandemic.

Figure 10 on the next page shows the Friends and Family Test score for our maternity services in 2020/21, and also the 2019/20 score trend line for comparison.

The graph highlights the impact of the pandemic and the variability of experience throughout the year; in 2020/21, patients reported a more positive experience at the height of wave one, which decreased in the middle of the year as the visiting restrictions were introduced.

As a Trust, we tried to ensure that the impact of these restrictions on the experience of mothers and partners was as low as possible, but the feedback shows that it was the restrictions in place that mainly impacted the women's experience of our services, and caused the decrease in positive score.

In addition to FFT feedback, national surveys provide the opportunity for us to hear about women's experiences of our care.

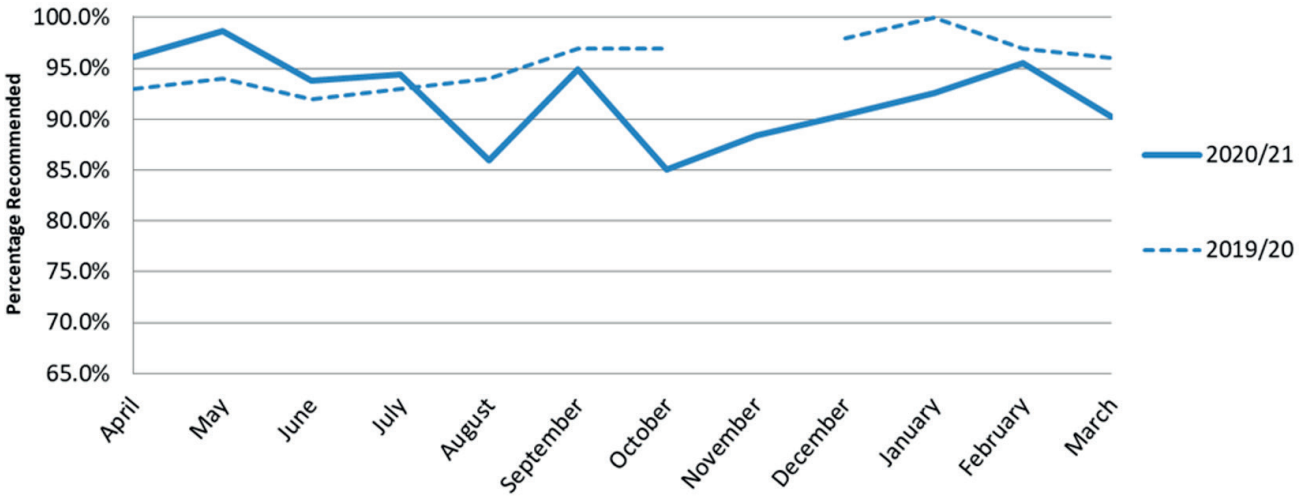
The original National Maternity survey was due early this year (field work originally due to take place in April), however this was cancelled due to COVID. Our external provider – Picker –arranged to run the survey on a voluntary basis, which is now called the "New mothers' experience of care survey 2020" (Fig. 11)

We agreed to participate in this programme, along with 11 other Trusts, to give us greater insight into the experience of women using our services.

The questionnaire was sent out to patients who gave birth during February 2020. Our sample was drawn in June, and fieldwork was carried out in July-August.

As a Trust, we ranked 3rd out of a total of 12 Trusts who took part in the survey. With a higher than average response rate of 32% (132 responses out of 408), our overall positive score was 90.96%.

Figure 10: Friends and Family Test score for our maternity services in 2020/21



A number of areas were identified in the survey where we had improved or were above the national average, as well as areas where further improvement was needed:

- 100% found staff to introduce themselves
- 99% had a partner or companion involved
- 99% Treated with respect and dignity
- 99% Given the help needed by midwives (postnatal)
- 84% felt they were given appropriate advice and support at the start of labour – this was lower than the average of 86%, and also down by 6% compared to our 2019 score of 90%
- 78% said they were able to ask questions afterwards about labour and the birth – this was lower than the average score of 82%, and also down compared to our 2019 score of 85%.

A workshop was held with Picker to review this data, and has been used to identify key areas for improvement.

A Maternity Improvement Plan has been developed, which incorporates actions in response to recommendations from the Ockendon Report as well as actions for patient experience improvement, with an emphasis on compassionate culture and improving communication between professionals and women.

A focussed experience improvement plan, using the learning from these surveys and other feedback mechanisms, will be developed in the Autumn, led by the new Head of Midwifery.

Plans for improvement 2021/22

Maternity services are developing a divisional strategy, and improving the experience of women accessing our services will be a key priority area.

The Trust has recently recruited a new Head of Midwifery, who will be leading on this strategy development.

The Head of Midwifery will also lead a programme in the Autumn 2021 to co-design an experience improvement plan with our Maternity Voices Partnership, staff across the division and women who use our services.

This workshop will reviewing all the data we currently have, including FFT, local surveys, complaints, concerns, feedback from Maternity Voices Partnerships and our New Mothers Experience of Care Survey, and triangulating to inform our priorities in the new strategy and areas for improvement.

One key programme of work that will continue into 2021/22 to improve the experience of women using our services will be the Continuity of Care work.

The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017).

Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016).

The Continuity of Care programme will be one of our Quality Indicators in 2021/22, aiming to put in place the building blocks by March 2022 so that continuity of carer is the default model of care offered to all women by March 2023.

Figure 11: New mothers' experience of care survey 2020 summary

Top 5 scores (compared to average)	
68%	F1. Given a choice about where to have check-ups
75%	F6. Saw the midwife as much as they wanted
69%	D2. Discharged without delay
84%	F7. Felt midwives aware of medical history (postnatal)
78%	B12. Offered NHS antenatal classes or courses

Bottom 5 scores (compared to average)	
78%	C21. Able to ask questions afterwards about labour and birth
84%	C1. Felt they were given appropriate advice and support at the start of labour
95%	C16. Able to get help when needed (during labour and birth)
89%	C2. Staff created comfortable atmosphere during labour
96%	F8. Felt midwives listened (postnatal)

Most improved from last survey	
68%	F1. Given a choice about where to have check-ups
69%	D2. Discharged without delay
95%	B8. Felt midwives or doctor aware of medical history (antenatal)
98%	F10. Had confidence and trust in midwives (postnatal)
84%	F7. Felt midwives aware of medical history (postnatal)

Least improved from last survey	
86%	F18. Received help and advice from health professionals about their baby's health and progress
86%	F16. Received help and advice about feeding their baby
78%	C21. Able to ask questions afterwards about labour and birth
84%	C1. Felt they were given appropriate advice and support at the start of labour
90%	E3. Felt midwives gave active support and encouragement about feeding

To improve Urgent and Emergency Care (ED) experience

Background

Our patients have told us through our Friends and Family Test and our National Survey programmes, that although we do provide good care for the majority of our patients, we don't always get it right for everyone.

In 2019/20, 82% of patients reported they would recommend our urgent and emergency care services to their family friends, meaning that 18% of our patients did not feel that they received the outstanding care that we aim to deliver.

This feedback provides us an opportunity to improve the quality of care that we deliver for our patients.

How we have performed 2020/21

Although nationally we were not required to capture Friends and Family Test data due to Covid, as a Trust we took the decision to continue with this to ensure that we could capture the experience of patients in our Emergency Departments, and understand the quality of service we were providing during our response to the pandemic.

The graph below (Fig. 12) shows the Friends and Family Test score for our urgent and emergency care services in 2020/21, and also the 2019/20 score trend line for comparison.

The graph highlights the impact of the pandemic and the variability of experience throughout the year; in 2020/21, patients reported a more positive experience at the height of wave one and during the second surge, and a more negative experience in the period between the two waves.

Thematic reviews were undertaken, to better understand the experiences of our patients, from August 2020 to January 2021 at Gloucester Royal Emergency Department. We focussed on Gloucester, as during this time Cheltenham Emergency Department was operating as a Minor Injury Unit as part of our temporary service reconfiguration.

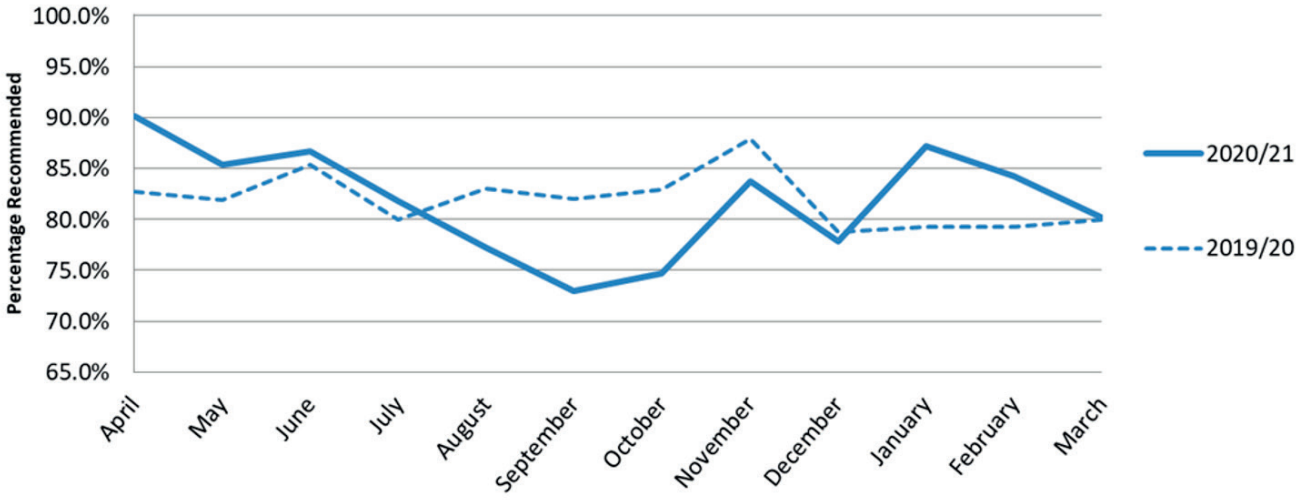
For the Period August 2020 – January 2021, Gloucestershire Royal Hospital received 3,109 FFT responses in total and 2,267 free text comments left. A total of 2,053 comments – 91% of all comments – were analysed and themed for this report. The remaining comments left did not fit in to the main theme categories, but were still shared with teams,

The majority of comments contained very positive remarks, and complimented staff and the NHS for their care and treatment.

The key themes that emerged from this work were:

- Waiting: this was divided into 2 themes; either long waits/overall time spent in ED, or seen quickly/not too long a wait overall. If a comment indicated a quick response in triage but then a long wait for results or in MIU then this would be listed as long wait overall. Similarly, if a comment suggested a very long wait for triage but once seen OK, this would still be listed as long wait overall.
- Staff: this category identifies all comments made about staff attitudes or helpfulness. The vast majority of comments refer to staff as professional,

Figure 12: FFT score for our urgent and emergency care services in 2020/21



kind, caring, helpful and polite. There are a number comments that indicate the majority of staff were good, however may have been let down by some or one staff member in particular.

- Communication: this category identifies all comments that referred to communication in one form or another. This may be as simple as being kept informed of wait times, or having their problem well explained. Other comments made reference to some sort of miscommunication, or lack of information regarding the problem or illness. Others inferred a general lack of update or explanation of what was to happen next. Also some mentioned concerns over long periods of time with no contact or any communication with staff.
- Cleanliness: this is split between Covid related precautions and general cleanliness.
- Processes: many comments referenced or inferred confusion and misunderstanding of general procedures. Many comments were concerned with their initial referral or reason for attending ED or being bounced between care centres. Others had issues with administration or internal process. Some indicated a perceived lack of coordination or organisation.
- Clinical Care: the majority of patients who left comments stated how well cared for they were or that they received an excellent service. Some comments however were identified where the patient felt the problem they attended ED for was not properly assessed. Identifying either a lack treatment or insufficient examination. Other comments mentioned missed medications, incorrect diagnosis, or that the problem was not solved.
- Emotional Support: this category was used to identify patients that indicated they were well supported or felt "reassured" by staff while in ED. There were also a number of comments that suggested a lack of emotional support, or in some cases a feeling that they were forgotten, or that they were wasting staff time. Others mention a feeling that no one cared and they shouldn't be there. There were also a few comments regarding mental illness and awareness.
- Physical Help: comments in this category identified patients that felt they needed

additional physical support due to their injury or illness, in particular when moving from one part of the hospital to another – e.g. Ed to Xray or MIU. This category was also used to identify any comments made about a lack of pain relief.

- Environment: a lot patients mentioned how busy or overcrowded the ED was. It should be noted that this did not correlate to an overall negative rating however. The majority of patients who mentioned how busy the department came across as appreciative and understanding of staff working under difficult conditions. There were some comments made that suggested an unsafe environment or that they felt scared while in the ED. It was also noted in this category that many patients felt the ED was a very impersonal environment and lacked privacy either when checking at reception or that they were examined in public areas.
- NHS pressures: there were a lot of remarks about general "NHS pressures" and or a lack of government funding. Generally patients are sympathetic to the pressures that staff are under, and are perceived to be overworked and understaffed.
- Facilities: used to identify comments about space or comfort in the waiting area. Poor toilet facilities, access, and signage. There were a number of comments regarding patients getting lost or having to find their own way from one part of the hospital to another.
- Food and drink: some patients also mentioned a problem with access to food and drink while waiting.

These themes were used by the urgent care leadership team to develop a patient experience improvement plan, which will continue into 2021/22. This plan is regularly updated and reviewed at the Trust Quality Delivery Group. Some progress has already been made in 2020/21, including:

- Launch of 3 Little Big Things campaign, focussed on pain relief, Comfort and Hydration
- Regular meals being provided to patients in emergency department
- Recruited volunteer roles to support the team with refreshments, hydration, helping with stocking of equipment, administration and welcoming patients
- Screens in waiting areas have been installed providing information for patients to keep them updated and better manage expectations
- Mobile phones have been purchased for staff to contact family members and provide more regular updates
- Using clear masks to improve communication between staff and patients with hearing loss/impairments
- Developed transfer cards for patients when leaving department and going to the ward, including PALS details, visiting times for each ward, key telephone numbers which can be shared with relatives

Plans for improvement 2021/22

A number of priority actions are ongoing in the patient experience improvement plan. The Trust is currently reviewing the recent National Urgent and Emergency Care Survey results, which will be used to review and update the improvement plan. The key focus areas for 2021/22 include:

- Setting up a Patient Experience Group for the department and recruiting experts by experience to be involved in identifying and prioritizing areas for improvement. This group will meet regularly to monitor delivery and review of the plan
- Introducing a Patient Guardian role into the department
- A focus on improving the care we provide for patients with mental health illness in the department, through the Mental Health Working Group which has experts by experience involvement
- Reviewing all signage in the department to improve accessibility
- Reviewing patient information leaflets
- Ensuring patient representation on working groups is diverse and representative of our communities

To improve Adult Inpatient experience

Background

Our National Adult Inpatient 2019 Survey scores are used to help us understand what we are doing well, where we can improve, and how we benchmark against other similar organisations in providing quality care and patient experience . Due to the pandemic, the 2020 National Adult Inpatient Survey was postponed, with the latest results expected in Summer/Autumn 2021.

In the last 12 months, the factors that have shaped our adult inpatient experience have changed significantly due to the pandemic. Of particular concern for our inpatients and relatives was the introduction of visiting restrictions, which meant relatives were often unable to get through to our patients and wards due to the volume of calls being put through to the wards at this time.

How we have performed 2020/21

As with other services, our Patient Experience team needed to adapt during the pandemic to better support our patients, relatives and colleagues across the hospitals.

Not being able to have regular contact with family and friends has a huge impact on patient experience, and so the patient experience team were reconfigured into the Patient Support Service, to support patients, relatives, families, carers and staff during this pandemic, offering a seven day service. This included:

- our PALS function, offering advice and managing concerns;
- a telephone helpline for relatives and carers to ring to help take the volume of calls away from the wards while providing reassurance to families;
- supporting virtual visiting and the management of iPads;
- acting as a central team for letters, photos and messages for patients, that can be printed and delivered to the wards;
- created a team manned by volunteers who manage belongings drop off for patients in our hospitals;

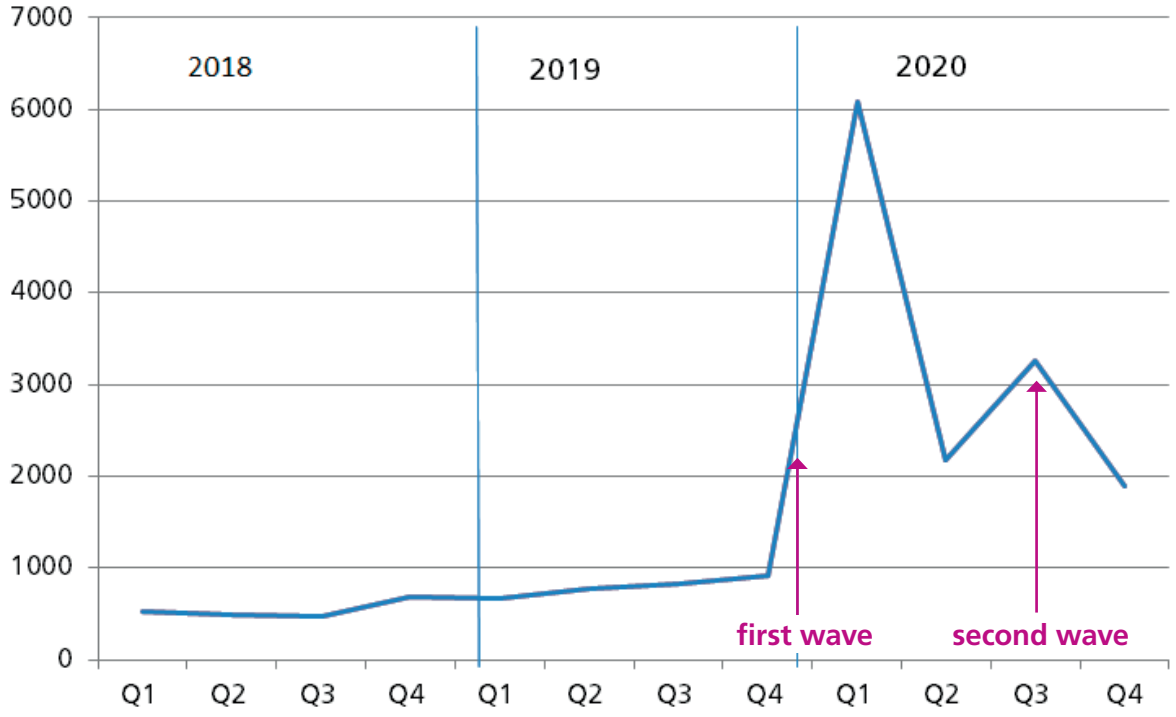
Since the service was set up on 3 April, we have taken 6800 calls, delivered over 1100 messages, letters and photos to patients on our wards, and collected over 4500 belongings from relatives unable to visit our patients. The belongings service has been staffed by volunteers at both sites, and has proved extremely popular and was available 7 days a week. The graph on the next page (Fig. 13) shows the significant increase in calls that the Patient Support Service have handled in 2020/21.

Plans for improvement 2021/22

In 2021/22, we will continue to develop the patient support service using the learning from our response to Covid, with a continued focus on extending our digital/ remote offer to patients and relatives alongside reintroducing face to face visits. The key themes that have emerged through PALS and our Patient Support Service this year as areas for improvement have been looking at communication, and management of property. Our work for 2021/22 will therefore include:

- Introducing volunteer roles that work closely with PALS and divisional teams to focus on improving communication and experience for our inpatients

Figure 13: Total number of calls to the office including concerns, enquries and hub calls



- Working closely with divisional and corporate teams to review and improve our property management and how we minimize lost property in our hospitals
- Working with teams across the hospital to look at how we can continue to develop our offer to carers of patients in our hospital
- Reviewing the National Inpatient Survey 2020 (which is expected in Summer 2021) to identify priority areas for improvement

To enhance and improve our safety culture

Background

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

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

How we have performed 2019/20

A variety of culture surveys were reviewed and the SCORE (Safety, Communication, Operational Reliability & Engagement Survey) survey by Safe and Reliable Care was selected. SCORE is an internationally recognised and scientifically validated way of measuring and understanding the culture that exists within organisations and teams.

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

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

The survey was undertaken in September 2019 across pre-operative, operative and post-operative settings in Gloucestershire Royal Hospital, Cheltenham General Hospital and Cirencester Treatment Centre. 62% of staff surveyed responded, which was above the quantity required for the results to be considered representative of the surveyed staff groups.

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

Focus groups to analyse the data by work setting and staff group were carried out across the theatres teams. Unfortunately, due to the impact of COVID-19, the surgical and anaesthetic focus did not take place as planned and the remainder of the programme was paused.

Plans for improvement 2021/22

The SCORE programme will be re-started in 2021–2022, beginning with a review of the data previously collected to understand any changes due to the passage of time. Once completed the next step of the process will be to develop a multi-disciplinary improvement collaborative using the data and feedback collected. This will utilise Quality Improvement methods and with the support of the Gloucestershire Safety & Quality Improvement Academy (GSQIA) involve the staff in developing and testing improvements in the identified areas. The SCORE survey will then be repeated to determine the impact of the interventions undertaken.

Steps completed:

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

Partially completed but paused due to COVID-19

- Staff group and work setting focus groups

Steps outstanding

- 'Sense check' of data collected due to programme being paused for 12 months
- Improvement collaborative: Test and learn
- Re-survey

To improve our prevention of pressure ulcers

Background

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

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

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

This past year has been challenging for everyone, none more so than health care workers .Despite this staff in the Trust have adapted and continued to make improvements in pressure ulcer prevention ensuring that patient safety is a priority.

How we have performed 2020/21

We are very much committed to continue to reduce the number of pressure ulcers developing in patients in our care and we continue to use our 3 Quality Strategy aims as a framework for future improvement.

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

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

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

The initial pressure ulcer prevention summit held in 2019 helped the Tissue Viability team with the development of their education and audit. It also facilitated a structured learning from investigating in the form of the Preventing Harm Hub. This year it is hoped that the development of a shared decision making council for the prevention of pressure ulcers will facilitate an inter-professional process of shared decision-making. This will ensure a non-hierarchical approach to collective leadership. This can drive forwards quality and service improvements, supporting innovation and delivering better outcomes for individuals, populations and staff.

The Tissue Viability Team will also continue to work with and support the link nurses to develop specific ward based pressure ulcer collaborative projects. Examples of these have already been successfully implemented and quality improvements have occurred as a result across all divisions in the Trust.

Figure 14: data for category 2–4 and unstageable Hospital Acquired Pressure Ulcers/1000 bed days

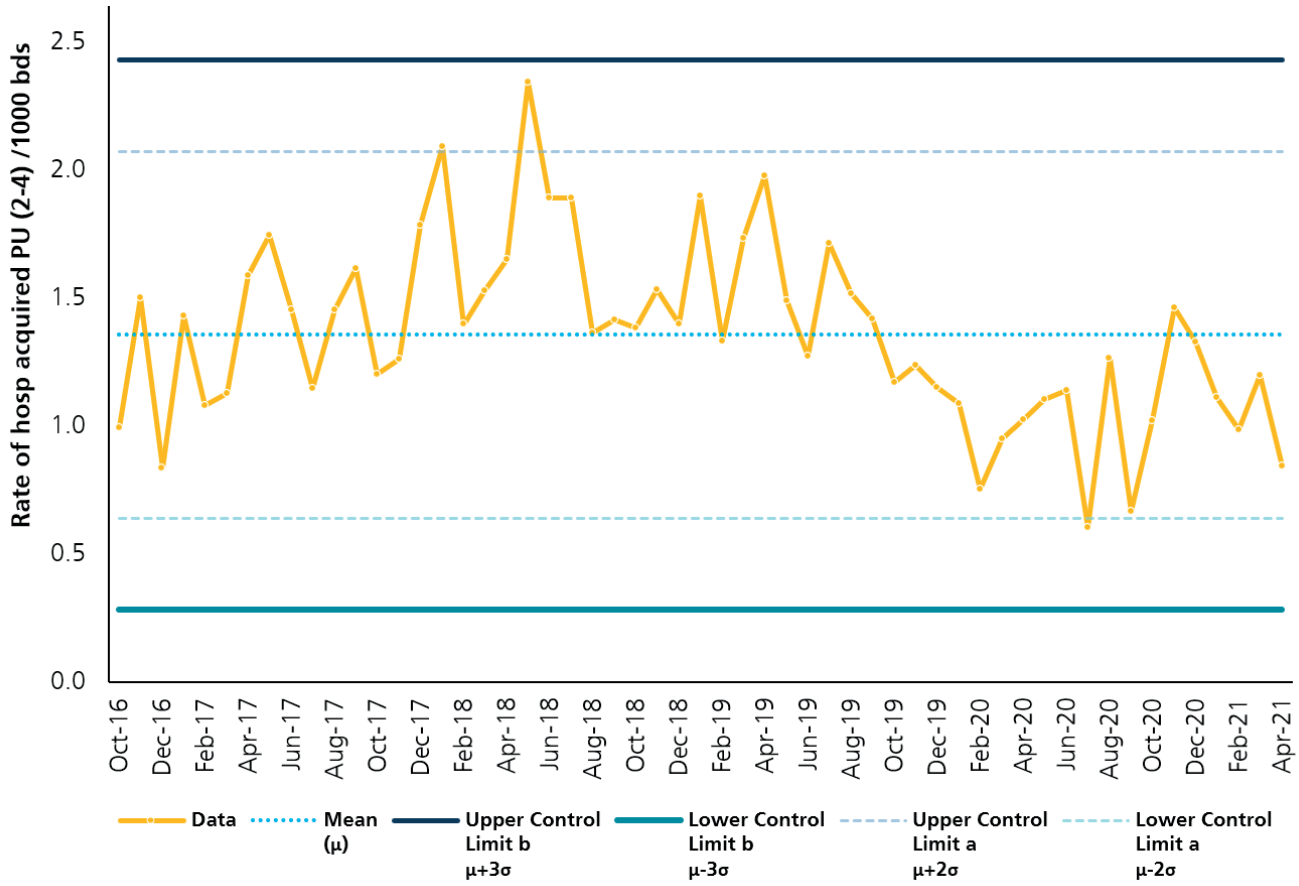
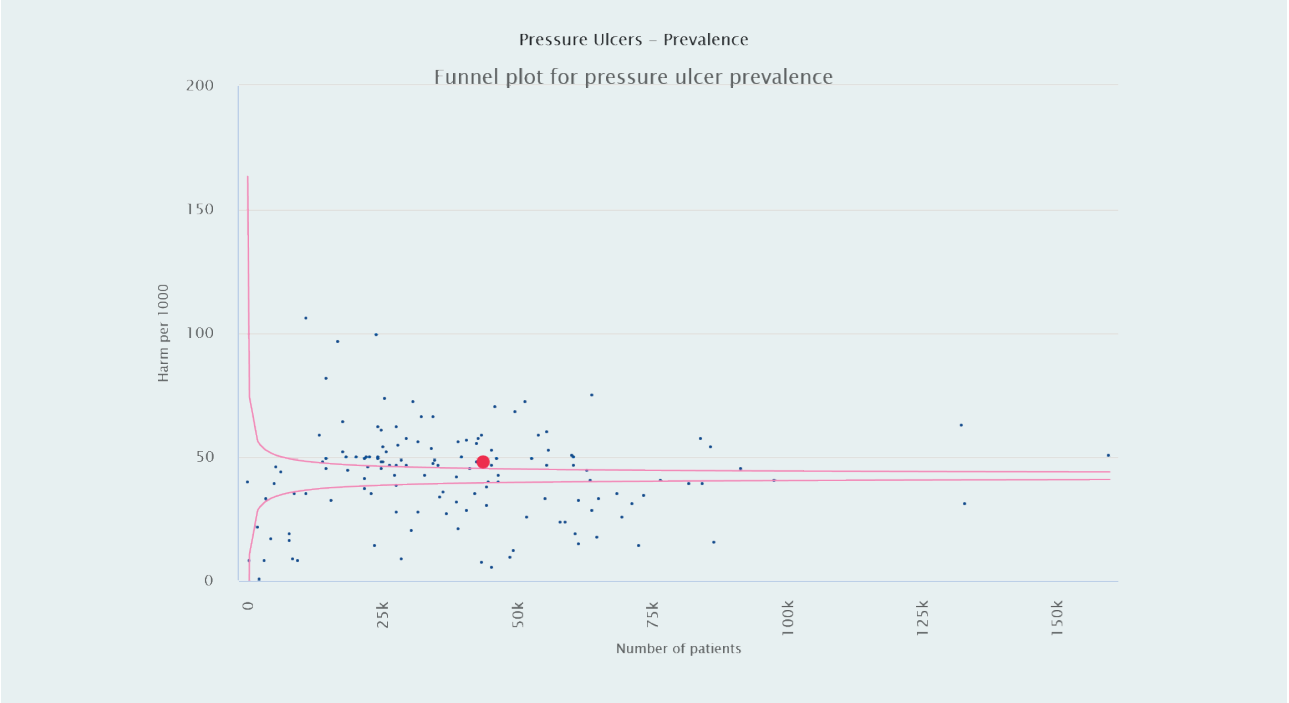


Figure 15: Funnel plot diagram for pressure ulcer prevalence



Plans for improvement 2021/22

Following our initial pressure ulcer summit, we had developed a pressure ulcer prevention quality improvement plan which was be led by the Tissue Viability Team.

Our first programme of work was to complete in depth diagnostic work of our data to turn this into insights so we could prioritise our improvement work.

The implementation of the Electronic Patient Record has enabled us to have better oversight of pressure ulcer risk assessments and prevention plans that are being put in place for our patients.

The focus for 2021 and 2022 will be to continue with this as well as some additions including these listed below.

Our work will focus on:

- Continued review of our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording.
- Establish a Shared decision making council to encourage that agreement about pressure ulcer prevention is reached in an inclusive and collaborative way.
- Continue to map all our current data sources so that we can develop a single item quality report.
- Continue to develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues.
- Regularly monitor data and undertake learning to improve care – develop quick feedback loops.
- Work with wards to set measurable targets appropriate for their area.
- Continue to provide speciality level data for pressure ulcers.
- Include pressure ulcers data at Divisional level reports in SPC charts.
- Continue to map where the high-risk wards are and provide focused improvement work in these areas.
- Provide all clinical staff with educational resources for pressure ulcer prevention, and to continue to think outside the box on innovative ways to deliver.
- Ensure that all areas have access to equipment to facilitate pressure ulcer prevention, including exploring a managed equipment service.
- Continue to work with a network of tissue viability link nurses to support the trusts improvement plans.

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To prevent hospital falls with injurious harm

Background

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

Nationally

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

Each year almost 3,000 falls in hospital in England result in hip fracture or brain injury, typically subdural haematoma. Costs for patients are high in terms of distress, pain, injury, loss of confidence, loss of independence and mortality, and costly in terms of increased length of stay to assess, investigate or treat even modest injury.

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

How we have performed 2020/21

Improvements set out in the Falls Prevention Improvement plan have been hampered by the COVID-19 crisis. At the beginning of the year during the first wave and has subsequently been affected by the second wave. During the first wave the falls specialist nurse was redeployed, which meant that there was no overall monitoring of repeat fallers and no falls prevention work happened for almost 3 months, with projects on the wards also put on hold.

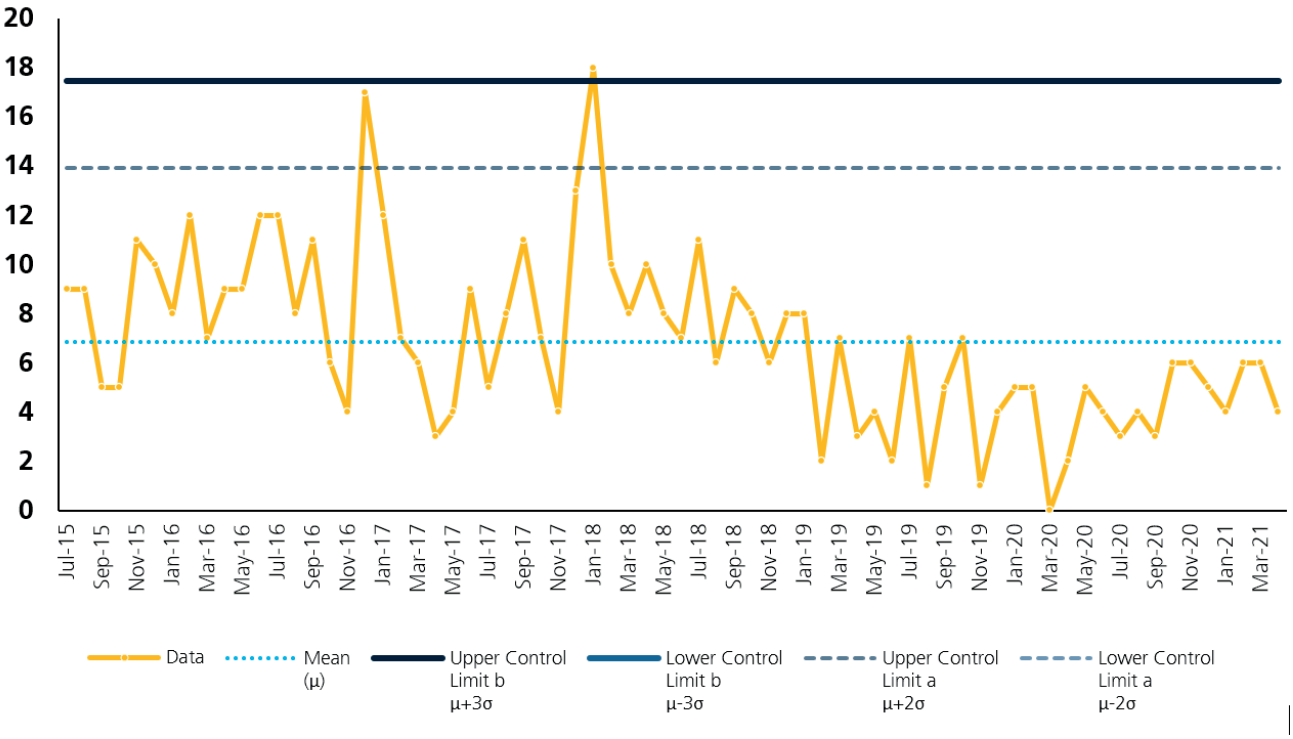
With restrictions around face to face teaching, staffing issues and increased work load on all staff there has not been as much work achieved as was previously set out in the quality improvement plan as had been forecast. The wards have also not necessarily been looking after patients within their speciality and wards have been closed, flipped from red to green at a moment's notice. This has therefore hindered the falls prevention program considerably.

Figure 16: Falls data for 2020/21

Q1			Q2			
Number of falls: 398			Number of falls:571			
Minor harm	Moderate harm	Severe harm	Minor harm	Moderate harm	Severe harm	Death
67	10	0	93	4	1	1

Q3				Q4			
Number of falls: 649				Number of falls: 649			
Minor harm	Moderate harm	Severe harm	Death	Minor harm	Moderate harm	Severe harm	Death
116	14	1	1	80	12	1	2

Figure 17: Falls data for 2020/21



There are number of reasons for the increase, despite fewer beds.

- Patient acuity has risen significantly, in the fact that older people who are admitted are considerably more deconditioned due to the inactivity during lockdown periods
- Increase in patient transfer between both sites and around sites. For the older person, especially with a cognitive impairment, this can cause disorientation. Likewise for the staff they are unable to get to know the patient and the continuity of care is not there
- Increase in the number of patients identified as requiring 1:1 enhanced care and shifts not being fulfilled
- Reduction in staffing levels due to Covid
- Outliers on inappropriate wards (i.e not the right speciality)
- Increased length of stay due to Covid restrictions in the community
- More 'memory' issues identified. People who appeared to be managing at home and now out of their environment evidence of poor cognition
- Non completion of the falls assessment on admission or post transfer into new area

Falls causing harm (moderate/ severe/death)

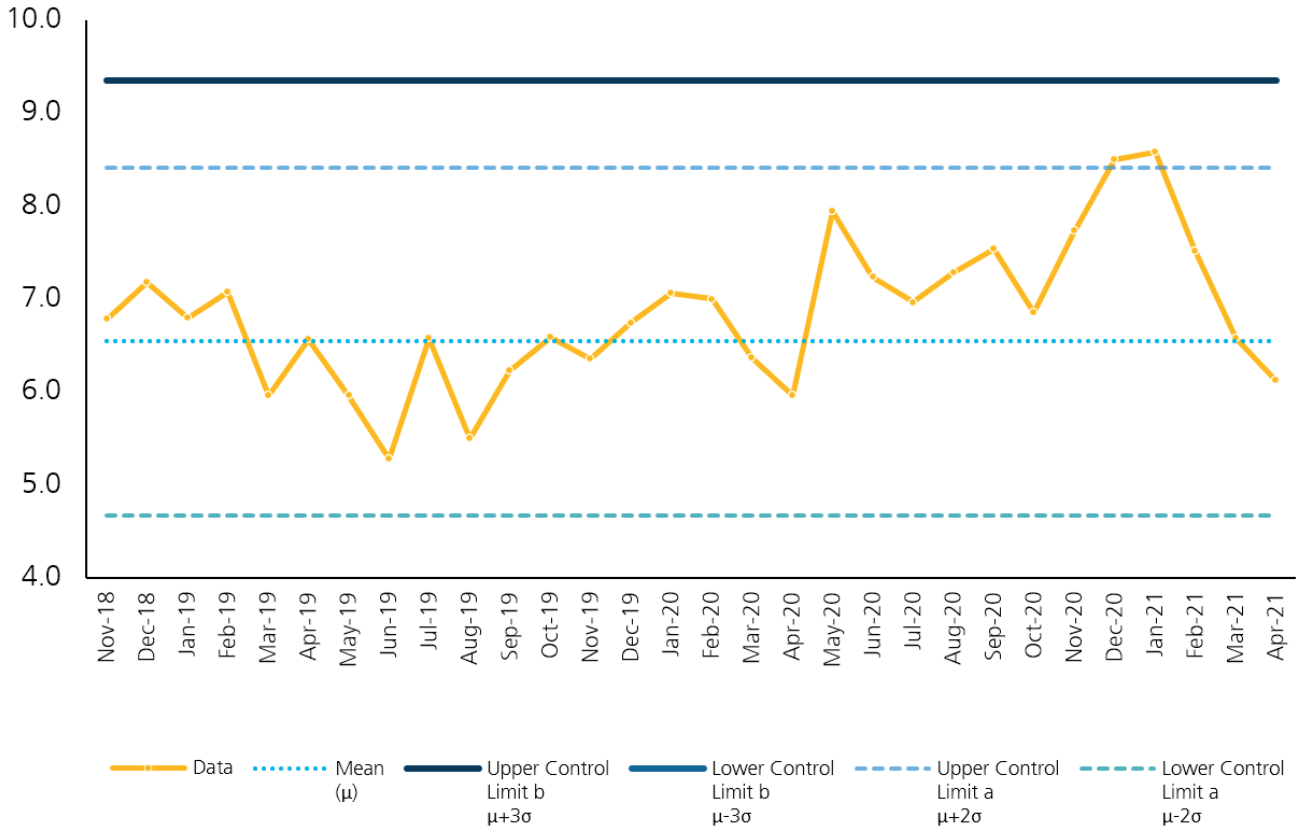
We have seen a transient increase in the number of falls per 1000 bed days (Fig. 18), due to the many of the reasons identified earlier around COVID.

In relation to other hospitals around the Southwest, we are on a par and not standing out as an anomaly.

Improvements that have been achieved 2020/2021

- Work has continued to improve the data recording for the EPR system. With data now being pulled for 'weekly assessment' data now available. This has enabled a more targeted approach to education around assessment.
- Following falls with harm that have been presented at the Preventing Harm Hub, local action have been taken forward at ward level, with 2 ward areas of concern commenced an over-arching action plan to improve their falls rates
- Wards have access to the data on EPR and can regularly monitor at a local level. Feed back to individual wards regarding the previous months data shared with wards and encouraged to share with the ward staff and to acknowledge achievement with regards to 'free from days' and compliance of EPR documentation
- Learning events have taken place for the surgical division and for the falls links on the wards. Monthly falls training was suspended for 6 months, however there have been local training sessions on wards, especially on the 'hotspot' wards and adhoc training when reviews of pts have taken place following inpatient falls. Formal numbers for training have been 214
- Wards with a high amount of falls encouraged to acknowledge 'free from' days as a way of celebrating the achievement
- All divisions are informed of falls data on a quarterly basis
- 2 wards had been identified as high-risk and substantial action plans were developed and are currently in progress, with promising results in falls reduction
- The Preventing Harm Hub has identified

Figure 18: Inpatient Falls per 1000 bed days



instance learning for individual wards following a fall with moderate harm or above. Allowing the wards to focus on the issues that have arisen and to put immediate learning in place for the staff

- Additional Hoverjacks (flat lifting equipment) has been purchased and allocated around GRH and CGH, ensuing that there is no delay in access to the equipment when retrieving a person off the floor
- The post falls protocol has been revised to include how to manage a suspected serious injury. Posters have been given to all wards ad departments and are in visible areas of the ward for the staff

Plans for improvement 2021/22

The quality improvement plan will continue to be a focus in the reduction of falls, using the Quality Strategy approach of insight, involve, improve.

Our work will focus on:

- Continue to identify hotspots and work with wards and Divisions to reduce inpatient falls
- To have criteria around reducing the number of transfers a patient can have during one admission
- To monitor the data from EPR to improve on the completion of the falls documentation on EPR
- Continue to provide trust wide falls prevention teaching
- Continue to work with the falls links to improve falls prevention at ward level
- Continue with learning from serious incidents via the Preventing Harm hub
- Identification of community dwelling people at risk of falls who are admitted to the acute to ensure preventative measures on place
- Recognition of 'free from Days'
- A Shared Decision Making Council for Falls and Pressure Ulcers has been commended so as to ensure ward level involvement for falls prevention.

To improve the learning from our investigations into our serious medication errors

Background

Medicines are used in all healthcare areas and the safe and secure handling of medicines is essential to ensure patient safety. Chief Pharmacists are required to ensure staff and medicines are managed in line with relevant legislation and regulations, and that national and professional guidance on medicines governance is followed within their organisations.

To achieve this standards on the safe and secure handling of medicines are set out with the Gloucestershire Hospitals NHS Foundation Trust Policy on Ordering, Prescribing and Administration of Medicines (POPAM). Six key areas are audited by pharmacy and reported monthly to senior nurses.

- Standard 1: Drug keys are in the possession of a registered nurse
- Standard 2: The treatment room door is kept locked
- Standard 3: The drug cupboards are locked
- Standard 4: That there are NO drugs left out un-secured
- Standard 5: The fridge is locked
- Standard 6: That monitoring of the fridge temperatures are being monitored on a DAILY basis.

How we have performed 2020/21

The target for each standard is a minimum of 90%. The tables and graphs on the next page (Fig. 19–20) show the overall compliance with the six standards in 2020/21, by division as well as providing a Trust overall score.

Standard Four (That there are NO drugs left out un-secured) has proved the most challenging for teams across the Trust during this year, particularly in Medicine and Surgery, where the overall compliance scores for the year were 83.8% and 86.6% respectively.

Where areas fall below the 90% compliance target, action is required by clinical area nurse managers, with an escalation process as below:

- Month 1 fail: clinical area nurse manager reviews results and highlight issue to their staff –
- Month 2 fail: email will be sent to the clinical area nurse manager and matron. Divisional directors and pharmacy director will receive a table of results which will include wards that are on a month 2 fail. An action plan is created by the clinical area management team and submitted to divisional boards which will be included in their Executive Review Quality report
- Month 3 fail: as month 2 but results will be sent to the Nursing Director.
- Month 4 fail: Pharmacy will ask for the wards action plans for review and will be passed onto the pharmacy teams to help advise the wards

Figure 19: Overall score – combined standards one to six:

Average of score	Division				
Month	D&S	Medicine	Surgery	W&C	Grand Total
April	93.8%	91.1%	87.4%	98.1%	92.1%
May	97.4%	89.8%	73.0%	98.5%	85.8%
June	95.8%	93.5%	92.8%	95.8%	93.8%
July	100%	91.0%	91.9%	97.4%	93.0%
August	97.9%	90.6%	92.2%	96.4%	92.5%
September	93.5%	90.9%	91.5%	97.6%	92.3%
October	93.9%	94.2%	93.8%	98.2%	94.7%
November	99.7%	93.5%	96.8%	97.9%	95.7%
December	97.7%	91.6%	95.1%	99.7%	94.5%
January	96.6%	95.6%	95.9%	99.0%	96.3%
Februrary	98.7%	94.9%	95.9%	99.9%	96.2%
March	97.7%	95.5%	96.0%	99.0%	96.4%
Grand Total	96.9%	92.8%	92.2%	98.1%	93.8%

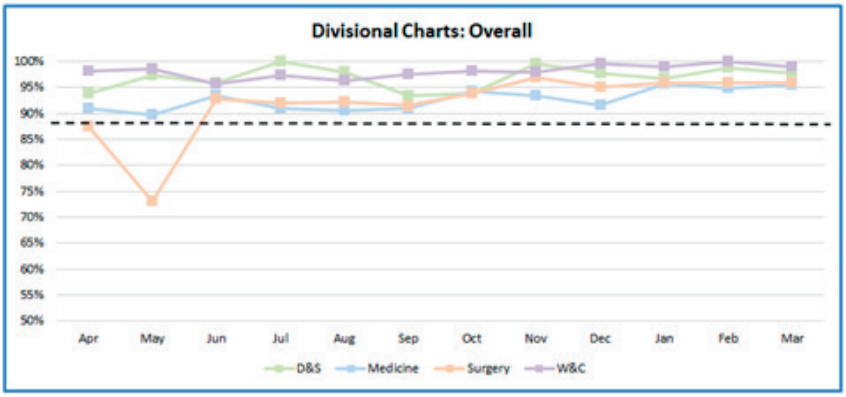


Figure 20: Overall compliance for each of the six standards

Standard	Compliance, %
One	98.1%
Two	96%
Three	93%
Four	87.4%
Five	95.4%
Six	95.3%

Plans for improvement 2021/22

The escalation process will be reviewed to ensure that where areas are identified as consistently not meeting the standards, we have appropriate support and review in place.

Achievement of standard 4, that no medicines are left out unsecured, has been the most challenging issue for teams.

The audit has identified issues include secure locations to leave medicine, transport bags and access to medicine cupboard keys. Further work in this area and to improve compliance with Standard Four will be a focus for work in 2021–22.

To improve our infection prevention and control standards (reducing our Gram-negative blood stream infections)

Background

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

How we have performed 2020/21

All episodes of Gram negative bacteraemia (E.coli, Klebsiella species and Pseudomonas aeruginosa) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements.

The Department of Health and Social Care (DHSC) has required Trusts to submit mandatory surveillance data on Escherichia coli bloodstream infections since June 2011.

Escherichia coli is part of the normal bacterial flora carried by all individuals. It is the commonest cause of clinically significant bloodstream infection. E. coli bacteraemia represents a heterogeneous group of infections.

E.coli constitutes the most common Gram-negative bacterium detected from clinical microbiology samples; in Gloucestershire there are on average 15 E.coli bacteraemias each month this has fallen from an average of 19 E.coli bacteraemias reported per month during 2019/20.

Most E. coli bacteraemia are not a reflection of Health Care Associated Infection (HCAI); most occur in patients due to underlying disease and are related to common infections such as urinary tract infection, intra-abdominal sepsis and biliary tract infection.

Most of these infections commence in the community (but being detected when patients are admitted for investigation and treatment).

A proportion of the E. coli bacteraemia are healthcare-associated and are related to recent previous hospitalisations and invasive interventions performed on patients, the most important of which is urinary catheterisation.

During 2019/20 there were 46 trust apportioned cases of E. coli bacteraemia; cases identified after day 0+1 (day 0 is taken as day of admission); this represents cases that were detected during an inpatient stay on GHNHSFT. During 2020/21 there have been 31 trust apportioned cases of E. coli bacteraemia; cases identified after day 0+1. A full break down on monthly E.coli bacteraemia cases can be seen in table 1. Therefore, there has been a 32.6% reduction in E.coli trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/21.

It also necessary to report patient episodes where blood cultures have yielded Klebsiella species and Pseudomonas aeruginosa. During 2019/20 there were 18 trust apportioned cases of Klebsiella sp. bacteraemia; cases identified after day

Data

Figure 21: Monthly number of E.coli bacteraemia cases

Month	Time of E. coli bacteraemia acquisition	
	Day 0+1 case	After day 0+1 case
Total 2018/19	225	44
Total 2019/20	185	46
Apr 2020	4	1
May 2020	13	3
Jun 2020	11	2
Jul 2020	11	4
Aug 2020	19	3
Sept 2020	15	0
Oct 2020	17	6
Nov 2020	15	3
Dec 2020	15	1
Jan 2021	10	2
Feb 2021	12	3
Mar 2021	20	3
Total 2020/21	162	31

Figure 22: Monthly number of Klebsiella bacteraemia cases

Month	Time of Klebsiella bacteraemia acquisition	
	Day 0+1 case	After day 0+1 case
Total 2018/19	52	31
Total 2019/20	41	18
Apr 2020	2	1
May 2020	2	2
Jun 2020	5	0
Jul 2020	3	1
Aug 2020	5	1
Sept 2020	4	1
Oct 2020	2	0
Nov 2020	5	1
Dec 2020	2	0
Jan 2021	4	3
Feb 2021	2	0
Mar 2021	2	2
Total 2020/21	38	12

0+1 (day 0 is taken as day of admission); this represents cases that were detected during an inpatient stay on GHNHSFT. During 2020/21 there have been 12 trust apportioned cases of Klebsiella sp. bacteraemia; cases identified after day 0+1. A full break down on monthly bacteraemia cases can be seen in table 2. Therefore, there has been an 18.18% reduction in Klebsiella sp. trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/21.

During 2019/20 there were 9 trust apportioned cases of Pseudomonas aeruginosa bacteraemia; cases identified after day 0+1 (day 0 is taken as day of admission); this represents cases that were detected during an inpatient stay on GHNHSFT. During 2020/21 there have been 6 trust apportioned cases of Klebsiella sp. bacteraemia; cases identified after day 0+1. A full break down on monthly bacteraemia cases can be seen in table 3. Therefore, there has been a 33.3% reduction in P. aeruginosa bacteraemia trust apportioned cases of bacteraemia when comparing the number of cases from 2019/20 to 2020/2021.

What did we do to make improvements in this area?

On 11 March 2020 The World Health Organization (WHO) declared a COVID-19 Pandemic, with Gloucestershire's first cases being confirmed earlier in February 2020. The emergence of this novel infection has placed significant pressure on all NHS and care organisations. The Infection Prevention & Control team have worked within Integrated Care System to prioritise addressing the challenges faced by the outbreak to ensure the safety of both our patients and staff. Unfortunately this has meant that some of the focused interventions for improvement proposed for 2020/21 including the review of cases of Gram negative blood stream infections with a hepatobiliary source and trust wide launch of the Urinary tract infection improvement work were not undertaken but will remain a key part of the 2021/2022 IPC prevention strategy.

Despite the challenges the Trust did however continue to engage in PreciSSIon; Preventing Surgical Site Infection across a regION. PreciSSIon involves implementation of a Surgical Site Infection bundle to reduce the incidence of Surgical Site Infection (SSI) after elective Colorectal Surgery. PreciSSIon is a collaborative project involving all hospitals in the West of England and the Academic Health Science Network (AHSN).

The PreciSSIon bundle consists of:

- 2% chlorhexidine isopropyl skin preparation for all cases
- Use of a dual ring wound protector
- Repeat dose of antibiotics after 4 hours operating time
- Antibacterial suture for mass closure and skin
- Change of gloves before closing the wound if contaminated (non-evidence based; added into GHT data only as option aspect of the bundle)
- Betadine into the wound on closing (in World Health Organisation guidance - weak evidence to support but added into GHT data only as an optional aspect of the bundle)

As a region the South west hospitals participating in PreciSSIon have halved SSI from a mean of 17.2% to 8.5% (representing a 49% reduction in colorectal surgical site infections). PreciSSIon was implemented in Gloucestershire Royal Hospital in

January 2020 we saw the colorectal elective SSI rate decrease from 14.6% to 8.5% (data collected until February 2021); this represents a 52.8% reduction in elective colorectal SSIs. PreciSSIon was also implemented in Cheltenham General Hospital in November 2019 we saw the colorectal elective SSI rate increase from 7.8 % to 8.6% (data collected until February 2021); this represents a 9.7% increase in elective colorectal SSIs. It is however recognised that out of the 7 participating trusts in PreciSSIon Cheltenham general hospital had the lowest elective SSI rate prior to commencement of the bundle and still remains one of the lowest in the project.

The mouth care matters programme also continued to be delivered across the system to support reductions in Pneumonia and associated Gram negative blood stream infections. A mouth care matters champion training day was provided to system colleagues and new mouth care products were introduced to enable staff to provide effective mouth care to patients. This has positively led to the suspended use of 'pink foam' sponges which carried a chocking risk hazard and ineffective plaque removal.

Plans for improvement 2021/22

The last trust apportioned MRSA bacteraemia case was in September 2019; it will be our ambition to sustain and maintain a zero tolerance approach to MRSA bacteraemia cases. To maintain this next year we will implement our new MRSA procedure which will see changes to MRSA screening protocols including enhancing screening of long stay inpatients, changes to decolonisation treatments and monthly monitoring processes of MRSA screening procedures.

Figure 23: Monthly number of P. aeruginosa bacteraemia cases.

Month	Time of Pseudomonas bacteraemia acquisition	
	Day 0+1 case	After day 0+1
Total 2018/19	19	12
Total 2019/20	12	9
Apr 2020	0	0
May 2020	1	2
Jun 2020	0	0
Jul 2020	2	0
Aug 2020	4	0
Sept 2020	3	0
Oct 2020	1	0
Nov 2020	0	0
Dec 2020	2	2
Jan 2021	0	0
Feb 2021	0	1
Mar 2021	2	1
Total 2020/21	15	6

Our HCAI reduction strategy will see us delivering actions to support further C. difficile reductions. The C. difficile objective is still unset for 2021/22, but

we will be aiming to finish the year 10% below the set objective. This will include the ongoing implementation of a faecal microbiota transplant service for patients with recurrent C. difficile, implementation of new treatment protocols to reflect new evidence and best practice recommendations and ongoing one system learning from cases of C. difficile.

To maintain a 3-5% reduction in hospital acquisition of Gram negative blood stream infections, a focus of our 2021/22 infection prevention and control strategy will be to address key areas for improvement using our insights/data. The following projects have been identified:

- Post infection reviews of Gram negative bacteraemias associated with health care interventions; this will mean a change to trust reporting processes. As trust apportioned cases will not only include hospital onset health care associated cases it will also include community onset health care associated cases; this includes patients who were identified as having a Gram negative bacteraemias on either day 0+1 of admission but also had health care contact at the trust within the 4 weeks prior to onset (this is as per national PHE definitions). This is so we can explore all causes and lapses of care associated with health care associated Gram negatives bacteraemia and lead to specific and localised improvement programmes to address identified issues.
- The plan will also continue to address Gram negative blood stream infections related to urinary tract infections and catheter associated urinary tract infections with the Trust wide launch of 'Alert before you insert', which is a process to guide staff on appropriate catheter insertion. This will also be supported by education and training for Nurses and Medical staff to competently insert catheters using an aseptic technique. A pilot across the Trust is also planned in which Chlorhexidine 1% sterile wipes will be used for meatal cleaning on catheter insertion, which has been evidenced to reduce catheter associated urinary tract infections. Engagement of the Trust will continue in the countywide urinary tract infection group which delivers system wide actions to prevent and manage urinary tract infections and catheter associated urinary tract infections effectively. As part of the nutrition and hydration group a number of interventions will also be implemented to support improving patient nutrition and hydration on wards; this will include enhanced snack rounds 'shake and cake', use of technology and support aids to support hydration prompts for both patients and staff
- The Trust will continue to delivers an evidence-based bundle to reduce colorectal surgical site infection but also explore implementation of evidence-based SSI prevention bundles for other surgical specialities including C. sections and Hip replacement surgery which will be supported by an enhanced Surgical Site Infection surveillance programme.

To improve our care of patients whose condition deterioriates

Background

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

The National Early Warning Score

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

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

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

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

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

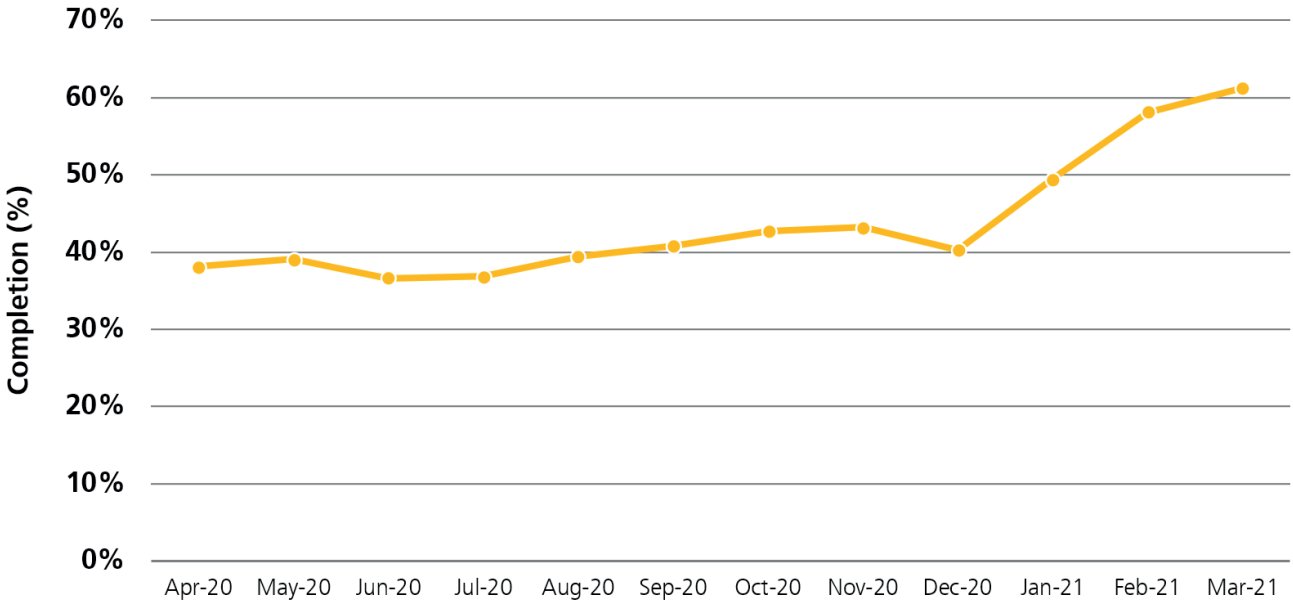
This is a pragmatic approach, with a key emphasis on system-wide standardisation and the use of physiological parameters that are already routinely measured in NHS hospitals and in prehospital care, recorded on a standardised clinical chart – the NEWS2 chart.

How we have performed 2020/21

In March 2020, the Trust decided to deploy the e-observations functionality within our Sunrise Electronic Patient Record, which enabled teams to record patient observations and escalate the management of deteriorating patients, all introduced amid the huge organisational change required to prepare for the pandemic.

The ability to record the NEWS2 electronically has led to huge improvements in accuracy of NEWS2 scores, numbers of sets of scores being recorded alongside greater availability and timeliness of data. The system generates list of patients with scores of 5 and over.

Figure 24: E-Observation Completion



Having e-observations in place within our electronic patient record has proved essential in managing our patients during the coronavirus pandemic. Our acute care response teams have been able to manage caseloads; senior nursing staff have used the data to manage staffing deployment; and teams have been able to track the numbers and locations of patients who are being supported by oxygen. The availability of data both at the bed side and remotely has improved visibility of the deteriorating patient.

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

The run chart above shows the percentage of observations completed within the recommended timeframe (Fig. 24), or outside of timeframe with clinical justification. The NEWS2 flowsheet was optimised in January 2021 which led to the increased in performance.

The current data highlights the need for education and engagement in this area, supported by the Trust Lead for Resuscitation and Divisional Directors for Quality and Nursing, as although we have seen an improvement in compliance throughout the year, our March 2021 data still showed only 61% compliance. These metrics are also being incorporated into our Nursing Assessment and Accreditation System (NAAS), to ensure ongoing monitoring of these metrics.

Plans for improvement 2021/22

Improving the care of patients who deteriorate will continue as a Quality Indicator for the Trust, and the priorities for 2021/22 include:

- Engagement with teams in divisions to understand and improve compliance with data being recorded in a timely manner
- Doctor's handover documents will be live on EPR from 12th May.

- Point of Care Testing and EPR: Plans to link blood gas machines to EPR. This will date stamp and put on the system all lactates, a key component of diagnosis of sepsis.
- Electronic prescribing will complete the chain of data from recognition of sepsis to time stamping all interventions including antibiotic prescribing and administration.
- Computer diagnosis of sepsis - Use of algorithms, based around vital signs and blood chemistry to diagnose early signs of sepsis July 2021.
- Medical Education – ongoing embedding of sepsis training for foundation doctors and clinical simulation, using sepsis as a basis of in-situ clinical simulation in addition to sessions run in the education centre.
- Referrals from the internal rapid response – looking into having a telephone number that relatives can call to talk to the acute care team.

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

Background

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

How we have performed 2020/21

In 2020, Healthwatch Gloucestershire published their report into people's experiences of Mental Health Services in our emergency department. The report (PDF) highlighted areas where care for our patients in Gloucestershire could be improved, and where partners across the system could work together more effectively.

The report was written following 10 interviews with people who have used our services, and survey feedback from a further 11 individuals. In the report:

- It was identified that patients attending ED with mental health needs were not always accessing prompt assessment and support from health practitioners especially after hours.
- Feedback identified that patients were being left unattended in busy environments, in isolation with no oversight.
- Only physical needs were attended to by the responsible medical practitioners in many instances.
- The above represents a challenging environment for those in a fragile state and in some cases resulted in patients self-discharging before treatment initiation.

In addition to the above issues being highlighted, it was recommended that people with lived experience were more proactively involved in designing the improvements in the department.

In response to this report, the urgent care leadership team relaunched the Mental Health Working Group in the department, and reviewed their improvement plan to incorporate the recommendations and feedback from this report. The improvement plan has the following four key work programmes identified:

- Physical Estate and Signposting
- Patient flow and patient experience
- Skill mix and staff training
- Communication

Across these four workstreams, the key deliverables and desired outcomes are:

1. Parity between Mental health and Physical health and co-streaming of medical healthcare and mental healthcare.

2. Appropriate discharge and follow up for all patients

3. Improved physical environment for patients experiencing a mental health related crisis.

4. Provide a strong multidisciplinary service between mental health, alcohol/substance misuse and emergency medicine professionals

5. Appropriate practice and application of relevant legal policy and procedure.

6. Standardised procedures and documentation relating to MH medical assessment.

7. Improved engagement with our patients and communities

8. Routine patient experience feedback through Friends and Family Test.

9. Reduction in time to see clinician: (4 hour performance)

10. To align programme work with wider Trust Mental Health Strategy

Progress made in 2020/21 against this plan includes:

- Engaged two Experts by experience to collaborate on the plan ahead
- Australian Triage Tool has commenced: early stages
- First draft complete of re-design of documentation and risk matrix
- Inclusion of Mental Health assessment in all ED documentation
- Funding approved for new furniture for Mental Health interview room
- Funding approved for Mural within Mental Health Interview room

Plans for improvement 2021/22

This will continue as a Quality Account Indicator for 2021/22, with work continuing against the workstreams highlighted. This work will continue to be monitored through the Mental Health Working Group, with involvement of experts by experience, and through divisional board and Quality Delivery Group.

To improve our care for patients with diabetes

Background

The Trust recognised that there were a rising number of insulin related incidents resulting in increased harm for our patients. The indicator of medication errors (related to insulin management) became a key focus for improvement in 2020/21 as a result.

Insulin mismanagement causes harm to patients by missing their medication and not measuring their blood glucose and ketone levels. These incidents result in moderate harm to patients and incur additional treatment costs, increased length of stay and poor patient experience.

How we have performed 2020/21

As part of COVID-19 response the Diabetes Specialist Nurse team monitored and managed diabetes inpatients and responded to changes in blood glucose/ ketone levels.

This period (April – May 2020) is significant in the number of incidents reported. This additional focus on inpatient management was possible due to planned outpatient activity being significantly scaled back during the initial pandemic wave 1.

The mechanism by which patients across all inpatient wards were able to be monitored by the Diabetes team was through a remote monitoring system whereby patient blood tests were uploaded into the system, analysed and the results sent electronically real time to the Diabetes team and Pathology service. Any patients who were outside of the expected control limit were automatically prioritised for nurse review and intervention which enabled harm to be reduced as a result.

A Diabetes Inpatient Specialist Nurse commenced in post June 2020 and the highest proportion of reporting coincides with this appointment. This demonstrates the impact of dedicated inpatient nurse capacity to monitor and support the wards with recognising harm to patients with diabetes and the increased education is enabling staff to recognise gaps in patient management that may have been missed previously.

The organisation had agreed to invest in more Diabetes Inpatient Specialist Nurse resource however we were unable to recruit into these key roles within year. To continue to improve insulin incident rates further in the future extra resource is a key enabler of our 2021/22 quality plan for Diabetes.

Data

The number of patient incidents relating to insulin medication in March 2020 totalled 5. Since the introduction of the remote monitoring and additional inpatient nurse workforce implementation the number of reported incidents has increased to an average of 10 per month.

This demonstrates the impact of ward education where staff have a better understanding of insulin medication errors occurring on the ward and are therefore increasing the reporting of incidents. By increased reporting the Trust can understand the areas that require intensive support and education from the Diabetes inpatient team.

Plans for improvement 2021/22

This work will continue as a Quality Account Indicator for 2021/22, as a Trust priority. It is now well documented that there is an increased risk of patients with diabetes becoming acutely unwell if they contract Coronavirus and in fact patients developing Diabetes following COVID infection due to the treatment required. The organisation is therefore prioritising recruitment and retention of Diabetes Nurses within the Inpatient team to focus on direct patient interventions and increased remote monitoring.

Education for wards is a large-scale endeavour that is required in addition to direct patient care. This takes the form of:

- 1:1 and Group teaching live on the ward.
- Provision of teaching and learning aids on the wards.
- Development of an eLearning module for all clinical staff.
- Review of the documentation we use to streamline and simplify where possible.

A trust wide rollout of education across both Cheltenham and Gloucester sites that start with wards experiencing the highest rate of incident will also be a focus for 2021/22.

Figure 25: Diabetes Medication Incident reporting

Date	Data
Mar 2020	5
Apr 2020	11
May 2020	12
Jun 2020	7
Jul 2020	14
Aug 2020	11
Sep 2020	5
Oct 2020	11
Nov 2020	10
Dec 2020	11
Jan 2021	15
Feb 2021	10
Total	122

To improve our care of patients with dementia

Background

NHS England & NHS Improvement asked hospital trusts to report their performance against the national dementia quality measure known as Dementia Assessment and Refer (DAR). The indicator asks how many patients over the age of 75 admitted for more than 72 hours are assessed for dementia. Hospital Trusts are also asked to show that patient care includes investigation and referral to specialist dementia services.

The Quality Account 2019/20 noted that NHS England & NHS Improvement were reviewing the future of this dementia indicator, but due to COVID-19 that process of review with a decision has not been completed.

In June 2020, the Trust agreed to review our 2017 Dementia Strategy using the Trust's Quality Strategy framework of Diagnose Design Deliver to ensure a robust evaluation with an in depth analysis of research and data. This process helped to set out key priorities for dementia alongside measures that would show progress and improvement.

How we have performed 2019/20

The resulting Dementia Improvement Plan set out 3 dementia priorities:

1. To improve Trust performance against national indicators; in addition to Dementia Assess Refer the Trust participates in a National Audit of Dementia every other year and has signed the Dementia Declaration for Dementia Friendly Hospitals.

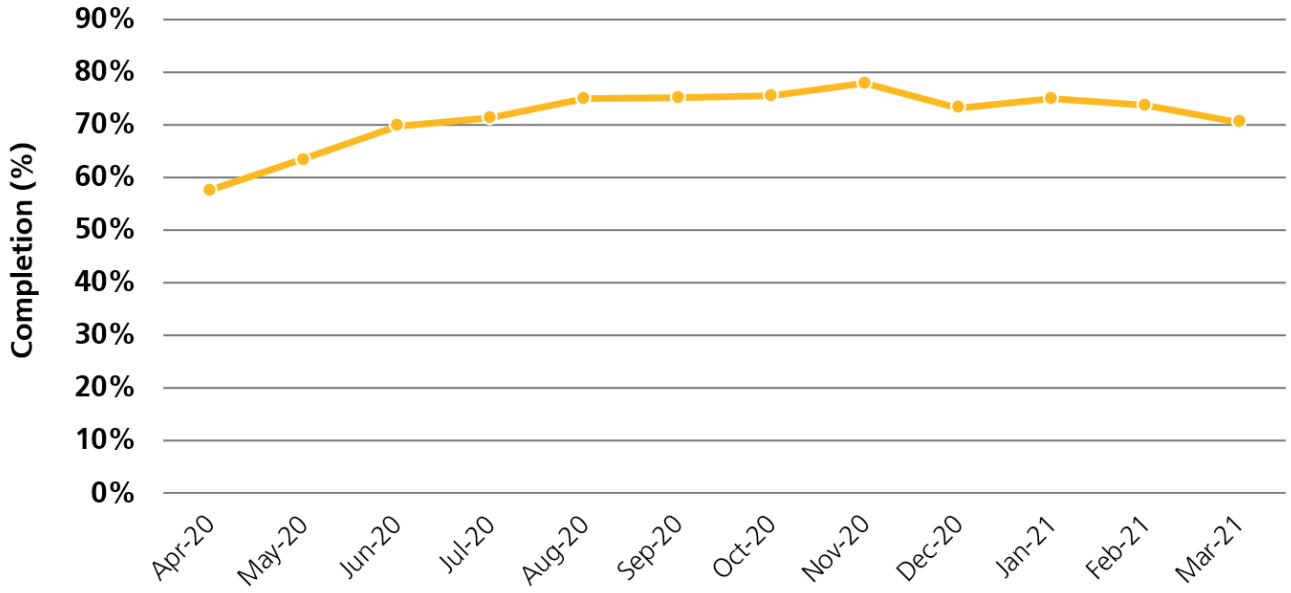
2. To develop dementia & delirium clinical pathways to ensure consistent assessment and care of individual with dementia. The clinical pathway needs to be linked to Patient Electronic Records to prevent and reduce the significant risk of delirium that can be harmful to those with dementia

3. To review the Trust's dementia training to ensure that it provides the right information to staff on caring for people living with dementia, as well as giving consistent and up to date information

Progress against this plan in 2020/21 includes:

- The arrival of the Trust's first Admiral Nurse through a joint funding initiative with Dementia UK. The Admiral Nurse very quickly began leading face to face support for ward staff, patients and families. Links were established with the local Alzheimer's Society Dementia Advisors to continue support following discharge, and more recently testing ways to reduce the number of bed moves for patients with dementia
- The Admiral Nurse has worked with colleagues to address concerns about multiple ward moves for patients with dementia. Frequent ward moves are unsettling to all patients, but the particular concerns for those living with dementia are that the patient may be moved away from a team that knows them and has the specialist dementia skills needed to manage dementia, delirium, prevent falls and work with families on complex discharge planning. An improvement plan is being piloted on 2 wards to assess daily the risks to patients moving to another ward using Red

Figure 26: Dementia Screening Completion



Amber Green (RAG) categories; Red is for patients not for transfer as the risks are high, Amber is for patients who should not move unless necessary and Green is the patients where the risks from a move are low. Guidance is in place to ensure that where patients are moved, essential information is shared with families and new ward staff to minimise the impact.

- The Admiral Nurse has worked with Dieticians and Infection Control Teams to improve nutrition and hydration using a sequence of coloured water jugs as a visual way to alert staff to an individual's hydration status.
- We no longer have to complete manual audits of dementia screening being completed, as this is now captured within the Nursing Admission documents in our EPR system. The metric reported in the graph below shows the Dementia Screening assessments which were completed within 24 hours of admission on EPR and the patient was aged 75 or over (denominator), and counts those where it was documented that either the patient was too unwell to screen, or there was an answer to the question 'Has the patient got a clinical diagnosis of Dementia'.
- The data shows that there is still work to do on improving the number of dementia screenings completed (Fig. 26) within 24 hours of admission, and the team have access to ward level data to target engagement and education on this, in partnership with divisional leads
- Trust dementia training has been mapped to ensure a partnership approach to consistent content and delivery and refreshed dementia eLearning to be available from July 21 and extended to additional key workers.
- The Trust Dementia and delirium pathways have been developed to address wider issues and needs for staff and family/carers, with a resulting action to develop a system-wide delirium pathway with system partners to reduce inappropriate admission and improve timely discharge and clearer understanding of action needed.

- Producing information leaflets for staff and friends & family on communicating with individuals living with dementia during COVID restrictions on visiting

Plans for Improvement 2020/21

This will continue as a Quality Indicator for 2021/22. The Trusts Admiral Nurse outlined the priorities for 2021/22:

- Further Dementia data to be recorded in ESR and available on Insight, as well as embedded within our Quality and Performance Reporting.
- Address DAR/FAIR issues if NHSE continues use as an indicator.
- Dementia & delirium screening/ assessment/treatment to be recorded in the Electronic Patient Record; work is already underway to with the digital team to identify how to capture collate and compare data.
- Work has commenced with ICS partners on a system-wide engagement with the delirium pathway.
- The Trust's Admiral Nurse and Dementia UK are developing an activity report to capture the impact of investment and the scope of the Admiral Nurse role.
- Trust Dementia Champions are being re launched as part of activity for May's Dementia Action Week.
- To complete current Quality improvement work including minimising bed moves for dementia/delirium patients, improving hydration and trails of whiteboards on wards 4a, 4b and 6b.

To improve outpatient care

Background

A 'proof of concept' pilot was already in progress to trial video calling for outpatient appointments as part of the Outpatients Transformation Programme. The platform to support the trial was 'Attend Anywhere' which is a web-based platform to conduct video appointments and was provided free of charge by NHSE/I who identified 4 Trusts in England willing to participate. With the outbreak of Covid19 and other factors included, national, regional and local, usage was likely to provide wider support and also give patients a common platform to use. It was confirmed in March 2020 that Attend Anywhere would be the video consultation platform rolled out across the Trust.

How we have performed 2020/21

The Pilot changed dramatically in March 2020 and became an implementation of capability across the Trust for outpatient specialities 'at pace'.

56 specialities in the Trust rearranged clinics to embark on video consultations.

The first challenge that we faced was to ensure that outpatient services continued and where it was deemed vital for a face to face these took place with special measures for COVID-19 in place. Other clinics were redesigned to ensure patients had either a telephone or video appointment across all disciplines.

The second challenge was to ensure that equipment was made available for all those clinical areas that were to conduct video clinics. Across the nation the demand for equipment both for business and private use rose exponentially and support came directly from NHS England (NHSE).

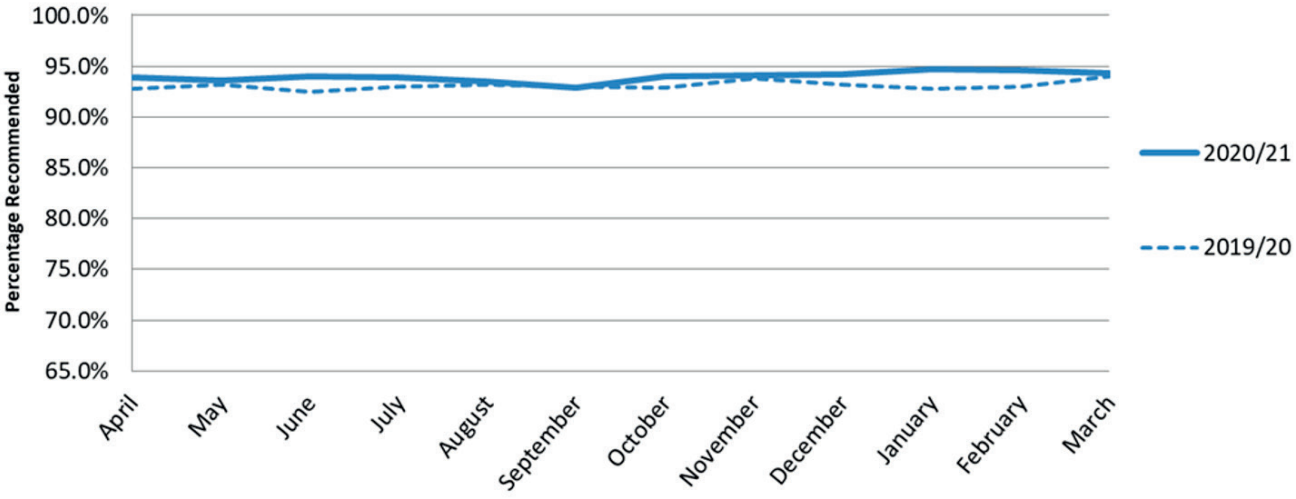
NHSE needed the Trust to perform at least 25% of our Outpatient appointments virtually (video or telephone) and the Trust has consistently met this goal and on data provided by NHS Improvement Model Hospital, the Trust has reached over 45% virtual outpatient appointments at the height of the second wave and continues to deliver at 40%.

There have been a number of benefits identified for the Trust and for patients alike.

- Reduction in travel (for patients and some clinicians)
- Enabling multi-disciplinary team (MDT) working
- Within a virtual context 'seeing' the patient can enable quality of care
- Reduced anxiety and enabled a 'circle of care' around the patient
- Enables service continuity
- The Trust declared a 'climate emergency' in December of 2019. The benefits to health and wellbeing are significant when reducing travel for outpatient appointments but there is also reduced impact on the environment in line with the NHS' plan for net zero carbon. From figures taken from the patient survey, to 31 November 2020, 5.15 tonnes of CO2 saved on average from 18,655 patient miles not driven.

In addition to the benefits listed above, patients consistently reported a positive experience of our outpatient services throughout the year, as shown in the Friends and Family Test scores in the graph on the next page (Fig. 27). The graph

Figure 27: FFT percentage of patients that would recommend our Outpatient services



shows the 2019/20 scores and the 2020/21, and patients have continued to report a positive experience of our outpatient services throughout the pandemic with the introduction of remote consultations.

Plans for improvement 2021/22

The significant upturn in the use of video appointments in response to the pandemic gave the Trust a valuable opportunity to embrace new technology. There was significant learning around the use of video consultation for outpatient appointments and this has shown what can be achieved in a short space of time with the right support in place. The key focus is to increase use of video consultation and to understand where video consultation is both appropriate and effective. The work done over the past months has shown that video consultation can be highly successful and in some cases more powerful than a telephone call.

The concept of Virtual is here in the future of outpatients and video appointments and is currently used as a tool to support staff and patients through the current pandemic but it is crucial for the short and long recovery of patient services as we emerge from this pandemic it is also needed to come in line with the NHS Long Term Plan aspirations. The Trust plans to continue to use Attend Anywhere for a further 12 months and review other platforms to get best value for money for the Trust. Currently there is funding in place from NHSE to finance the licence for Attend Anywhere for another year and in the meantime another platform Dr Doctor will be introduced and is expected to be in place within the next year. Dr Doctor will enable automated communication to patients direct from clinic software and enhance patient services further.

Although the reason behind the unexpected growth of video appointments has been and continues to be the pandemic, it is clear from the patient responses that they will continue and be embedded in the ever improving Outpatient Services from Gloucestershire Hospitals NHS Foundation Trust.

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

Background

In 2015 NHS Improvement identified ten clinical standards to be met by NHS Trusts, with 4 priority standards. Trusts were required, each year, to complete 7 Day Service self-assessments to understand if these standards were being met.

An audit of the ten clinical standards took place in July 2019 and the audit evidenced that two standards were not being met:

- Clinical Standard 2: Time to first consultant review
  - All emergency admissions must be seen and have a thorough consultant assessment as soon as possible but at the latest within 14 hours of admission to hospital
  - Standard is met if compliance is 90%
- Clinical Standard 8: Ongoing patient review
  - All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway. Measured for first 5 days of admission
  - Standard is met if compliance is 90%
- The requirement to complete a further self-assessment is now no longer required by NHSI. However, as part of an ongoing Trust commitment to improve medical review performance as well as a commitment to apply learning from the Trust's response to Covid, the Medical Director commissioned a review to:
- Compare performance against the 2019 assessment, with specific reference to Clinical Standard 2 and Clinical Standard 8
- Understand more fully how medical reviews are being carried out and learning from COVID
- Identify potential opportunities to improve Trust performance.

How we have performed 2020/21

The scope of the medical records audit was to view an agreed number of medical notes to assess the extent to which clinical standards 2 and 8 were carried out, who performs the assessment/ review and how it was recorded. The audit included both unplanned and planned admissions and meet the inclusion criteria specified by NHSE/I i.e.

- Admission within the audit period
- Admission of > 14hours in length
- Admission not via an ambulatory care setting or non-consultant led service (such as midwifery)

Two samples were taken, one from pre-COVID period in February 2020 and one within the COVID period April 2020. We have collected a sample size of patient medical record notes from every day of the week, covering one weeks' time period.

The samples consisted of 177 medical record notes pre-COVID and 193 during the COVID timeline, across 6 main clinical specialities as seen in the following tables.

Figure 28: Results of the audit: Clinical Standard Two, time to consultant review

Overall consultant reviews held	Pre-COVID Feb 2020			COVID April 2020		
	Wkday	Wkend	Total	Wkday	Wkend	Total
Within 14 hours	88	10	98	90	19	109
Outside 14 hours	35	18	46	38	13	51
Total (87%)	123	28	154	128	32	160
% Seen in less than 14 hours	**72%**	**36%**	**64%**	**70%**	**60%**	**68%**

Comparable data from the last 4 audit periods of % seen in less than 14 hours

September 2016	March 2017	April 2018	2019
68%	54%	65%	62%

Figure 29: Results of the audit: Clinical Standard Eight ongoing review

Overall reviews held	Pre-COVID			COVID			2019	
	Wkday	Wkend	Total	Wkday	Wkend	Total	Wkday	Wkend
Consultant	55	23	78	103	28	131	324	
SpR	3	3	6	9	4	13	39	
SHO	12	2	14	6	1	7	105	
F1	–	–	–	2	–	2	2	
Other	1	1	2	2	–	2	0	
Overall reviews	71	29	100	122	33	155	472	
Proportion of consultant led reviews	**77%**	**79%**		**84%**	**85%**		**69%**	**86%**

A larger proportion of notes was requested for Obs and Gynae however, because the maternity notes are kept by patients it proved to be difficult to assess this department.

Results of the audit: Clinical Standard Two: Time to Consultant Review (Fig. 28)

During the first COVID surge in April 2020 the clinical standard results were the highest matching the first audit completed in 2016, although further improvement is still required to match the NHSI set target of 90%. The 2020 result is a slight improvement from last year, especially at the weekends. In 2020 performance at weekends almost doubled during the COVID time period, from 36% to 60%. Although in COVID we had significant redeployment of speciality doctors to help with Acute Medicine at the front door

Results of the audit: Clinical Standard Eight: Ongoing review (Fig. 29)

During the weekday performance has improved in 2020 however the weekend was lower than in 2019.

In addition to the audit, a number of semi-structured interviews have been conducted (beginning 21 October 2020) with key stakeholders including Divisional and Speciality Clinical Leads to:

- Understand the current medical review/assessment processes, their effectiveness and any gaps/issues
- Identify operational lessons learnt from COVID
- Identify suggestions on potential areas for service improvement through lessons learnt from COVID.

The following challenges were identified through the interviews and observations as impacting delivery of the clinical standards and creating delays along the patient pathway:

Patient Lists

- Access to accurate patient list which identifies all ward round in-patients (a particular problem for the respiratory team)
- Identifying or medical staff (consultants, registrars, F1's) being notified of new outliers locations
- Multiple avenues to refer patients to speciality (including emails, phone call, Trak and Ereferrals) which causes confusion and duplications of referrals

Ward/Board rounds

- The outcome of Ward/Board rounds do not necessarily get recorded in notes. There is not a standard clear process for Ward/Board rounds at weekends
- Lack of accuracy and inconsistency of the quality of handover documents to provide an update to the consultant with the patients pathway
- Ward round documentation – issues capturing accurate timing of ward rounds and legible ward round notes and storing notes in findable locations

Resourcing

- Shift patterns limit the ability of consultants to review inpatients who have been admitted in the afternoon/ early evening within 14 hours
- Barriers to achieving good documentation include time pressures on clinical staff and a wider cultural view that directly delivering patient care takes precedence over recording its details.
- Patient Pathway
- Inpatients who are admitted at midday do not receive their medical investigations results in a timely manner which impacts the consultant being able to review the results on the same day of admission
- Timely consultant reviews of patients who arrive late in the afternoon or early evening are particularly challenging

General Practitioner Assessment Unit (GPAU)

The GPAU project was included as part of the Medical Review Project, as it supports patients being seen within 14 hours. The aim of this project is to improve acute medicine services in Gloucestershire Royal Hospital, by reducing the time to review for patients referred to Medicine by GPs through the introduction of the General Practitioner Assessment Unit (GPAU). It was anticipated that the introduction of the Unit would ensure that patients referred to the acute medicine department by primary care would be:

- Triaged quickly
- Escalated to the relevant clinician/ specialty for assessment and therefore treatment would be started earlier.
- Seen within the appropriate clinical environment
- Supportive of the trust-wide objectives to improve Emergency Department performance against national quality indicators, including reducing length of stay.

The overall time, as measured by the Continuous Quality Improvement Standard Data was collected pre-GPAU going 'live' and post-GPAU.

The data shows that the creation of a separate area within ED, allocated specifically for GP referral patients, has significantly improved the time the patient is seen by a doctor, from arrival to the hospital. Pre-GPAU 52% of patients had their observations taken within 30 minutes of arrival to hospital and 65% were seen by a doctor within 4 hours of arrival, this increased to 84% of observations taken within 30mintes and 100% seen by a doctor within 4 hours of arrival once GPAU was implemented.

This ultimately improves patient safety and helps improve flow within the hospital, by arranging for specialty reviews as needed or sending directly to a ward and bypassing AMU if the patient has also been reviewed by a consultant. This area also allows for patients to be assessed quickly and discharged if needed. This area is separate to AMIA which is used for ambulatory patients. GPAU allows for patients to be triaged and assessed quickly with prompt treatment initiated.

A number of recommendations have been drafted based on the GPAU project, which will be reviewed alongside the wider recommendations made in the Medical Review Project.

Plans for improvement 2021/22

This will continue as a Quality Account Indicator for 2021/22, implementing the recommendations from the Medical Review Project, led by the Medical Director. These recommendations include:

- Sunrise patient list pilot to be rolled out to respiratory and paediatrics teams
- Staff education and training to access newly created patient lists on EPR
- All patient referrals should come through one avenue to simplify the referral process using our Sunrise EPR
- Refresh of Trakcare to avoid patients being allocated to Consultants who have left the Trust
- iPad pilot study starting with respiratory to simplify access to EPR and patients lists on ward rounds
- Consultants to contact Juniors during night shifts to provide support for early decision making. Suggestion at 10pm and 6am
- To include the time column next to the date column on the pro-forma used for elective work (to accurately audit clinical standards in the future)
- To ensure Medical Records on wards are readily available and stored in common agreed location
- Enabling Registrars to become relevant senior reviewers for acute admissions and inpatient reviews (suggested by multiple Consultants)
- Consultants to start shift times earlier to enable better patient flows e.g. similar to respiratory and surgery
- Specialties to carry out additional audits to support their area as we were unable to obtain significant numbers for all specialities due to the timeframe and volume of work the project entailed eg.obs and gynae

In addition to the above recommendations, benchmarking with other Trusts has been done to understand what has worked well elsewhere, and the recommendations from this work will be used to support improvements against these two clinical standards.

Part 2.2

Statements of assurance from the board

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

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

Health services

During 2020/21 Gloucestershire Hospitals NHS Foundation Trust provided and/or subcontracted 111 NHS Services. Gloucestershire Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 111 of these relevant health services.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust can confirm compliance with this requirement for the 2020/21 financial year.

Information on participation in clinical audit

From 1 April 2020 to 31 March 2021, 49 national clinical audits and 1 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 94% national clinical audits and 100 % national confidential enquiries which it was eligible to participate in. Participation was suspended due to Covid, in line with National agreements for some audits. Where national audits could not be undertaken, for non Covid reasons, then local data was collected and reviewed.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in during 2020/21 are as follows:

	Eligible	Participated	Status
Antenatal and newborn national audit protocol 2019 to 2022	Yes	?	?
BAUS Urology Audits: Renal Colic Audit	Yes	Yes	Completed
British Spine Registry	Yes	Yes	Ongoing
Case Mix Programme (CMP)	Yes	Yes	Ongoing
Elective Surgery (National PROMs Programme)	Yes	Yes	Ongoing
Emergency Medicine QIPS (RCEM): Fractured Neck of Femur (care in emergency departments)	Yes	Yes	Completed
Emergency Medicine QIPS (RCEM): Infection Control (Care In Emergency Departments)	Yes	Yes	Completed
Emergency Medicine QIPS (RCEM): Pain in Children	Yes	Yes	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP): National Audit of Inpatient Falls	Craig Bradley	Yes	Ongoing
Inflammatory Bowel Disease (IBD) Audit	Yes	No	n/a
LeDeR - Learning Disabilities Mortality Review	Yes	Yes	Ongoing
Mandatory Surveillance of HCAI	Yes	Yes	Ongoing
Maternal, Newborn and Infant Review Programme Clinical Outcome	Yes	Yes	Ongoing
National Asthma and COPD Audit Programme (NACAP): Adult asthma secondary care	Yes	Suspended due to Covid	PTP

	Eligible	Participated	Status
National Asthma and COPD Audit Programme (NACAP): Paediatric Children and young people asthma secondary care	Yes	No	PTP
National Asthma and COPD Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD)	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Ongoing
National Audit of Care at the End of Life (NACEL)	Yes	**Yes**	NYR
National Audit of Dementia (NAD)	Yes	**n/a**	NYR
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	**Yes**	Ongoing
National Bariatric Surgery Registry (NBSR)	Yes	**Yes**	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	**Yes**	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	**Yes**	Ongoing
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Yes	**Yes**	Ongoing
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	Yes	**Yes**	Ongoing
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Audit Harms (NaDIA-Harms)	Yes	**Yes**	Ongoing
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	Yes	**Yes**	Ongoing

	Eligible	Participated	Status
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Yes	**Yes**	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	**Yes**	Ongoing
National Emergency Laparotomy Audit (NELA)	Yes	**Yes**	Ongoing
National Gastro-intestinal Cancer Programme	Yes	**Yes**	Ongoing
National Joint Registry (NJR)	Yes	**Yes**	Ongoing
National Lung Cancer Audit (NLCA)	Yes	**Yes**	Ongoing
National Maternity and Perinatal Audit (NMPA)	Yes	**Yes**	Ongoing
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	**Yes**	Ongoing
National Ophthalmology Audit (NOD)	Yes	**Yes**	Ongoing
National Paediatric Diabetes Audit (NPDA)	Yes	**Yes**	Ongoing
National Prostate Cancer Audit	Yes	**Yes**	Ongoing
National Vascular Registry	Yes	**Yes**	Ongoing
Medical and Surgical Clinical Outcome Review Programme - Dysphagia in Parkinson's Disease (NCEPOD)	Yes	**Yes**	Complete
Perioperative Quality Improvement Programme (PQIP)	Yes	**Yes**	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Yes	**Yes**	Ongoing
Serious Hazards of Transfusion (SHOT)	Yes	**Yes**	Ongoing

	Eligible	Participated	Status
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	**Yes**	NYR
Surgical Site Infection Surveillance Service	Yes	**Yes**	Ongoing
The Trauma Audit and Research Network (TARN)	Yes	**Yes**	Ongoing
UK Cystic Fibrosis Registry	Yes	**Yes**	Ongoing
UK Registry of Endocrine and Thyroid Surgery	Yes	**Yes**	Ongoing

- **Ongoing:** relates to continuous data collection, please note some audits have suspended data collection due to COVID-19
- **NYR:** data collection has not yet started
- **PTP:** plan to participate in the next round (affected by Covid)

The reports of the above national clinical audits were reviewed (or will be reviewed once available – many have been postponed due to Covid) by the provider in 2020/21.

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?
Antenatal and newborn national audit protocol 2019 to 2022	The maternity team is participating in this and will be submitting data by 30 June 2021.
British Spine Registry	The British Spine Registry (BSR) is a web-based database for the collection of information about spinal surgery in the UK., it was established with the aim to improve patient safety and monitor the results of spinal surgery. The Trust shares, discusses and reviews its BSR results at the regional Southwest Spine Network quarterly. The Trust results are in line with expectations.
Case Mix Programme (CMP)	The CMP is an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland. Currently 100% of adult, general critical care units participate in the CMP. The results from CMP are reviewed at individual M&M meetings/ lessons shared. They are now also reviewed in specific COVID reports and rapid mortality meetings. The reports provide information on mortality rates, length of stay, etc. and provide the Trust with an indication of our performance relation to other ICUs. Where trends are identified then these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society. 2020/21 was an exceptional year and difficult to interpret, however both units were performing above national standards in the areas assessed. Separate COVID reports suggest units are both meeting standards with similar admission demographics.
Elective Surgery (National PROMs Programme)	Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement and knee replacements. It provides an indication of the outcomes or quality of care delivered to NHS patients. The results have been good and are an ongoing reflection of consultants work and is used as part of their appraisal.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Falls and Fragility Fractures Audit programme (FFFAP): National Audit of Inpatient Falls	The National audit of inpatient falls is one of a suite of national audits under the Falls and Fragility Fracture Audit Programme (FFFAP). The FFFAP audits provide a quality improvement platform for trusts in England – aiming to help local clinical teams and health service managers understand why people fall in hospital, the care that should be provided for fragility fractures, and what can and should be done to prevent future fractures. All the FFFAPs are reviewed annually as soon as the reports are released online, at the appropriate clinical and governance meetings. The recently published interim audit for inpatient falls will be reviewed at the next Falls meeting in July 2021.
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database (NHFD)	The report was reviewed as soon as it was released online in January 2021. Improvements work continued around consolidation and embedding of previous years actions, together with looking at additional theatre availability. This year saw an additional need to manage COVID and try to ensure minimal disruption to hip fracture care.

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?
LeDeR: Learning Disabilities Mortality Review	There were 21 reported learning disability deaths in 2020/2021. Of these 19 were rates: 14 (74%) were rated 2 (good care) and 5 (26%) were rated 3 (adequate care). There were 2 patients from out-of-area placed in Gloucestershire – whilst reviewers were complimentary we did not see the final report and therefore do not know the grading of care. The information is reported at every Safeguarding Adults Operational Group, Learning Disability Steering Group and Safeguarding Strategy Group and is also presented at the Hospital Mortality Group. There were no reviews which raised any serious concerns, however there were some recommendations for improvements and these have already been considered and actioned as follow: The Trust has Mental Capacity Act improvement plans; this work should help improve the understanding of the importance of mental capacity assessments, and ReSPECT form (alongside the ReSPECT) project). The Learning Disability Liaison Nurse will be sitting on Trust Nutrition and Hydration quality improvement project group. The importance of listening to relatives and carers will be included in learning disabilities teaching sessions for qualified and unqualified nursing staff, it is hoped that there will also be the opportunity to reach medical and therapy staff being. In relation to improving communication with non-verbal people, the Learning Disability Liaison Nurse can provide Easy-Read/pictorial information. It is also included in the learning disability training sessions. Audiology has excellent information available and BSL and Makaton translators can be booked. In addition to this in some cases reasonable adjustments can be made for familiar carers to stay with patient. Oliver McGowan training due to take place that covers communicating with patients and carers. In relation to mis-match between what clinicians think they have conveyed to relatives and carers and what has been understood and retained leaflets are due to be developed regarding; What to expect at a Best Interests meeting, summary of what we discussed (Outpatient appointments) and summary of what we discussed (Inpatient stay). These can be linked as suitable responses on all the Vulnerable Patient webpages accessed via the Vulnerable Patient Portal.

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?
Mandatory Surveillance of HCAI	All cases are reported and reviewed at a board level on a monthly basis. The outcomes are also discussed at the Trust infection committee.
Maternal, Newborn and Infant Review Programme Clinical Outcome	All losses over 22 weeks are reviewed at the appropriate risk meeting then the results inputted on the PMRT. Whilst there have been no specific actions required, learning points are always disseminated throughout the service.
National Asthma and COPD Audit Programme (NACAP): Adult asthma secondary care	This audit was suspended locally during the COVID pandemic. The department are restarting the asthma component of this ongoing national audit to take into account asthma admissions from the start of April 2021 onwards.
National Asthma and COPD Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease (COPD)	The Trust has improved acquisition by over 100% and is looking to improve this further by using Sunrise to generate patient group lists. In addition to this we have looked at our staffing and having dedicated time for this audit. The data is reviewed on a 3 monthly basis ad around 30 patients a month are enrolled.
National Audit of Breast Cancer in Older People (NABCOP)	Cases and reports are reviewed at departmental meetings. This year's report is due at the end of Summer 2021.
National Audit of Care at the End of Life (NACEL)	Data collection was suspended nationwide for 2020/21. The 2019–20 report was published and reviewed by the trust at the Hospital Mortality Group (June 20), Grand Round (Oct 20) and the Gloucestershire CCG EOL Collaborative (Sept 20) There have been many improvements that have incorporated end of life care. The ReSPECT improvement project, which was an incredible Trustwide collaborative through the first wave of Covid. The EOL strategy and steering group is in process of review and refresh of this initiative with the goal of developing and maintaining the engagement, momentum and oversight through: ▸ Shared care plan uptake and use ▸ Education and support e.g. communication skills ▸ Pan-Gloucestershire approach ▸ Purple: initiative to support the management of patients whose outcome is uncertain but who are sick enough to die. Pilot commenced

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Epilepsy12 aims to help epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. Reports are reviewed at the appropriate specialty governance meeting
National Bariatric Surgery Registry (NBSR)	The National Bariatric Surgery Register is a comprehensive, prospective, nationwide analysis of outcomes from bariatric surgery in the United Kingdom and Ireland. It contains pooled national outcome data for bariatric and metabolic surgery in the United Kingdom. All cases performed in Gloucester are submitted to NBSR. These are then reported on the NBSR Website. The results are presented at the SQAG (Surgical Quality Assurance Group) Meeting and at the Upper GI Surgical Governance Meeting. A local audit is currently underway to assess the Trusts revision rates for primary bariatric surgery (national revision rates are ~8%).
National Cardiac Arrest Audit (NCAA)	All reports are reviewed as a department as well as within the Deteriorating Patient & Resuscitation Committee quarterly. The Trust also ensures that the reports are available to all relevant parties. The Trust ensures that up to date data is shared within induction and mandatory training events. Any inappropriate CPR attempts are reviewed and any training required is highlighted and simulated. The Trust is in the process of using data to investigate situations prior to the event further by using additional data from working closely with Acute Care Response Team.
National Cardiac Audit Programme (NCAP)	Data collection continues, and additional support has been given to meet the required data entry. The reports are reviewed within the appropriate governance meetings when published.
National Adult Diabetes Audit (NDA)	Awaiting the reports which will be reviewed at appropriate specialty and governance meetings.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Early Inflammatory Arthritis Audit (NEIAA)	The NEIA audit aims to improve the quality of care for people living with inflammatory arthritis, collecting information on all new patients over the age of 16 in specialist rheumatology departments in England and Wales. Following the report publication, results are discussed by the Rheumatology team
National Emergency Laparotomy Audit (NELA)	The data submitted to NELA is reviewed at the quarterly joint surgical and anaesthetic QI meetings to review morbidity and mortality and compliance with other NELA standards of care. The data has been used to help the service reconfigure to GRH site only. The Trust is now in the top 3 busiest emergency laparotomy sites in the country and notwithstanding this our performance continues to be strong with mortality well below national average and performance against Best Practice Tariff standards still. The Trust is a positive outlier in terms of elderly care perioperative care seeing all over 65 year olds (over and above the NELA standard). Our results are well above the national average for Consultant lead care from both Surgeons and Anaesthetists for our high risk patients and for admission of these patients to critical care post op. The elderly Care post-operative service is now well established. It is envisaged that quality improvement work using data from database and elsewhere will increase again following the second surge of pandemic.
National Gastro-intestinal Cancer Programme	The Trust submits data for the NOGCA. The reports are reviewed at the appropriate specialty and governance meetings when they are published.
National Joint Registry (NJR)	The National Joint Registry (NJR) collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery. The results of the NJR are shared with the Medical Director and Chief Executive and is discussed at hip and knee MDT meetings amongst all hip and knee surgeons. Individual reports are used as part of the appraisal process for all arthroplasty surgeons Outlier data is used to change practice and improve performance the reports is discussed at a team level and with individuals in order to identify steps to improve outcomes. The consent rate is not as good at Gloucestershire Royal Hospital but it was identified that this was due to trauma cases and delirium/dementia patients.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Lung Cancer Audit (NLCA)	The National Lung Cancer Audit (NLCA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and works with a number of specialists to collect hospital and healthcare information and report on how well people with lung cancer are being diagnosed and treated in hospitals across England, Wales, (and more recently) Jersey and Guernsey. The outcomes are reviewed at the Lung AGM and appropriate specialty and governance meetings. Quality improvement projects to improve our service and pathways are ongoing.
National Maternity and Perinatal Audit (NMPA)	The National Maternity and Perinatal Audit (NMPA) is a large scale audit of NHS maternity services across England, Scotland and Wales. The NMPA aims to support improvements in the care for women and babies by providing national figures and enabling comparison between maternity services. The data and reports are reviewed by the Trust at Divisional and Executive board reviews. The Trust has expresses a concern with NMPA regarding exclusion of data from our stand alone midwifery services.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	The NNAP aims to helps neonatal units improve care for babies and their families by identifying areas for quality improvement in relation to the delivery and outcomes of care. The Trust continually takes part in this ongoing audit of all Neonatal Unit admissions. NNAP online provides updated annual data relating to all audit standards via it's publicly visible website. This information is reviewed at Paediatric governance and neonatal consultants meetings.
National Ophthalmology Audit (NOD)	The data submissions for the 2020/21 NHS year are currently occurring; this will include data from the Trust with the annual report scheduled for publication by the end of 2021.
National Paediatric Diabetes Audit (NPDA)	The results of the audit are discussed at the appropriate departmental audit meeting. The Trust also participates in the Southwest Regional Diabetes Network . A programme of improvement has taken place in relation to Paediatric Diabetes within the Trust over the last few years, which has included feedback from patients and carers

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Prostate Cancer Audit	The National Prostate Cancer Audit (NPCA) is a national clinical audit assessing the process and outcome measures from all aspects of the care pathway for men newly diagnosed with prostate in England and Wales. The findings help to define new standards and help NHS hospitals to improve the care they provide to patients with prostate cancer. The Trust submits data for NPCA and reviews the reports at the appropriate specialty and governance meetings when they are released. There has been an improvement in data entry. There has been a recent review with Cancer services and Business intelligence to improve further the data drawn down as they come from more than one source. 2020 has been very difficult with COVID however late 2020 early 2021 the Trust made significant changes in the early diagnosis pathway for suspected prostate cancer referrals and also an increase and adaption of the andrology service. The andrology service has now been increased from 8 sessions to 13 sessions per month. This has reduced the waiting list to 2 months for all Trust wide andrology referrals. A new pathway has been developed for men diagnosed with prostate cancer, with early intervention and improved continuity in the assessment and management of erectile dysfunction this should show an improvement in penile rehabilitation and erectile dysfunction recovery following and during treatment for prostate cancer over the next 18-24 months.
National Vascular Registry	The NVR data entry system is a secure online database where vascular specialists working in NHS hospitals in the UK can enter their data for vascular procedures they carry out. 100% of data is extracted from the NVR database. The reports are reviewed at the specialty meetings and there are no reported actions.
Perioperative Quality Improvement Programme (PQIP)	PQIP is a national research and quality improvement initiative to improve care along the perioperative pathway. Data collection continued but this year's numbers were reduced due to Covid. The PQIP report is reviewed as part of the Anaesthetic QI group. Additional work and audit has taken place relating to diabetes, risk assessment and thirst.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Sentinel Stroke National Audit programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme that measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence based standards, including the 2016 National Clinical Guideline for Stroke. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. The Trust is able to access the SSNAP data directly and it is used to provide regular data for a number of purposes and is reviewed on a regular basis by ED, radiology, Stroke nurses, consultants and the wider stroke team. It helps inform potential quality improvements within the stroke service.
Serious Hazards of Transfusion (SHOT)	SHOT collects and analyses 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 UK. Where risks and problems are identified, SHOT produces recommendations to improve patient safety. The recommendations are put into its annual report which is reviewed by the Trust. A gap analysis is being undertaken to identify areas of improvement.

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?
Surgical Site Infection Surveillance Service	Due to the impact of COVID-19 pandemic on elective surgery and on SSI (Surgical Site Infection) team resources SSI surveillance active methodology surveillance was suspended during quarter 1 2020-2021 with the exception of passive surveillance; no patient visits were undertaken but patient reported SSI data collection (post discharge questionnaires) for colorectal (large and small bowel) surgery continued. From quarter 2 20/21 active SSI surveillance methodology was recommenced for large and small bowel surgery and total hip replacements. For Quarter 3 2020/21 total hip replacement SSI surveillance was submitted to Public Health England. All SSI surveillance data is reported monthly to the Infection Control Committee and surgical speciality to review our local SSI rates against national benchmarks and implement changes in practices as needed. The Trust continues to engage in PreciSSIon; Preventing Surgical Site Infection across a region. PreciSSIon involves implementation of a Surgical Site Infection bundle to reduce the incidence of Surgical Site Infection after elective Colorectal Surgery. PreciSSIon is a collaborative project involving all hospitals in the West of England and the Academic Health Science Network (AHSN). The PreciSSIon bundle consists of: ▸ 2% chlorhexidine isopropyl skin preparation for all cases ▸ Use of a dual ring wound protector ▸ Repeat dose of antibiotics after 4 hours operating time ▸ Antibacterial suture for mass closure and skin ▸ Change of gloves before closing the wound if contaminated (non-evidence based; added into GHT data only as option aspect of the bundle) ▸ Betadine into the wound on closing (in WHO guidance - weak evidence added into GHT data only as option aspect of the bundle) As a region the south west hospitals participating in PreciSSIon have halved SSI from a mean of 17.2% to 8.5%. By December 2020, six out of seven hospitals had reduced SSI, and the seventh had a very low SSI rate already (7.7%). Table 2 provides a summary of the results. CGH is outlier as the seventh hospital that has not seen the reductions but as discussed had the lowest baseline SSI rate pre-intervention. Further theatre engagement work is being done to improve compliance to the bundle and documentation of compliance.

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 Trauma Audit and Research Network (TARN)	TARN was developed by the Trauma Audit & Research Network to help patients who have been injured. The Trust has continued to ensure 100% submission rates with cases submitted within the 40 day dispatched deadline. TARN reports are reviewed every two months within the Major trauma meeting. In response to the report data rehab co-ordinators have been introduced to ensure compliance with rehab prescription measure.
UK Cystic Fibrosis Registry	The UK Cystic Fibrosis Registry is a secure centralised database, sponsored and managed by the Cystic Fibrosis Trust. It records health data on consenting people with cystic fibrosis (CF) in England, Wales, Scotland and Northern Ireland. CF care teams enter data at every specialist centre and clinic across the UK, with over 99% of people with CF consenting to their data being submitted. This information is used to create CF care guidelines, assist care teams providing care to individuals with CF, and guide quality improvement initiatives at care centres. The Trust submits data to the registry and reviews the report data at the appropriate specialty meetings when it is published. Due to Covid we are awaiting reports from last year. This is usually fed back at a yearly Cystic Fibrosis Trust Registry Annual General Meeting/Conference in July.
UK Registry of Endocrine and Thyroid Surgery	This audit is clinically reviewed at the ENT governance meetings. No further actions have been required this year.

Local clinical audits

The reports of 183 local clinical audits were registered in 2020/21 and these are reviewed and actioned locally.

This includes 7 'Silver' quality improvement projects which graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2020/21 (graduation events were put on hold for most of the year due to clinical priorities relating to Covid).

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

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Sleep Service Quality Improvement	A QI project was undertaken in the Respiratory and lung function department to reduce waiting time breaches by 80% over a 1–2 year period for sleep studies, clinic appointments and starting CPA. In 2017 the service suffered from long waiting times for sleep studies (an average of 16 weeks compared to the 6 weeks deadline), starting CPAP - continuous positive airway pressure (an average of 37 weeks compared to the 18 week deadline) and for clinic attendance (an average of 32 weeks compared to the 52 week deadline) and a 29% breach rate. On top of this the number of referrals were increasing. Potential causes for these delays included referral numbers being higher than necessary (potentially due to accepting inappropriate referrals) and bottlenecks in the form of waiting for doctors to vet referrals and then report sleep studies, low number of clinics and a small number of sleep study analysis slots. Another issue with the sleep service was that patient data was in many different, non-organised locations and there was a potential for patients to become “lost in the system”. Changes included: creating a dedicated referral proformas with strict vetting criteria, the discharge mild OSAHS patients with mild tiredness, lung physiologists vetting referrals, patients using choose and book to book their own sleep study, lung physiologists determining pathway after sleep study, increased number of clinic appointments, senior physiologists to run sleep clinics, introduction of a dedicated sleep MDT and sleep service coordinator, stop writing and sending out sleep report letters before clinic, storing all information regarding sleep patients in one place with a dedicated database and to automate some tasks to reduce errors. Following the changes there were significant improvements with a drop in waiting time breaches of 81% for sleep studies, 79% for starting CPAP and 90% for clinic appointments.

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Improving smoking cessation advice in the Emergency Department	1 in 4 people presenting to hospital smoke and over half a million acute hospital admissions are directly linked to smoking. Despite this, the National Smoking Cessation Audit 2019 and baseline data from our ED showed that many people are not having their smoking habits addressed by healthcare professionals. For some patients, an admission to ED with an illness can be a sobering experience, thus presenting a good opportunity for beneficial intervention. If discharged, ED clinicians may be the first or only medical professional they see regarding this. Very Brief Advice (VBA) is an effective way of offering smoking cessation advice and support to patients. It is used by General Practitioners within their time-pressured consultations, presenting a solution for similar constraints in ED. This quality improvement aimed to improve the number of patients having their smoking habits addressed when presenting to the Emergency Department with smoking related diseases by 50% in 4 months. Improvements included; departmental and "on-the-spot" teaching sessions. personalised emails to different staff group members highlighting VBA and "Message of the Week" and reminder prompts around ED. There was also increasing availability of written information for patients. Increased visibility and reminder prompts throughout ED had the most positive effect as it worked as constant prompt.
Documentation of Do Not Attempt Cardiopulmonary Resuscitation (DNA-CPR) Decision within 24 Hours of Emergency Admission	National recommendations (NCEPOD, Time to Intervene, 2012) state CPR status should be assessed within the first 12 hours of emergency admission during a consultant review. Trust DNA-CPR Audit in December 2018 demonstrated poor compliance (56%) within first 24hours with ¼ of decisions made > 3 days (deteriorated since previous annual audits). The aim was to improve documentation of DNA-CPR decisions within the first 24 hours of emergency admissions. Engaging stakeholders and empowering staff through education and regular audit resulted in a 40% improvement in overall documentation of DNA-CPR decisions on the 3 wards initially involved. Since this improvement started there is now a Trust wide ReSPECT improvement..

Audit title	Where was the report reviewed and what actions were taken as a result of audit/use of the database?
Compliance with the Saving Babies' Lives Care Bundle Version 2: Element 1 Reducing Smoking in Pregnancy	As part of the Saving Babies' Lives Care Bundle an audit found that whilst 79% of women were CO screened at booking none were screened at 36 weeks. 11.6% were screened at delivery, which equated to 45% of women eligible for screening (pre-COVID) were actually screened. Results fall below the standard of 80% so an action plan was formulated to achieve the recommended 95% compliance for best practice. The pandemic caused a change in clinical practice leading to the newly established CO screening being paused. Screening has now been reintroduced in the Trust (February 2022), all staff with antenatal contact are booked onto a Very Brief Advice training programme as well as mandatory e-learning to support a smoke-free pregnancy. As well as training and support for staff, accurate recording of CO screening needs to be documented in maternity notes. LMNS are hoping to introduce a maternity specific system for capturing data as well as monitoring and audit purposes. To be re-audited in 6 months' time
Audit to assess non-elective postnatal readmission rate and identify causes in order to make improvements	This audit was conducted as a result of CQC stating that readmission rates for the Trust were high for Trust expectations. Results showed that readmission and overall management of readmission were 100% appropriate for all cases reviewed. The audit identified errors in the way patients were coded on re-admission to the unit, therefore the improvement identified the need to selecting the correct admission method on Trakcare and make completion of the "reason for admission box" mandatory.
Audit of documentation of medical considerations in trauma patients against Heartlands "HECTOR" standards	Hector stands for Heartlands Elderly Care, Trauma and Ongoing Recovery Project. The aim of this project is to improve outcomes for elderly patients who sustain trauma injuries. An audit was undertaken against the HECTOR standards and initial compliance varied from 5.1% in VTE prophylaxis documentation to 59% documentation of NEWS score. The audit revealed variable baseline documentation for various potential issues. Introduction of a mnemonic improved documentation in all domains to a significant extent. Following interventions, sustained compliance rose to between 12% for VTE prophylaxis to 86% for NEWS score. The main reason for the small change in VTE prophylaxis is possibly due to the plan being made post-operatively and very unlikely to change, therefore not necessary to review daily. Further work improving compliance includes demonstrating effects on patient outcomes, and obtaining more widespread support and uptake for this structure inside and outside of the division

Participation in clinical research

The number of patients receiving relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 4779.

Commissioning for Quality and Innovation (CQUINS)

Due to the pandemic, in 2020/21, there was a block payments approach for arrangements between NHS commissioners and NHS providers in England which was deemed to include CQUINS.

Care Quality Commission (CQC)

Gloucestershire Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Good".

Gloucestershire Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2020/21

The CQC carried out a focussed inspection on our infection control services on 19 February 2021. The inspection report was published on 23 April 2021 on the CQC website.

Secondary uses services data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 99.9% for admitted patient care (national average: 99.5%)
- 100% for outpatient care (national average: 99.7%)
- 99.5% for accident and emergency care (national average: 98.2%)

The percentage of published data which included the patient's valid GP practice code was:

- 100% for admitted patient care (national average: 99.8%)
- 100% for outpatient care (national average: 99.7%)
- 100% for accident and emergency care (national average: 99.9%)

Information Governance Incidents

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

Ten incidents have been reported to the ICO during the 2020/21 reporting period. This compares to fourteen reported in the previous period.

Summary of incidents reported to the ICO under Article 33 GDPR

Month Reported	Nature of Incident	Number involved and how they have been informed
April 2020	CT result of another patient of the same name, and an MRN with one digit difference and two days apart in age had been placed in this patient's record. Unnecessary care planned and communicated to the patient as a result of incorrect filed result.	1, letter
	Lessons learnt: Human error. Staff reminded of importance of checking 4 points of patient identification. Incident used as case presentation for training purposes	
June 2020	Patient discharge Summary printed on discharge from ward. Two copies included in information given to other patients husband and now returned via PALS.	1, not informed
	Lessons learnt: Human error, multiple patients being prepared for discharge on busy ward. Staff reminded to ensure the notes are not mixed incorrectly. Incident used as case presentation for training purposes	
July 2020	Lost Record, SAR received. Records unable to be located. Records required as evidence in impending court case.	2, letter
	Lessons learnt: System in place not followed. Lessons learnt and recurrence prevention meeting held with supplier and improvement to process agreed	
August 2020	An email containing confidential patient information was accidentally sent to an unintended recipient (another patient)	1, letter
	Lessons learnt: Human Error. Attention to detail in confirming correct email recipient required. Regular staff communication reminders needed.	

Month Reported	Nature of Incident	Number involved and how they have been informed
October 2020	A copy of a patient's psychology summary letter to GP was enclosed with a summary letter sent to another patient.	1, letter
	Lessons learnt: Human error. Highlight the importance of double checking information within data protection training for staff. Regular reminders need to be issued to staff.	
October 2020	Paediatric clinical summary report sent in error to the wrong recipient. Parent received two letters in different envelopes following an outpatient appointment. One regarding their child, the other regarding another child who attended the clinic.	1, letter
	Lessons learnt: Human Error. Ensure attention to detail when completing work with patient information. Incident used as case presentation for training purposes	
October 2020	34 pages of a patient's health record accidentally included in another patients SAR and disclosed in error	1, letter
	Lessons learnt: Human Error difficult to eliminated entirely, mitigated by regular reminders and training. Ongoing transition to EPR will reduce reliance on copies of scanned paper record in time.	
October 2020	Concern raised that member of staff has inappropriately accessed patients record	2, letter
	Lessons learnt: Further staff communication and record access monitoring required	
December 2020	Inappropriate access to information relating to staff	3, not informed
	Lessons learnt: Further staff communication and record access monitoring required	

Month Reported	Nature of Incident	Number involved and how they have been informed
February 2021	Patient miss identified and incorrectly linked to another patients NHS number and record. Discharge summary sent to GP of wrong patient and episode included in patients GP record.	
	Lessons learnt: Human Error within SWAST process, importance of handover and shared learning between organisations	

Summary of confidentiality incidents internally reported 2020/21

The ten reported incidents have been closed by the ICO with the ICO expressing satisfaction with the steps taken by the Trust to mitigate the effects and minimise the risk of recurrence in each case. Advice and guidance received from the ICO has been considered and incorporated into the lessons learnt.

A large number of the near miss reported incidents (221) relate to lost SmartCards which are disabled when reported as missing.

Reportable breaches (as detailed in the table above)	10
Number of confirmed Non-reportable breaches	154
Number of no breach / Near miss incidents.	289
Total number of confidentiality incidents internally reported	453

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 DQ reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'Insight'
- The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.
- Gloucestershire Hospitals NHS Foundation Trust regularly send data submissions to SUS and via these submissions we receive DQ reports back from SUS. Based on SUS DQ reports we action all red and amber items highlighted in report to improve Data Quality.
- In data published for the period April 2020 to March 2021, the percentage of records which included a valid patient NHS number was:
- 99.9% for admitted patient care (national average: 99.5%)
  - 100% for outpatient care (national average: 99.7%)
  - 99.5% for accident and emergency care (national average: 98.2%)
- The percentage of published data which included the patient's valid GP practice code was:
  - 100% for admitted patient care (national average: 99.8%)
  - 100% for outpatient care (national average: 99.7%)
  - 100% for accident and emergency care (national average: 99.9%)
- A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly
- These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as:
  - Outpatients including attendances,

- Outcomes, invalid procedures
- Inpatients including missing data such as
- NHS numbers, theatre episodes
- Critical care including missing data, invalid
- Healthcare Resource Groups
- A&E including missing NHS numbers,
- Invalid GP practice codes
- Waiting list including duplicate entries, same day admission

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

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

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

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

Learning from deaths 2020/2021

During 2020/2021 2147 of Gloucestershire Hospitals NHS Foundation Trust patients died. This comprised of the following number of adult in hospital deaths which occurred in each quarter of that reporting period:

- 513 in the first quarter
- 431 in the second quarter
- 610 in the third quarter
- 593 in the fourth quarter

These quarterly results are broken down by Division in Figure 30.

- The total number of deaths across all Divisions for the reporting year 2019/20 is 2147 of which 100% are reviewed by the Medical Examiner as per Trust policy.
- Of these 2147 deaths 453 have been triggered for an investigation by structured judgement review
- Of these 2147 deaths, 332 have so far been subjected to a detailed investigation by way of satisfying the criteria to trigger a Structured Judgement Review (SJR). (Q4 deaths may not have been completed due to 3 month time lag for review)
- Of these 2147 deaths 21 have been reviewed by other means (harm review/ investigation, PIR, complaint)
- Of these 332 SJRs carried out, 0 have identified that the cause of death is judged to be more likely than not to have been due to problems in the care provided to the patient. (ie that means went on to be a harm investigation)

Therefore, across all four Divisions for Quarters 1 – 4:

- The percentage of deaths which were selected for SJR=21%
- The percentage of deaths which have been reviewed as an SJR=15% (Q4 deaths may not have been completed due to 4 month time lag for review)
- The percentage of deaths reviewed by other means =1%
- Out of all 332 SJRs conducted (up until 21/05/2021), the percentage of deaths identified as having sub-optimal care as a contributing factor to the death = 0%

Figure 30: Number of patient deaths

Division	Q1 Total	Q2 Total	Q3 Total	Q4 Total	Divisional Year Total
Surgery	79	72	89	101	341
Medicine	414	341	503	474	1732
D&S	19	18	18	17	72
W&C	1	0	0	1	2
Total	**513**	**431**	**610**	**593**	**2147**

- Therefore, out of the total number of deaths reported across the Trust, the percentage of deaths for which sub-optimal care was a contributing factor (up until 21/05/2021)= 0%

Learning themes

Learning themes from all deaths reported, with particular focus on any sub-optimal care, are brought on a rotating quarterly basis to the Hospital Mortality Group by the Divisional Mortality representative from where recommended suggestions for improvements are passed on to the relevant committee or group, in addition all serious incidents have individual action plans and national reports on deaths e.g. LedeR inform improvement plans.

The most frequent high level theme involves the deteriorating patient and end of life decision making on admission.

The above data is taken from the following sources:

1. Mortality stats report on the BI tool – Insight;

2. SJR stats taken from Datix;

3. Quarterly Learning from Deaths Reports authored by the Medical Director and taken through Quality & Performance Committee and then on to Main Board;

4. Outcomes from the monthly Hospital Mortality Group, chaired by the Medical Director.

Additional information is provided in the supporting tables:

- Fig. 31: breakdown of above data
- Fig. 32: Summary of Learning Themes to come out of the SJR process
- Fig. 33: Learning from Deaths – Using the SJR methodology

Figure 31: Quarterly Breakdown of deaths which triggered an SJR and any poor care attributable

	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified
Surgical division				
Q1	79	79	19	0
Q2	72	72	30	1
Q3	72	72	30	1
Q4	101	101	26	0
Year Totals	**341**	**341**	**105**	**1**
Medical division				
Q1	414	414	76	1
Q2	341	341	67	0
Q3	503	503	100	3
Q4	474	474	86	1
Year Totals	**1732**	**1732**	**329**	**5**
D&S Division				
Q1	19	19	5	1
Q2	18	18	5	0
Q3	18	18	5	0
Q4	17	17	3	1
Year Totals	**72**	**72**	**18**	**2**
W&C Division (Paediatrics follow their own review process)				
Q1	1	1	1	0
Q2	0	0	0	0
Q3	0	0	0	0
Q4	1	1	1	0
Year Totals	**2**	**2**	**2**	**0**

Figure 32: 2020/21 Summary by Division

Division	No. of deaths	Total No of ME reviews	No. of SJRs triggered	No. of deaths where poor care overall identified
Surgery	341	341	105	1
Medicine	1732	1732	329	5
D&S	72	72	18	2
W&C	2	2	1	0
Total	**2147**	**2147**	**453**	**8**

Figure 33: In percentage terms, by Division

Division	Total no. of deaths for Quarters 1–4	% of SJRs triggered vs total number of deaths – Qs 1 to 4	% where sub-optimal care was identified vs no. of SJRs undertaken	% of sub-optimal care identified vs total number of deaths: Qs 1–4
Surgery	341	31%	0.95%	0.29%
Medicine	1732	19%	1.51%	0.28%
D&S	72	25%	11.11%	2.77%
W&C	2	50%	0%	0%
Totals	**2147**	**21%**	**1.76%**	**0.37%**

Statement NHS doctors in training rota gaps

Doctors in Training rota gaps

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receives, and patient feedback about the care provided. As part of our Quality Account 2020/21 we are providing a statement on our Trust Doctors in Training Rota Gaps, which we are required to report on annually through the following legislation schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

Monitoring, Delivery and Assurance

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

Improvements (2020/21)

2020/21 has been a challenging period, not only for NHS doctors in training, due to the COVID pandemic. This placed additional pressures on all areas of the Trust, which ultimately meant significant changes to working patterns/rotas during the last 12 months. With these additional pressures, it was not possible to fulfil all our objectives in 2020/21, but we maintained regular reviews of the demands on the services to provide resourcing where required by:

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

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

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

Next Steps (2021/22)

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

Part 2.3

Reporting against core indicators

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

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

Figure 34: Reporting against core indicators

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/ rate/number, and so the quality of its services, by these actions listed.
a) The value and banding of the Summary Hospital level Indicator SHMI for trust for the reporting period	2015/16	1.13	1	1.178	0.68	2020/21 data period: Apr12 – Dec20 (latest published data as at 03/06/21)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17	1.12	1	1.23	0.73		
	2017/18	1.09	1	1.11	0.89		
	2018/19	1.0462	1.0012	1.2058	0.7069		
	2019/20	1.0128	1.0036	1.1957	0.6909		
	2020/21	1.0		1.1	1.0		
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	2015/16	20.90%	28.50%	54.60%	0.60%	2019/20 data period: Dec18 – Nov19 (latest published data as at 03/06/21)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group & End of Life Steering Group (delivery) and Q&P Committee (assurance).
	2016/17	21.00%	31.10%	58.60%	11.20%		
	2017/18	32.10%	32.80%	59%	12.60%		
	2018/19	35%	35.84%	60%	12%		
	2019/20	33%	36.81%	59%	11%		
	2020/21	36%		46%	31%		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/ rate/number, and so the quality of its services, by these actions listed.
Number of patient safety incidents / number which resulted in severe harm or death	2015/16	11,517 / 40	9,465 / 39	23,990 / 60	3,510 / 26	Pre 2019/20: data covers the last 6 months in the financial year. 2020/21 data period: Apr20 – Mar21 (latest published data as at 03/06/21).	The actions to be taken have already been described within this report and are monitored by the improvement group Safety and Experience Review Group (delivery) and Q&P Committee (assurance).
	2016/17	6,932 / 22	4955 / 19	23,990 / 60	3,510 / 26		
	2017/18	7,523 / 35	5,449 / 19	19,897 / 51	1,311 / 0		
	2018/19	6,780 / 12	5,841 / 19	22,048 / 72	1,278 / 12		
	2019/20	7,216 / 15	6,276 / 19	21,685 / 95	1,392 / 20		
	2020/21	14,866 / 58		1,445 / 10	772 / 1		
Rate per 1000 bed days of patient safety incidents resulting / rate per 1000 bed days resulting in severe harm or death	2015/16	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	Pre 2019/20: data covers the last 6 months in the financial year. 2020/21 data period: Apr20 – Mar21 (latest published data as at 03/06/21).	
	2016/17	41.82 / 0.13	39.89 / 0.15	71.81 / 0.6	21.15/0.06		
	2017/18	45.00 / 0.21	42.55 / 0.15	124.0 / 0.05	24.19 / 0.00		
	2018/19	41.32 / 0.07	46.06 / 0.15	95.94 / 0.32	16.90 / 0.16		
	2019/20	44.88 / 0.09	49.78 / 0.16	103.84 / 0.01	26.29 / 0.31		
	2020/21	52.67 / 0.21		55.51 / 0.39	49.14 / 0.06		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/score/ rate/number, and so the quality of its services, by these actions listed.
Rate of C diff (per 100,000 bed days) among patients aged over two	2015/16	11.4	15	62.6	0	As at 03/06/21	The actions to be taken are within an improvement plan and are monitored by an improvement committee The Infection prevention and Control Committee (Delivery) and Q&P Committee (assurance).
	2016/17	12.5	13.2	82.7	0		
	2017/18	17.4	13.1	90.4	0		
	2018/19	16.9	11.7	79.7	0		
	2019/20	not available	not available	not available	not available		
	2020/21	not available	not available	not available	not available		
Percentage of patients risk assessed for VTE	2015/16	93.30%	96.10%	100.00%	88.60%	2020/21 data period: Apr20 – Mar21 (as at 03/06/21)	The actions to be taken are that we have a Task and Finish Group set up to improve this indicator been described within this report and are monitored by the improvement group. The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17*	93.50%	95.60%	100.00%	78.70%		
	2017/18	90.00%	95.30%	100.00%	77.00%		
	2018/19	93.71%	96.70%	100%	74.30%		
	2019/20	93.79%	99.03%	100%	71.72%		
	2020/21	91.2%		94.6%	87.0%		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Percentage of patients aged 0–15 readmitted to hospital within 28 days of being discharged	2011/12*	9.88%	10.26%	14.94%	6.40%	As at 03/06/21	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
	2020/21	n/a	n/a	n/a	n/a		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Readmissions within 28 days: age 16 or over	2011/12*	10.52%	11.45%	13.80%	9.34%	As at 03/06/21	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
	2020/21	n/a	n/a	n/a	n/a		
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	As at 03/06/21	
	2016/17	67.7	69.6	86.2	58.9		
	2017/18	65.8	68.6	85.0	60.5		
	2018/19	65.1	67.2	85.0	58.9		
	2019/20	not available	not available	not available	not available		
	2020/21	not available	not available	not available	not available		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Staff Friends & Family Test Q18d (was Q12d) (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2015/16	69.0%	65.0%	85.4%	46.0%	2020/21 data period: Survey in Oct19-Dec19 (as at 14/05/21)	The actions to be taken are monitored by the improvement group Staff and Experience Improvement Group (delivery) and People and OD Committee (assurance).
	2016/17	64. 0%	70.0%	84.80%	48.9%		
	2017/18	61%	70 %	93 %	42%		
	2018/19	65%	70%	87%	41%		
	2019/20	64%	70%	88%	41%		
	2020/21	70.5%	74.3%	91.7%	49.7%		

Patient Reported Outcome Measures (PROMs)

The trust's patient-reported outcome measures scores for:

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

This reduced to two items, which are detailed below.

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

Part 3

Other information

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

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

Indicator	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	National target (if applicable)	Notes/ Other information
Maximum 6-week wait for diagnostic procedures	0.28%	0.45%	3.16%	**19.48%**	<1%	Mar 21 snapshot
Clostridium difficile year on year reduction	56	56	97	**75**	2019/20: 114	Total Apr 20 – Mar21
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	4	6	2	**0**	0	Total Apr 20 – Mar 21
MSSA	100	80	18	**18**	<=8	Total Apr 20 – Mar 21
Never events	6	2	6	**8**	0	Total Apr 20 – Mar 21
Risk assessment for patients with VTE	87.03%	93.20%	93.19%	**91.2%**	>95%	2017/18 = Jul to Mar based on submissions (did not have data Q1) Apr 18 – Mar 19
Crude mortality rate	1.24%	1.09%	1.19%	**1.66%**	No target	Total Apr 19 – Mar 20
Dementia 1a: Case finding	0.80%	1.90%	0.80%	**68.0%**	>=90%	Total Apr 19 – Mar 20
Dementia 1b: Clinical assessment	65.00%	27.90%	29.40%		>=90%	Total Apr 19 – Mar 20
Dementia 1c: Referral for management	11.00%	2.80%	0%		>=90%	Total Apr 19 – Mar 20
% patients spending 4 hours or less in ED	86.70%	89.60%	81.58%	**75.11%**	>=95%	Total Apr 19 – Mar 20
No. of ambulance handovers delayed over 30 minutes *(<=1hr)	506	666	1,177	**2,151**	Annual Target TBC (<=40 per month STP)	Total Apr 19 – Mar 20
No. of ambulance handovers delayed over 60 minutes	15	14	34	**1,577**	0	Total Apr 20 – Mar 21
Emergency readmissions within 30 days: elective and emergency	6.9%	6.9%	7.0%	**8.0%**	<8.25%	Total Apr 20 – Mar 21
% stroke patients spending 90% of time on stroke ward	88.2%	90.8%	87.70%	**83.5%**	>=80%	Total Apr 20 – Mar 21
% of women seen by midwife by 12 weeks	89.50%	89.80%	88.90%	**92.8%**	>90%	Total Apr 20 – Mar 21

Indicator	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	National target (if applicable)	Notes/ Other information
Number of written complaints	1031	898	781	**614**	No target	Apr18 – Mar 19
Rate of written complaints per 1000 inpatient spells	6.26*	5.65	4.72	**5.08**	No target	Apr18 – Mar 19
Cancer: urgent referrals seen in under 2 weeks from GP	82.30%	90.10%	92.50%	**94.7%**	>=93%	Total Apr 20 – Mar 21 (unvalidated)
2 week wait breast symptomatic referrals	90.40%	95.90%	97.50%	**92.5%**	>=93%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (first treatments)	96.30%	94.60%	93.40%	**97.9%**	>=96%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – surgery)	94.80%	95.30%	93.60%	**95.2%**	>=94%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – drug)	99.80%	99.90%	99.40%	**99.4%**	>=98%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – radiotherapy)	99.10%	99.30%	94.90%	**98.0%**	>=94%	Total Apr 20 – Mar 21 (unvalidated)
Cancer 62-day referral to treatment (urgent GP referral)	75%	74.80%	73.10%	**83.3%**	>=85%	Total Apr 20 – Mar 21 (unvalidated)
Cancer 62-day referral to treatment (screenings)	92.20%	96.50%	95.40%	**90.8%**	>=90%	Total Apr 20 – Mar 21 (unvalidated)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	Not reported in 2017/18	79.75%	79.79%	**69.40%**	92%	Mar 21 snapshot

Annex 1

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

Statement from NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group's (GCCG) response to Gloucestershire Hospitals NHS Foundation Trust's Quality Accounts 2020/21.

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2020-21. The past year has continued to present major challenges across both Health and Social care in Gloucestershire as we continue to work through the COVID-19 pandemic. In the past year we have continued to see GHNHSFT working closely with partner organisations including the CCG to deliver a system wide approach in what has been some extremely difficult time. This joint working has enabled us to further develop, review and improve the quality of commissioned services and the outcomes for service users in Gloucestershire and none more so than the recent work of the Vaccination Programme, with its successful roll out in the county and impact on the health of our residents.

Firstly, the CCG would like to thank the Trust and their staff for all the outstanding efforts, dedication and hard work over the past year in dealing with the ongoing COVID-19 pandemic. There have been so many acts of kindness and courage and the CCG wish to pay homage to all Trust colleagues involved. The CCG have continued to work with partners in both health and social care to monitor and support the effects of the pandemic on NHS staff and as we continue to move through the pandemic, NHS workers health and wellbeing has never felt more important.

Prior to the COVID-19 pandemic, the Trust were further progressing their 'Journey to Outstanding' following the award of 'Good' from the Autumn 2018 CQC inspection. The CCG continues to have good visibility of the Trust action plans and note the plans for improvement 2020/21 and the Trusts response to the CQC unannounced visits that have been undertaken this year. The CCG is also pleased to see that one of the focuses of the new vision is to be that of improving the experience for patient in Emergency Care and looks forward to working in partnership with 'Front Door' teams to support the work around the identified themes in the Patient Experience Improvement Plan.

The CCG is also pleased to note the other priorities listed in this year's Quality Account. The report is open, transparent and comprehensive document which demonstrates the Trusts commitment to continuous quality improvement. The CCG endorses the Quality priorities that the Trust have selected for 2021/22 and are particularly pleased to see work to include the enhancement of the safety culture and the improvement measures around reducing hospital falls and the prevention of pressure ulcers. The CCG is also pleased to see the ongoing work around mental health, dementia and a revised focus on improving care for patient with diabetes.

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

monitored and embedded within the clinical environments. Also that wider system learning and development is shared, as part of the feedback to system partners, community teams and Primary Care. The Trust's Safety and Experience Review Group, with representation and challenge from the CCG, continues to function successfully to retain detailed oversight of all Serious Incidents and Never Events and complaints. The Safety team alongside colleagues from the CCG and members of the Learning Academy, maintain a clear and robust system for ongoing monitoring of all action plans and recommendations. Action plans are closed down only when fully completed and assurance gained on implementation of learning using clinical audit and patient and staff feedback.

As part of the work on serious incidents, the CCG is also pleased to see the improvement plan related to Maternity Services as a key priority, coupled with the Trust's detailed response to recommendations from the Ockendon Report. The CCG have welcomed the opportunity to be involved the new Maternity Delivery Group and Maternity Champions and acknowledge the recent developments and work on the divisional strategy. The focused approach for improving the experience of women accessing the service as part of the Better Births programme, has been widely acknowledged alongside the embedding of Continuity of Carer and the desire to address improved engagement with BAME communities in the development of services.

The CCG acknowledges the content of the Trust Quality Account and will continue to work with the Trust to deliver acute services that provide best value whilst having a clear focus on providing high quality safe and effective care for the people of Gloucestershire. The CCG confirms that to the best of our knowledge we consider that the 2020/21 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT and we look forward to continued close working as we form the Integrated Care System in Gloucestershire.

Dr Marion Andrews-Evans
Executive Nurse and Quality Director

Statement from Healthwatch Gloucestershire (HWG)

Healthwatch Gloucestershire's Response to Gloucestershire Hospitals NHS Foundation Trust's Quality Statement 2020/2021

Healthwatch Gloucestershire welcomes the opportunity to comment on Gloucestershire Hospitals NHS Foundation Trust's quality account for 2020/21. Healthwatch Gloucestershire exists to promote the voice of patients and the wider public with respect to health and social care services. The Trust is an exemplar in its positive working relationship with local Healthwatch and, over the past year, we have continued to work together to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously.

After the hiatus at the start of the pandemic the Trust made it known how services would be configured during Covid. Their quick action in reconfiguring services and redeploying staff is to be commended. Feedback from the public praised the care and dedication of staff in continuing to deliver services to patients in exceptionally difficult circumstances.

Throughout the year the Trust has placed patient experience at the heart of their service and we are pleased to know that patient experience is to remain a priority in plans for 2021-2022. We welcome their proactive stance in seeking Experts by Experience and community engagement to help inform decision making and service delivery. We have good working relationships with key Trust teams focussed on quality, patient experience and communications; this has allowed us to raise issues, share information and be confident in the Trust's actions. We are particularly pleased that the Trust has an established place for a Healthwatch Governor and we know that patient experience is a high priority for the Trust's leadership.

Through our regular partnership working and through patient feedback, we have confidence that the Trust holds high clinical standards in patient care. We are aware that a particular challenge for the Trust this year has been in communicating with patients, their families and carers around treatment and discharge plans. The visiting restrictions due to Covid-19 have highlighted this area but we are confident that the Trust have taken these concerns seriously. The Trust does not always get everything right but they are an open and learning organisation that strives to get better.

During the year we were asked to look at the Fit for the Future programme which continued, even during the pandemic. We were satisfied with how the team went about consultation in partnership with others in the system and look forward to the outcomes being acted on soon. Gloucestershire Hospitals NHS Foundation Trust will have a key part to play in the county's Integrated Care System and will have an important role to play in addressing inequalities in access and outcomes for the people of Gloucestershire.

We are particularly pleased with how the Trust has responded to the findings in our report, Experiences of Urgent Mental Health care in A&E. Their positive and proactive response in establishing a Mental Health Strategy and the inclusion of Experts by Experience to co-design improvements.

Action has already been taken, including in the triaging process and we look forward to the longer-term aspects of patient experience in terms of patient flow, the physical environment, staff training and skills development and communication all making a difference to patient care.

Healthwatch Gloucestershire looks forward to maintaining our strong working relationship with Gloucestershire Hospitals NHS Foundation Trust over the coming year to ensure that the experiences of patients, their families and unpaid carers continue to be heard and taken seriously.

This year, above all others, we thank all of the Trust's staff, managers, volunteers and leaders for what they have achieved in exceptional circumstances.

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Gloucestershire Health Overview and Scrutiny Committee, I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Quality Account 2020/1.

Whilst a very new committee, with a number of new members on board, I am pleased to report a positive and enthusiastic start to our work.

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

Members acknowledge the temporary service changes introduced in place in 2020 and welcome further conversations on how the planned approach changed in response to the pandemic and how the changes will be managed going forward.

In spite of the significant challenges experienced during the past year, the committee commend the many achievements and successes of the Gloucestershire Hospitals NHS Foundation Trust during this time. Notable key milestones include the treatment provided to cancer patients and the incredible roll out of the Covid-19 vaccination programme in Gloucestershire.

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

Cllr Andrew Gravells (Chair)

Health Overview & Scrutiny Overview and Committee

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

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

Annex 2

Statement of directors' responsibilities for the quality reports

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 2020/21 and supporting guidance Detailed requirements for quality reports 2020/21
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2020 to March 2021
  - papers relating to quality reported to the board over the period April 2020 to March 2021
  - feedback from commissioners 16 June 2021
  - feedback from governors 24 June 2021. Our Governors have contributed to identifying the priorities for next year 2020/21 and have also provided us with feedback on this year's Quality Account
  - feedback from local Healthwatch organisations 24 June 2021
  - feedback from overview and scrutiny committee 25 June 2021
- the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated T.B.C. https://www.gloshospitals.nhs.uk/contact-us/feedback-and-complaints-pals/
- the 2019 National Patient Survey published 02/07/2020
- the 2020 national staff survey published 26 May 2021
- CQC inspection report dated 07/01/2019 https://www.cqc.org.uk/provider/RTE

This quality report presents a balanced picture of the NHS foundation trust's performance over the period covered. The performance information reported in the quality report is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

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

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

By order of the board

Chairman

Chief Executive

Quality Account

2020/21