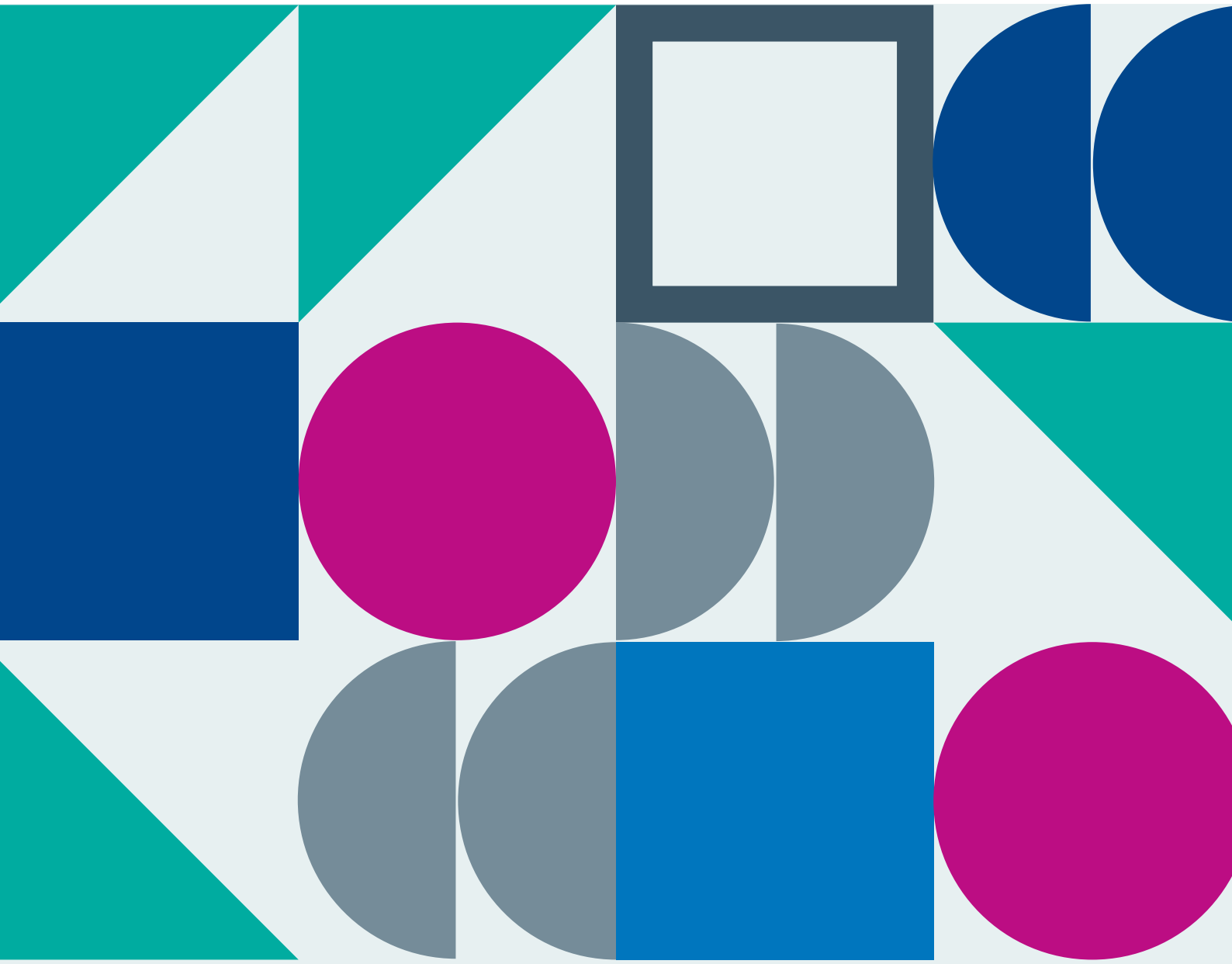
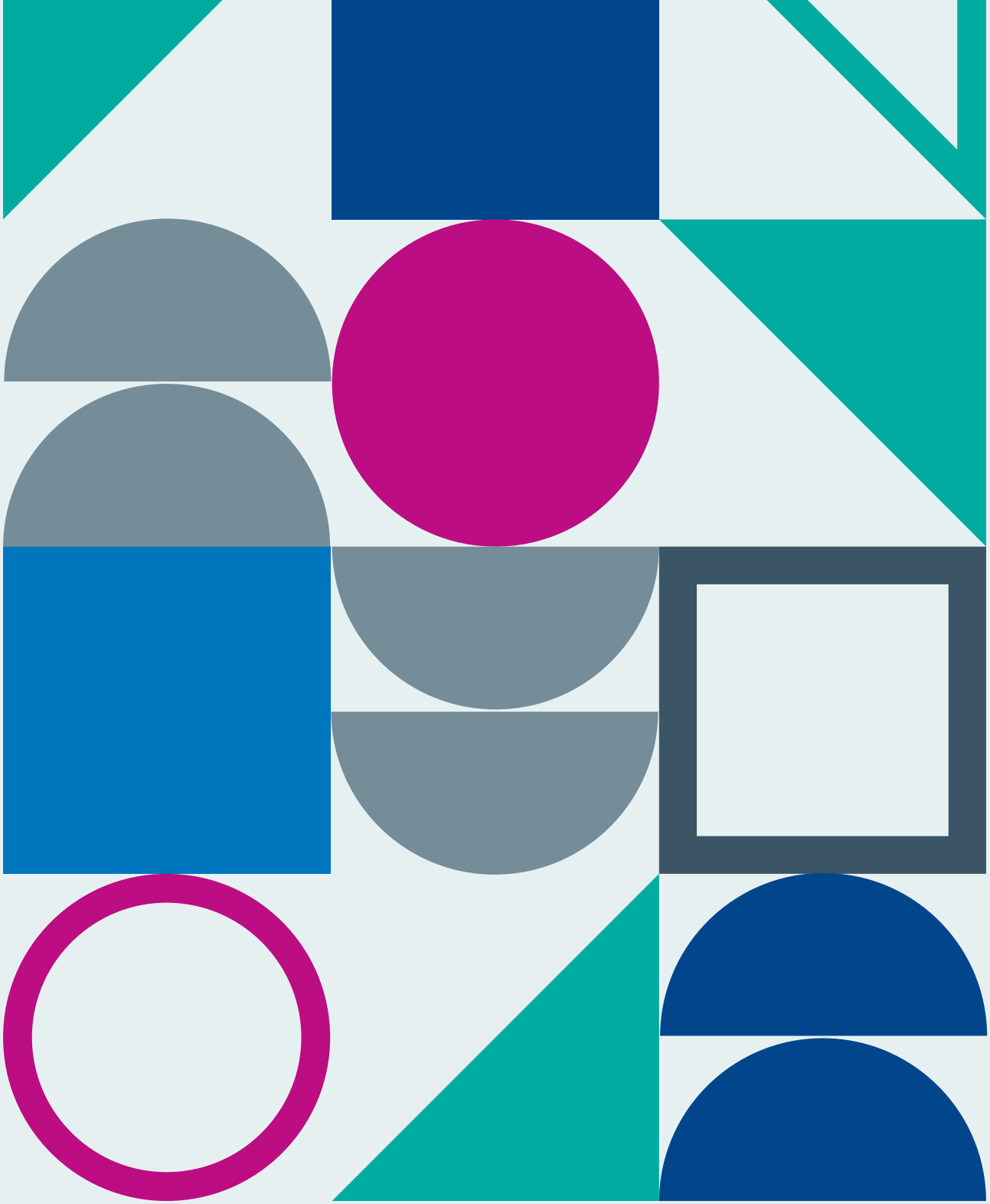
NHS
Gloucestershire Hospitals
NHS Foundation Trust



Quality Account 2021–2022



Our Quality Account 2021/22

Our Quality Account is our annual report about the quality of our services provided by us, Gloucestershire Hospitals NHS Foundation Trust. Our Quality Accounts aims to increase our public accountability and drive our quality improvements. Our Quality Account looks back on how well we have done in the past year at achieving our quality goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

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Part 1

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

For decades to come the last two years will be remembered for the pandemic and the shadow it cast across every corner of the globe. Billions of people have been affected and we will be counting the true cost of COVID-19 for many more years to come.

The global death toll stands at 6.3 million while more than 1500 people in Gloucestershire have lost their life, with the ripples of these deaths reaching far and wide. Sadly, it has also highlighted the grave inequalities within our society. The stark reality is that we have not all been affected in the same way with, for example, people from minority ethnic backgrounds have been disproportionately impacted; those with a learning disability have poorer outcomes and those in older age groups, particularly those living in care homes, being especially vulnerable.

The huge success of the vaccination programme gives us real hope of improving times although as we emerge from the pandemic, and a new normal emerges, the pressures on our hospitals are greater than ever. I've heard colleagues best describe this as 'unrelenting' as up and down the country, images of queuing ambulances

outside our Emergency Departments are all too familiar while waits for planned care such as hips and knee replacements, cataract replacements remain too long.

The Year Just Gone

Whilst it is hard to frame the last 12 months in positive terms there is much to be celebrated and proud of in the Trust's response to the pandemic. Our teams at Cheltenham General and Gloucestershire Royal are rightly proud for continuing to provide a wide range of outpatient care, operations and specialist diagnostic tests throughout the pandemic. We delivered more elective surgery and cancer care than any other Trust in the Region, due to

the model of service we adopted. We are confident that by utilising our two hospital sites in the way that we did, we saved lives. It has also meant that we are in a stronger position as we emerge from the pandemic in terms of catching up on postponed work.

As a system Gloucestershire led its own vaccination programme resulting in more people receiving vaccines more quickly than anywhere else in the country. We also recruited more patients into the urgent COVID public health studies and trials than any other system in the Clinical Research Network helping to improve our understanding of the virus thus improving treatments.

The pandemic continues to have a significant impact on our colleagues who've had to cope through the toughest of times. The establishment of our 2020 Health and Wellbeing Hub has supported and guided colleagues throughout this period.

Since its inception in May 2019 the 2020 Hub has had 18,656 contacts of which 14,978 have been made during the two years of the pandemic. Our colleagues have told us how challenging the workplace remains, in the national staff survey.

What is very apparent in this year's results is that whilst we can mobilise many initiatives to support staff, to improve their experience and support their development, ultimately staff come to work to deliver high quality care and when they feel they can't do this it impacts on their sense of purpose and how they feel about the organisation.

However, this year hasn't just been about surviving a pandemic and, as such, we're 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;

- We started works on our ambitious £100m-plus capital investment programme across both sites which will see significant investment in new buildings, equipment and improved practice across specialist services. This is the realisation of our centres of excellence vision, part of One Gloucestershire's longer term approach to health provision in the county. Patients are already starting to see the benefits of this following the opening of two new departments in the last months. At Cheltenham General, the Radiology Department has undergone a £6.5m programme of extensive refurbishment. Waiting areas have been redesigned, three new CT scanners installed, four new digital x-ray machines, two new ultrasound machines, a new MRI scanner and a new interventional suite. This means that patients accessing the town's A&E with sprains, fractures and breaks will benefit from improved services. At Gloucestershire Royal a newly repurposed Medical Same Day Emergency Care (SDEC) unit has opened. The unit will enable more patients to be seen and treated on the same day helping to avoid hospital admissions and avoiding the need for treatment at the Emergency Department (ED) altogether.
- We've made significant progress in digitalising our patient health records (Electronic Patient Record) using better, faster, safer technology to help us document patient care. The system, called Sunrise EPR, provides a single place for clinicians to go with up-to-date information on every bed and every adult inpatient that can be accessed anywhere. It is reducing our reliance on paper, helping to reduce risk, saving time, improving patient safety and releasing time to care.

- 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. We've carried on in our journey 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 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 organisation's highest priorities in the coming year.

The Year Ahead

Despite the unprecedented scale of challenge ahead we enter 2022 with many goals within our grasp. The reconfigured landscape for system partners presents us with an opportunity for even closer joint working to help improve 'flow' through our hospitals thus improve turnaround times for ambulances and waiting times for patients at our Emergency Departments. We've already started to see the impacts of our elective catch up work which has seen the number of patients waiting more than 52 weeks drop from a peak of 3,061 in April 2021 to 1,125 at the end of March 2022. There will be renewed focus and energy to reduce this further in the coming 12 months.

At Board we've started deeper discussions about how we support and enable colleagues to provide the best possible care they can in the current circumstances. We remain absolutely committed to listening and acting on what colleagues have told us and in our pursuit of making our organisation one where people feel valued and included.

We will also continue the good work started in relation to vulnerable adults and children including the work on caring for those with mental health conditions, those with a learning disability and young people as they transition from children's services to adult care.

Our exciting capital investment programme will take an enormous step forward in the coming 12 months with the completion of the programme expected in the summer of 2013. With this will come some real benefits aligned to our commitment to become a carbon neutral Trust by 2040.

Thank you

It serves for me to thank you, the reader, for everything that you have brought to the Trust whether as a colleague, a governor, a partner, a public member or a patient.

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

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 2022/23 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 2021/22:** 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 2022/23

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

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

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

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 2022/23

Priority for 2022/23	Why we have chosen this indicator
To improve children and young people's experience of transition to adult services	Transition for young people remains a Trust priority; the Trust has launched a pilot Diabetes transition service and learning will be embedded for review of other transition pathways
To improve maternity experience	The priority for 2022/23 will be focussed on improving the maternity ward experience in partnership with women, monitored through FFT and feedback from Maternity Voices Partnership
To improve Urgent and Emergency Care (ED) experience	Improving Urgent and Emergency Care remains a Trust priority area and is part of the Operational Planning Contract Guidance
To improve Adult Inpatient Experience	Inpatient experience has seen a decrease in positive score through the pandemic, and work is ongoing to improve this, with a particular focus on communication with relatives
To improve experience of discharge	This programme will include focus on Criteria to Reside, End PJ Paralysis and campaigns such as the perfect week
To enhance and improve our safety culture	Remains a Trust priority with the implementation of the National Patient Safety Strategy
To improve our prevention of harm through pressure ulcers and falls	To remain a quality priority on preventing harm, combining a focus on pressure ulcers and falls, echoing the Preventing Harm Council work
To improve our care of patients whose condition deteriorates	Introduction of new digital systems and work on sepsis
To improve mental health care for our patients coming to our acute hospital	Remains a Trust priority with development of a Trust Mental Health Strategy, and is part of the Operational Planning Contract Guidance

Priority for 2022/23	Why we have chosen this indicator
To improve our care for patients with diabetes	Diabetes inpatient services remain a Trust priority
To reduce health inequalities	New Health Inequalities programme being delivered by the Trust focussed on smoking cessation services for colleagues and inpatients

Part 2.1

How have we done in 2021/22?

1. Colleague Health and Wellbeing

The challenges that colleagues have faced in caring for our patients and communities over the last year have been huge, against a backdrop of COVID-related admissions, elective recovery, and staff COVID sickness absence In 2021/22 we have maintained and developed the health-wellbeing offers available to colleagues, with our 2020 Staff Advice and Support Hub, Peer Support Network, introduction of TRIM practitioners, Employee Assistance Programme (EAP) and the establishment of our Colleague Wellbeing Psychology Service.

How have we performed in 2021/22?

The 2020 Staff Advice and Support Hub

From 1st April 2021 – 31st March 2022 there have been 5,301 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). Since the Hub's launch in May 2019, it has responded to a total of 18,656 contacts.

Method of contact as follows:

Contact Method	% of contacts
Telephone	87.5%
Email	12.5%

The 2020 Hub has remained the primary place for all staff to contact if they have any queries or concerns regarding the COVID-19 pandemic. This includes: symptoms, testing, isolation periods etc. COVID queries accounts for 63.9% of contacts.

There have been 742 contacts (14% of contacts) relating to anxiety and mental health (either directly relating to COVID-19 or other reasons) which includes engaging or referring colleagues to our new Colleague Wellbeing Psychology service, as well as signposting to wellbeing resources.

In addition to providing a responsive telephone, email and walk-in service to all staff, the following has been launched and embedded over the last 12 months:

- **Salary Finance** – a package of financial wellbeing packages and resources including access to the following: loans (with repayments made through salary/payroll); savings and the Government's Help to Save scheme;

financial education resources; advance access to salary already earned

- **Mobile Hub** – the Hub team now visits teams and departments to talk about the services available, attending meetings or hosting a stand for staff to learn more about the support they can access
- **Volunteer** – a volunteer now supports the Hub team on a weekly basis to distribute wellbeing information and resources to all wards and departments, including offering to fill colleagues' water bottles or make cups of tea
- **Menopause at Work** – a Menopause at Work group has been established which meets monthly on each site. An informal, safe space for colleagues to share their experiences of menopause and provide mutual support. Webinar talks have also been hosted with external speakers
- **Links with ICS health-wellbeing services** – the Hub team works in partnership with ICS colleagues to collaborate and share resources on areas of mutual concern. For example, an ICS-wide Long COVID support group has been established to support colleagues who are suffering from Long COVID.
- **Peer Support Network** – we continue to offer colleagues access to a Peer Supporter if they need someone to listen to them. Peer supporters are fellow colleagues who volunteer to listen with a confidential and non-judgemental ear, and offer to "walk alongside" someone who may be going through a difficult time in or outside of work. Between April 21 – March 22, just less than half of our trained Peer Supporters have reported giving support to colleagues on 63 occasions. At the time of writing this report we are still waiting to hear back from the other members of our Peer Support Network so we expect the total number to be well over 100 occasions.
- **Trauma Awareness Training for Managers** – 160 colleagues participated in half-day Trauma Awareness training for Managers which was delivered by the Trauma Specialist charity, PTSD Resolution.
- **TRiM model** – we have established a support system called TRiM (Trauma Risk Incident Management) which is a trauma-focused peer support system to help employees after traumatic events by providing support and education to those who require it. Fifty colleagues have been trained as a TRiM Practitioner or TRiM Manager. Since its launch, the model has been used on many occasions, predominantly in the Emergency department, Theatres, and the Women and Children division.

Vivup Employee Assistance Provision (EAP)

Vivup provides quarterly reports on access to their Employee Assistance Programme (EAP). The employee assistance programme offers colleagues someone to talk to any time of day or night, 365 days a year. They have trained counsellors with an NHS background and are available to provide help and support with pressures at work or at home and are completely confidential. They normally offer 5 to 6 sessions.

Overall 79 new clients have entered the counselling service in the last 12 months, and between them have accessed 299 individual counselling sessions. The top presenting issues raised by clients are work-related stress, non-work related stress, anxiety, trauma and relationship issues.

Colleague Wellbeing Psychology Service

The Colleague Wellbeing Psychology service was initially launched in October 2020 with 0.5 WTE Psychology Link Worker for six months following the pandemic. In 2021-22, additional investment has been secured using the Charities Together funds. Furthermore, colleague wellbeing vacancies in the Health Psychology team were redesigned and are now situated within the People & OD department to provide an integrated service, delivered in partnership with existing colleague health-wellbeing offers, including the 2020 Hub.

The service offers 1:1 support for individuals and managers, team interventions such as decompression groups and drop-in sessions. It provides specialised training such as Compassionate Resilience workshops as well as bespoke teaching sessions for junior doctors and teams. The team is comprised of the following:

- **Colleague Wellbeing Psychology Lead** – 0.8 WTE (0.5 WTE substantive; 0.3 WTE fixed-term until Feb 23)
- **Colleague Wellbeing Psychologist** – 1.4 WTE (2 roles fixed-term for 23 months)
- **Colleague Wellbeing Psychologist** – 0.4 WTE (substantive)
- **Colleague Wellbeing Psychologist Resilience Trainer** – 0.3 WTE (fixed term for 23 months)

Across the last 12 months there has been a total of 1572 direct points of contact with colleagues who have accessed support via the following:

- Individual support sessions (153 colleagues, attending 601 appointments)
- Drop-in sessions (102 sessions, attended by 198 colleagues)
- Group sessions (37 sessions, attended by 240 colleagues)
- Teaching/training sessions (37 sessions, attended by 275 colleagues)
- Compassionate Resilience workshops (10 workshops, attended by 105 colleagues)

Plans for improvement 2022/23

As we look to the year ahead the following actions are proposed:

- We will undertake granular analysis of the health-wellbeing related questions in the staff survey to identify priority areas around experiences of health-wellbeing. This will lead to an action plan for providing additional support to these areas, working in partnership with divisional tris and HR Business Partners.
- In Q1, we will develop a suite of additional short-term 'quick-win' actions which can be implemented swiftly to provide additional support to colleagues, along with formulation of medium-longer term actions that can be costed and approved accordingly.
- We will work with the Trust's Cancer team to devise a programme called 'Cancer at Work' which will provide pastoral and educational support to colleagues who have cancer, and their line managers/team members.
- We will pilot a 'Wellbeing Champion' role for three months with a selected number of departments/ teams. On completion of the pilot, we will take the learning from this to rollout the Wellbeing Champion role across the Trust.

- We will launch new training courses to support managers and colleagues in the following topics. These will be facilitated by the Health & Wellbeing Coordinator and EDI Training Specialist:
  - Disability Awareness training for Managers
  - Mental Health First Aid Awareness for Managers – half-day course.
  - Mental Health First Aid – full two-day course. This will be targeted at Peer Supporters, HR Advisory Team, Freedom To Speak Up Guardians
- We have recently purchased 500 licenses of a 4-week "Compassionate Mind Skills" online learning programme, which gives colleagues the opportunity to develop a more helpful approach to their own and others' feelings and struggles. Licenses will be allocated to individuals who want to develop and use these skills for themselves, and will also be issued to those who want to support the practices for their teams e.g., individuals who become the wellbeing champions for their local area.
- We have started designing a workshop aimed at managers to support their teams, which will commence in Q2 22/23. This is being developed in response to feedback from team leaders who have reported finding it difficult to know and understand the psychological and emotional distress of their colleagues, and how to respond. The focus of the workshop will be in two parts, firstly to support managers to be sensitive to and understand their own distress, which will then help them to apply this knowledge and understanding to the needs of their team.
- We are recruiting a full-time Assistant Psychologist role to support the Colleague Wellbeing Psychology service, who will act as a link to the 2020 Hub around triaging referrals as well as co-facilitating workshops, groups and training courses. The role will also hold and manage our database which will enable us to improve the immediate and long-term measurement of our clinical and teaching interventions.
- We will continue to strengthen our engagement and involvement with ICS-wide health-wellbeing initiatives, such as the ICS Wellbeing Line team
- We will work with the senior People & OD leadership team to develop a business case which considers the ongoing and long-term requirement for psychological support for colleagues. In early 2023-24 the 1.7 WTE charity-funded posts will come to an end. We will use evidence gained from the measuring the impact of current service provision to develop a more sustained model of colleague support going forwards.

2. 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. Their standards have been developed with a number of outcomes created by people and families — which 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 2021/22

The 2020 return asked for data such as number of outpatient appointments, number of occupied bed days, number of adverse incidents, number of complaints, how many patients have a learning disability marker on their records, readmission rates, number of safeguarding referrals received about patients with a learning disability, number of in-hospitals deaths, our workforce profile (whether we employ learning disabled or autistic staff), and a survey of both staff and patients with a range of detail under this.

It was obvious from collecting the information for the 2019/2020 return that the greatest impediment to having useful information to improve the service was not having Learning Disability data disaggregated from general data. Business Intelligence were able to do this in June 2021 and that has given much greater visibility of Learning Disabilities patients within all areas of our service and enabled us to see where improvements were needed. The 2020/2021 return has asked for different information with a focus on ante-natal screening and cancer services, which was not previously required.

The 2021 return was due on 31st January, but in view of another wave of COVID this was extended to the end of March. Most of our responses have been submitted and the patient and staff surveys have been undertaken. Clearly there are no results yet, due to the extended submission date.

What our data tells us

Having now disaggregated our data we know that Learning Disability patients make up 1% of our service users, but use our services more frequently than an average member of the Gloucestershire population, due to underlying physical comorbidities requiring our intervention.

Deaths of people with Learning Disabilities average 2 a month and that has been the case over the last several years. Generally these deaths mirror the general population in following an obvious frailty pathway, albeit at an earlier chronological age for those with multiple comorbidities. This is a tribute to all those involved in providing every type of healthcare to people with Learning Disabilities and Autism over several years.

What progress have we made?

We wrote an improvement plan based on what we could not answer positively for NHSI Benchmarking and learning points coming out of LeDeR reviews. These were grouped into four areas of focus:

Data capture and management

The disaggregation of LD data achieved by Business Intelligence has had the practical benefits of patients with LD being clearly visible on waiting lists, clinic lists and daycase lists and the ability to generate a daily inpatient, daycase and outpatient reports for the Learning Disability Liaison Nurses, releasing the equivalent of two days of clinical time per week.

Within elective care, being able to see how many patients with a Learning Disability are on which waiting list has enabled more nuanced prioritisation of those lists. The waiting list monitoring team have been able to adjust their approach to phone calls, knowing that they will be speaking to either a person with a Learning Disability or a carer about their condition. This has been very positively received.

Patient experience

After many years' of campaigning by Karen Pitcher, (mother of a patient) we were finally able to open our 'Changing Places' toilet facilities for disabled adults, enabling the same levels of basic dignity as the general population enjoy when visiting our premises. We have also taken delivery of a Sensory Voyager for each hospital site to provide structured sensory stimulation to patients.

Work in January 2021, as a response to large numbers of LD inpatients with COVID, illustrated the benefit of pre-emptively assessing all LD inpatients for signs of deterioration. The LD Liaison Nurses are making their own assessment of each LD inpatient now and are working on a project with the Acute Care Response Team to gauge the value of daily monitoring by ACRT. Primary Care colleagues are working on including ReSPECT form completion into Annual Health Checks to ease decision-making at the point of acute deterioration.

Relative/carer experience

Paediatrics have passed on a total of four Z-beds, two stored at each site, available for use by unpaid (family) carers staying overnight with LD patients.

The LD liaison nurses have worked hard to ensure family and paid carers are aware of the adjustments that can be made to visiting restrictions for patients with a cognitive impairment of any type. There are tensions with LD patients as the 'Triangle of Care' (patient, hospital, family) which works for all other patients tends to pull out into a 'Square of Care' for LD patients (patient, hospital, family, paid carers). To ease that tension the LD liaison nurses have been routinely asking families and

carers who should be our main/first point of contact and have found that many families and carers had not considered that question before and just assumed it would be them. Asking this question pre-emptively gives everyone the chance to agree what the expectation should be and takes some tension out of communications.

We have written a suite of leaflets about Best Interest meetings for patients and relatives, in collaboration with dementia specialist staff and the MCA lead for the county. These are likely to be adopted as the countywide standard for all professionals who hold Best Interest meetings once the approvals processes are complete.

Staff experience

The outstanding items on the improvement plan are related to making it easier for staff to care well for this group of patients. We planned to make several changes within EPR and to information available on the intranet. These are in the final stages of preparation before being launched.

Plans for improvement 2022/23

Work will continue to improve the care we provide for patients with Learning Disabilities and Autism, with a focus on improving data capture and management, as this remains a significant challenge for the teams. The priority workstreams include:

- All amber rated items on the current improvement plan to be completed
- Disaggregate complaints and incidents data to increase visibility of LD within these
- A better system for highlighting people with autism on hospital records
- A business case for augmenting the nursing team with specialists in neurodiversity
- Improved bathing facilities for those with physical disabilities whilst inpatients
- Pursue allocated consultant physician time for those with multiple complex disabilities

3. 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 broader transition agenda has been delayed during 2021/2022. 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.

How we have performed 2021/22

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 was formally launched in November 2021. The estimated patient numbers were 50, but the actual number has been 226; as a result of this, the service have created a young adult (16+) team, with dedicated administration support, a Youth Worker, a Nurse Specialist and Dietetics. All patients age 16-21 who contacted the department after 1 Nov have now been re-directed to the 16+ team.

There have been difficulties with recruitment of key members of the team which has created a gap between the proposal and the professional capacity currently in place to deliver the service; however, new ways of working have been established and the following benefits are already being seen:

- The new Youth Worker has been engaging with young people, signposting to mental health services, building rapport and enabling patients to get HbA1c checks who would otherwise have gone with out
- New initiatives have been launched including HbA1c blitz, virtual appointments, and plans for socials to create peer groups

- Improved follow up responses obtained after >1yr no contact
- Administrative support has improved ability to evaluate outcomes going forward and to ensure a cross reference with Infoflex

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 is being 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 2022/23

This work will continue as a Quality Account Indicator in 2022/23, with the aim to provide full proposed service to patients who transition this year (43 patients), plus:

- Target those in list of 180 who have been out of contact the longest and bring them in
- Attend 16+ clinics and offer support to current patients, collecting data on how much of the full service has been provided.
- Data collection to better understand the staffing required to provide the full service to 225 patients as proposed at the outset

Work will continue to develop the service through:

- Implementing the NICE recommendation released on 31st March that CGM and Libre is available to all patients with Type 1 Diabetes. We anticipate a large volume of contacts regarding this and once funding is secured, we now have the patient information to efficiently upgrade our population to the new technology.
- Launching the Digibete app to share resources, send newsletters and allow the patients to track their medication and results. We will be aiming to provide education sessions and social events in person and virtually.
- Recruiting another youth worker or HCA to aid with launching additional social media such as Instagram and Facebook and creating newsletters for Digibete. They will also be able to assist in connecting people to clinic to share data. Our aim is still to recruit another member of clinical staff and we will continue to explore options with stakeholders.
- Providing education virtually as a webinar in April (inviting all patients to online training including update on the Insulin advice app, Digibete app, Libre/ CGM eligibility, youth worker introduction).
- Providing a social event at the Walk for Wards event in May to help answer topics raised in the Q&A in the April virtual meeting.
- Continued evaluation of the pilot against our agreed outcome measures and via patient and staff questionnaires

There is potential to learn from this model and scale up on a speciality basis, and this will feed into the wider Children and Young People's strategy work, including the delivery of a programme to transform outdated processes and pathways, which will incorporate transition into adults services.

4. To improve maternity experience through delivery of Continuity of Care programme

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.

One key programme of work in 2021/22 to improve the experience of women using our services has been 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).

How we have performed 2021/22

In spring 2021, three Continuity of Care teams were launched; Bartongate and Lighthouse in Gloucester, and Gardeners Lane team in Cheltenham. These areas were launched as the first three teams, as these areas include some of the higher areas of deprivation in the county. Tackling health inequalities is a key agenda for our teams, and prioritising the launch of Continuity of Care teams in these areas means that approximately 10% of the most vulnerable women in our county, including those from ethnic minority groups, will benefit from the Continuity of Care programme.

Maternity services are one of the CORE20 Plus5 areas where we are looking to make real improvements for people facing health inequalities in our county.

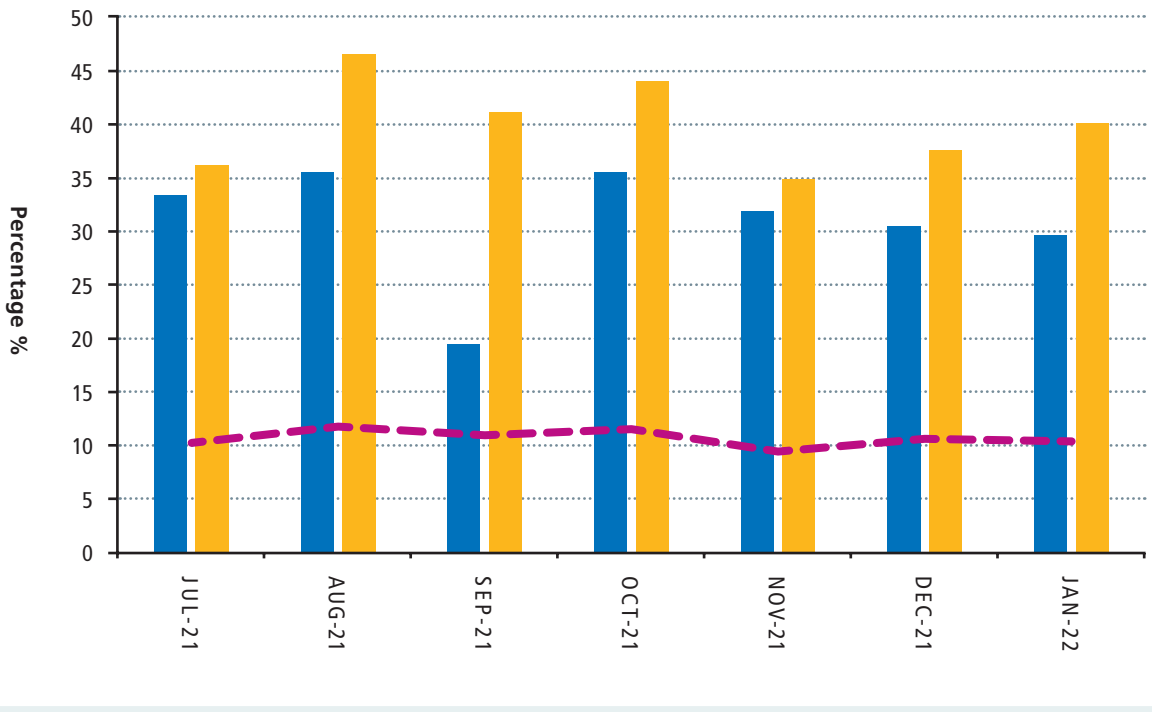
The graph below demonstrates the impact of launching Continuity of Care programme in the three teams, with a significant proportion of our Continuity of Care bookings being made for women who are in Index of Multiple Deprivation (IMD) decile 1 (the 10% most deprived communities in the country), or who are from an ethnic minority background. As a Trust, we have had 10.9% of all women booked onto a Continuity of Care programme, compared to 31.8% of ethnic minority women in our service and 41.6% of women from an IMD decile 1 areas.

Figure 2 shows greater detail about the percentages of women from an ethnic minority being supported by the Continuity of Care team through to delivery in the three areas, compared to an overall 5% of women who are from an ethnic minority who delivering their babies not through the Continuity of Care programme.

Evaluation of this work is ongoing, but early evaluation shows an encouraging positive impact on the mode of delivery for the women who are being supported by the three Continuity of Care teams, as illustrated in the graph below.

The original Business case has been revised and an implementation plan developed to support a model which consists of 21

Fig. 1: Continuity bookings by Ethnicity and IMD Decile 1

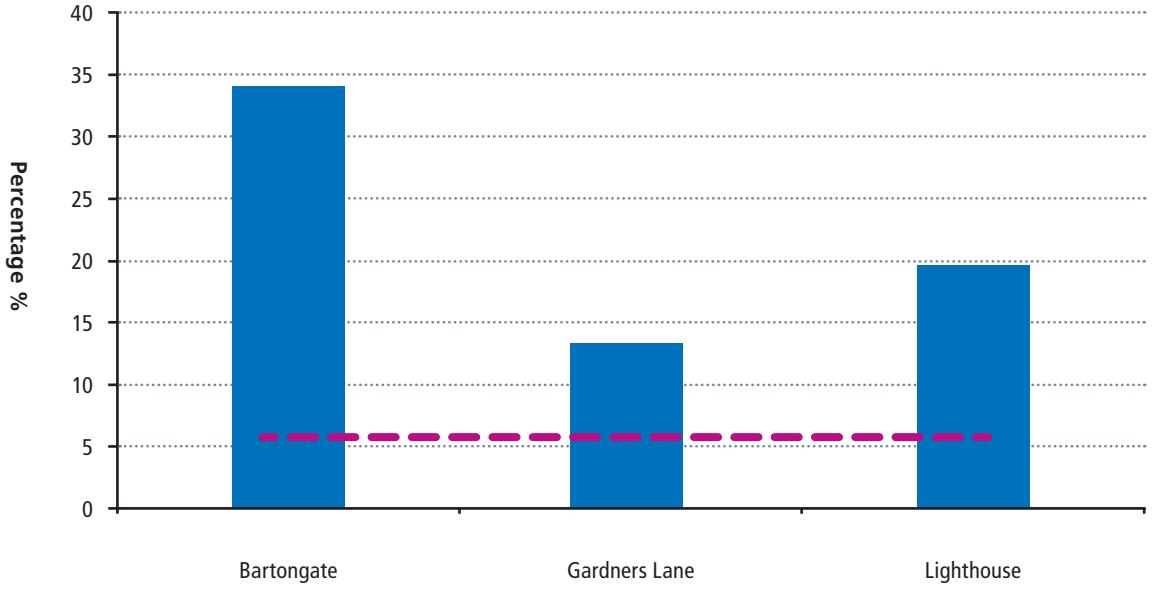


Percentage Ethnic minority * Bookings under CoC Team

Percentage IMD Decile 1 Bookings under CoC Team

Is woman booked on Continuity of Care Plan: defined criteria

Fig. 2: Percentage of Ethnic Minority Deliveries by Continuity Team



Percentage of ethnic minority deliveries by continuity team

Percentage of ethnic minority deliveries by continuity team (non continuity)

Continuity of Care teams who will provide of Continuity of Care for 92.7% of women and birthing people by July 2024. The new Business Case includes plans to secure additional funding requires to recruit the additional midwives required to launch teams 14 to 21, which will support 60-92% of women and birthing people with Continuity of Care. This was signed off by Divisional Board in December 2021, and is being progressed to the Trust Leadership team for approval before submission to the Regional and National teams.

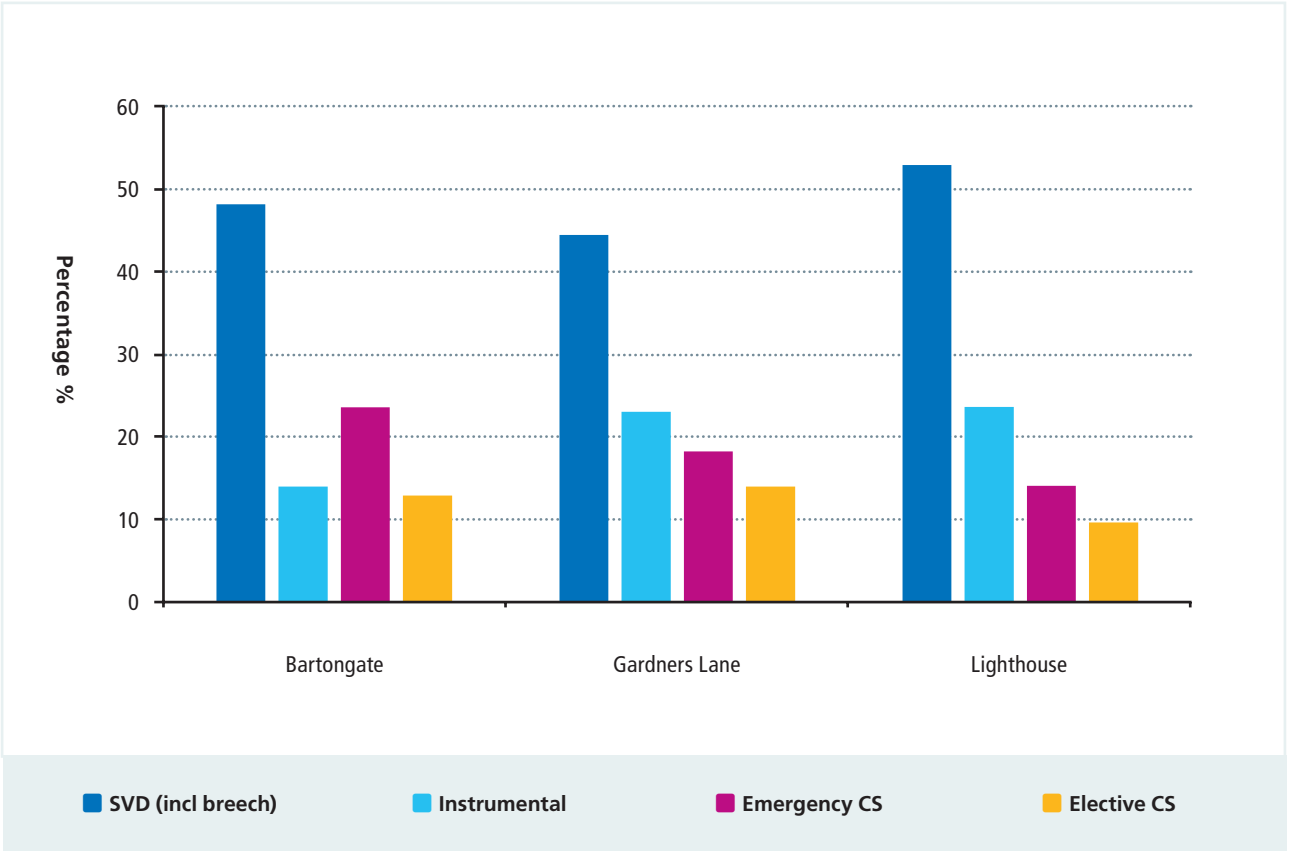
A Birthrate Plus reassessment is currently in providing a review of the midwifery and maternity support worker workforce. This will confirm additional workforce required to support Continuity of Care roll out as default for all pregnant women/ birthing people in Gloucestershire.

Plans for improvement 2022/23

A focus on improving the experience of women using our maternity services as one of our Quality Indicators in 2022/23, aiming to ensure that all pregnant women and birthing people in Gloucestershire receive the best care.

Further evaluation of the work to date will be completed, as well as progressing the business case to secure additional funding to embed Continuity of Care as the default. The maternity services and the new Head of Midwifery are working closely with our Maternity Voices Partnership to ensure that the voice of women and birthing people continues to play a key role in developing our services.

Fig. 3: Mode of delivery by team, year to date



5. To improve Urgent and Emergency Care (ED) experience

Background

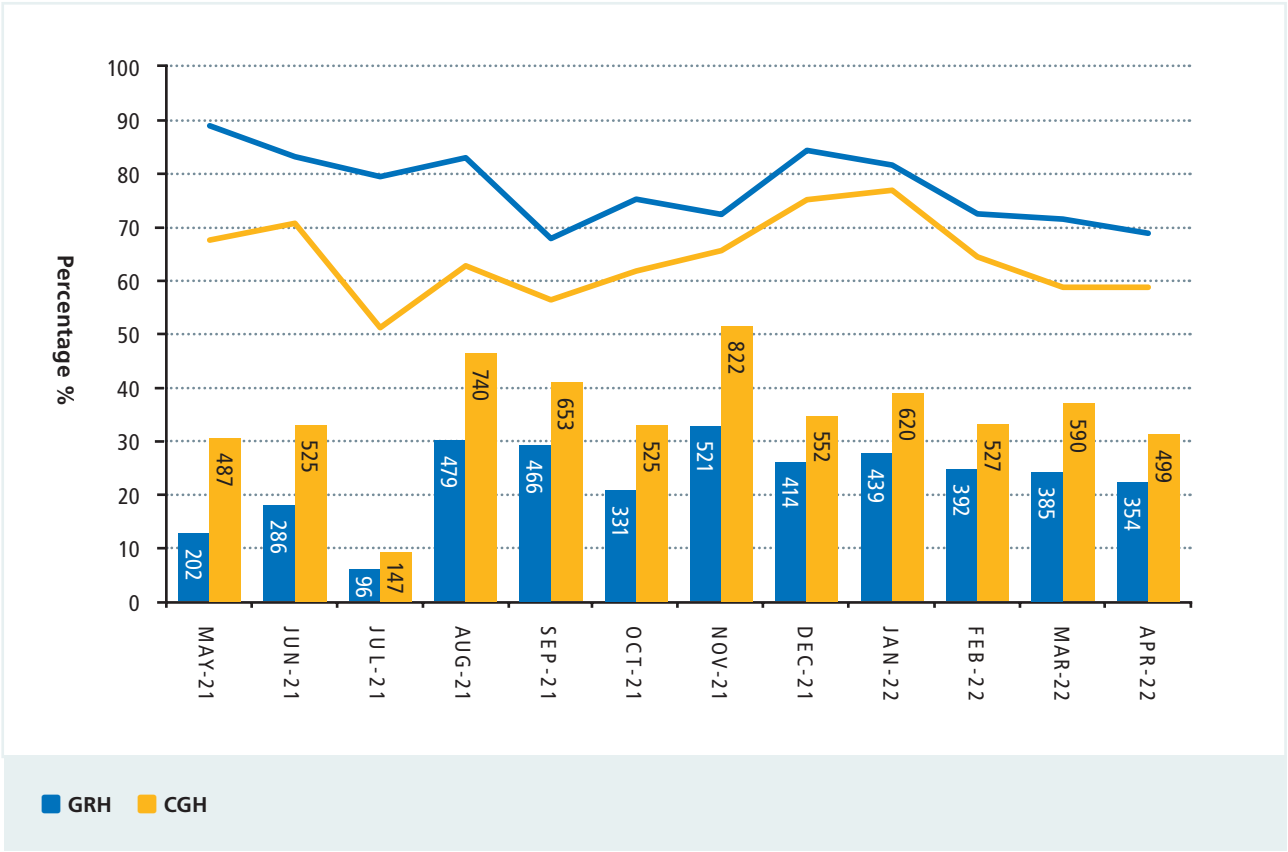
Our patients have told us through our Friends and Family Test (FFT) and our National Survey programmes, that although we do provide good care for the majority of our patients, we don't always get it right for everyone. In 2021/22, 70.3% of patients reported they would recommend our urgent and emergency care services to their family friends, meaning that 29.3% 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 2021/22

The graph below shows the Emergency Department FFT total responses and positive score by site. In July, we had an issue with our systems during the EPR launch in Gloucester Emergency Department, which meant that less surveys were sent out to patients, and contributed towards our lowest positive score in the year.

The main theme emerging across the comments which is impacting the positive score has been wait times, due to operational pressures in the Trust. To identify other areas in feedback where

Fig. 4: ED FFT total responses and percentage of positive ratings



experience improvements can be made, the teams moved to receiving their FFT data weekly, so that trends in comments could be analysed and reviewed along with PALS themes and feedback, and actions taken quickly to improve experience for patients.

In November the team recruited a Patient Experience Lead to support with this work and the delivery of the Patient Experience Improvement Plan. This work has had a number of priority areas, with progress this year in the following areas:

- Communication within the department with patients and relatives
  - Information slide deck in the waiting area of Dept with relevant information
  - Patient information leaflet and poster (with QR code) providing information regarding triage and managing expectations of timings and treatments
  - Designated telephone line for relatives 8am -6pm
  - Patient experience lead role in the department on secondment for 6 months who updates and communicates with patients and relatives
  - Poster with QR code regarding pain management and medication instructions for patients
  - You said we did boards for the department – using FFT comments to improve services
- Patient Care
  - Patients frail and elderly are moved onto appropriate beds and mattresses in 4 hours of arrival
  - All trolleys have soft mattress cover on for comfort
  - Falls red blanket initiative – to highlight to staff the need for careful observation
  - #Purpleprotect initiative where patients with cognitive impairment are provided with purple wrist band, arm band and slippers/ socks to inform staff of need for extra observation and support
  - Trial of use of social worker within the department working alongside the Hospital Homeward assessment team
  - Therapy Dog visiting the department for patients and staff wellbeing
  - QI project to produce an Epilepsy emergency department drugs box to ensure prompt and continuous use of routine medication when admitted
- Volunteer support
  - Recruited and trained volunteer team for patient facing roles in the department – supporting with refreshments / communication
  - Hot meals provided for patients awaiting admission to the ward
  - Sandwiches provided for patients in the department over meal periods
  - Activity boxes/ Newspapers – Volunteers supplying activities to support patients whilst waiting in the department

Plans for improvement 2021/22

A number of priority actions are ongoing in the patient experience improvement plan. The key focus areas for 2022/23 include:

- QI project producing a Dementia quiet space for patients in the department
- QI project producing a gynaecology quiet space in the department
- Working in conjunction with Macmillan on providing an information/display board

for patients and relatives newly diagnosed with cancer and directing them to support services within the trust and community

- Working in conjunction with Age UK to provide an information hub/ volunteer for patients and relatives re home from hospital support
- Patient story videos from experience in Emergency department
- Continue to expand and support the role of the patient experience lead role across departments
- Continued recruitment of volunteers across site
- Complaints leads allocated in department to monitor and respond to complaints

The strategic site development programme comprises of the capital investment of £44.5 million at Gloucestershire Royal Hospital and Cheltenham General Hospital, £39.5 million funded through STP wave 3 capital and £5 million through Trust capital.

The Gloucestershire Strategy Site Development (GSSD) scheme has been developed to reduce unwarranted variation in clinical quality and efficiency, and improve both non-elective and elective care by:

- streamlining of emergency and urgent care
- increased capacity to manage urgent and emergency patients
- appropriate acute assessment and investigation facilities to support efficient patient flow
- provision of improved inpatient ward
- increasing theatre capacity
- improved day surgery patient accommodation

The GSSD scheme will provide:

- an extension and a reconfiguration to the emergency department at Gloucestershire Royal Hospital to improve streaming and patient flow plus provide additional capacity
- an acute medical assessment and investigation unit at Gloucestershire Royal Hospital using existing reconfigured accommodation
- two new operating theatres and extension and reconfiguration of the day surgery unit at Cheltenham General Hospital
- a new inpatient ward at the Gloucestershire Royal Hospital site

6. To improve Adult Inpatient experience

Background

Our National Adult Inpatient 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 published in Autumn 2021. Although our national survey results were postponed, as a Trust we continued with our Friends and Family Test throughout the pandemic, to ensure that we continued to understand the experience of our inpatients.

How we have performed 2021/22

Overall, our patients report a mostly positive experience of our inpatient services, with 89.5% of patients recommending our services through the Friends and Family Test (FFT). While this provides reassurance that we get it right for the majority, 10.5% of our patients are consistently not receiving a positive experience, and this has certainly been the case as we start our recovery journey.

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.

The tables below show our top and bottom 5 scores in the 2020 National Adult Inpatient Survey compared to the Picker average scores.

A number of the areas identified as needing further improvement through our National Adult Inpatient Survey results related to communication (explanations for changing wards, being provided with information, asked to give their views, or told who to contact if worried). These themes have been echoed in our Friends and Family Test and PALS data, with patients and families telling us that communication has been a challenge across all of our inpatient areas.

In February and March 2022, we put additional ward clerk shifts in to wards that had been identified through our PALS and FFT data as areas which had higher levels of concerns about communication. During this time, an additional 546 hours of ward clerk cover, to support ward teams in managing workload and improving communication. The evaluation of this additional support will inform a ward clerk service review happening in Summer 2022.

Top 5 scores vs picker average	Trust	Picker average
Q2. Did not mind waiting as long for admission	72%	68%
Q10. Able to take own medication when needed to	90%	89%
Q18. Nurses answered questions clearly	98%	97%
Q14. Got enough to drink	95%	95%
Q19. Had confidence and trust in the nurses	99%	98%

Bottom 5 scores vs picker average	Trust	Picker average
Q7. Staff completely explained reasons for changing wards at night	73%	83%
Q38. Given written / printed information about what they should or should not do after leaving hospital	64%	73%
Q47. Asked to give views on quality of care during stay	6%	14%
Q3. Did not have to wait long time to get to bed on ward	74%	82%
Q41. Told who to contact if worried after discharge	74%	78%

Additional support has also been made available to our PALS team to support a sustained increase in concerns from patients, carers and relatives, and this is monitored through our Quality Delivery Group to ensure we can continue to effectively support patients, carers and relatives.

One of the other key themes emerging through FFT and PALS data for our inpatients has been wait times, and not understanding the reasons for the waits. The Patient Experience team worked with colleagues on the Surgical Assessment Unit (SAU) to create an infographic on the wall, that helps patients to understand their journey through SAU. This gives details about the time it takes for different diagnostic procedures, and links to more information.

Other inpatient areas are requesting a similar journey poster for their ward, to help managing expectations of patients and communicating change, and we will be looking to role an adapted version of this out to other areas in 2022/23.

Plans for improvement 2022/23

This will continue to be a Quality Priority in 2022/23, as our FFT, National Survey and PALS data still identify clear areas for improvement. Our work for 2022/23 will include:

- Reviewing our reporting into divisions, to provide more holistic patient experience reports that give themes across insight sources
- Introducing a focus on storytelling to support improvement, taking a community of inquiry approach
- Supporting teams with the patient experience improvement plans in divisions, providing QI coaching support
- Developing patient discharge support volunteer role to support wards and patients in enhancing the discharge experience
- Working with teams across the hospital and our Hospital Reflection Group to look at how we can continue to develop our offer to carers of patients in our hospital
- Increasing awareness of and access to our translation and interpretation services
- Roll out of projects such as the SAU journey poster which focus on informing patients and relatives, and improving communication of processes

7. 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.

In 2019, the NHS Patient Safety Strategy published the intention to develop a more proactive approach to patient safety through the development of safer systems embedded in a just culture. The strategy included the introduction of the following:

- Patient Safety Specialists
- Learn From Patient Safety Events (LFPSE)
- Framework for involving patients in patient safety
- Patient Safety Syllabus
- Patient Safety Incident Response Framework (PSIRF)

How we have performed 2021/22

The SCORE (Safety, Communication, Operational Reliability & Engagement Survey) survey by Safe and Reliable Care was undertaken in September 2019 across pre-operative, operative and post-operative settings in Gloucestershire Royal Hospital, Cheltenham General Hospital & Cirencester Treatment Centre. 62% of staff surveyed responded, which was above the quantity required for the results to be considered representative of the surveyed staff groups. Unfortunately, due to the impact of COVID-19, the programme was paused but has now been incorporated into a wider Theatres improvement programme.

Trust-wide, work designed to generate a just and restorative culture commenced based on an approach utilised by Mersey Care NHS Foundation Trust. 9 staff from Gloucestershire Hospitals have been trained through Northumbria University and a Just and Restorative Steering Group has been established to coordinate the approach within Gloucestershire Hospitals.

A wider Patient Safety Plan has been developed, incorporating the requirements of the Patient Safety Strategy and local Trust initiatives. An accompanying improvement (Patient Safety Improvement Forum) and assurance (Patient Safety Systems Delivery Group) structure, chaired by the Quality Improvement & Safety Director and the Medical Director, respectively, has been established to oversee development and implementation.

The following actions have been taken so far:

- Two Patient Safety Specialists have been nominated within the Trust and are actively involved in the national networking and sharing activities.
- A new incident and risk management system has been purchased which is compatible with the LFPSE system. A project is currently underway configuring and testing the system prior to implementation.
- The nationally produced Level 1 and Level 2 patient safety training packages have been published and reviewed

by the Patient Safety Improvement Forum. A proposal to make the Level 1 training mandatory for all staff is to be submitted to the Trust Education and Learning Group.

- A draft PSIRF is being tested within the women's and children's division and the emergency department.

Plans for improvement 2022/23

- The Theatres improvement programme incorporating work to understand and generate a safety culture will continue to progress, led by the surgical division.
- The Just and Restorative Steering Group will work to plan, coordinate and implement a programme of work over the coming year with the aim of introducing ways of working that support the creation of a Just and Restorative Culture across Gloucestershire Hospitals.
- The new risk and incident management system will enable the Trust to report into the LFSPSE system
- Patient Safety Partners will be introduced in line with the Framework for involving Patients in Safety
- Level 1 and Level 2 Patient Safety Training will be rolled out to staff and any further national patient safety training that is released (levels 3 – 7 are outstanding), will be reviewed and an implementation strategy will be planned.
- Work to introduce the Patient Safety Incident Response Framework will continue.

8. To improve our prevention of pressure ulcers

Background

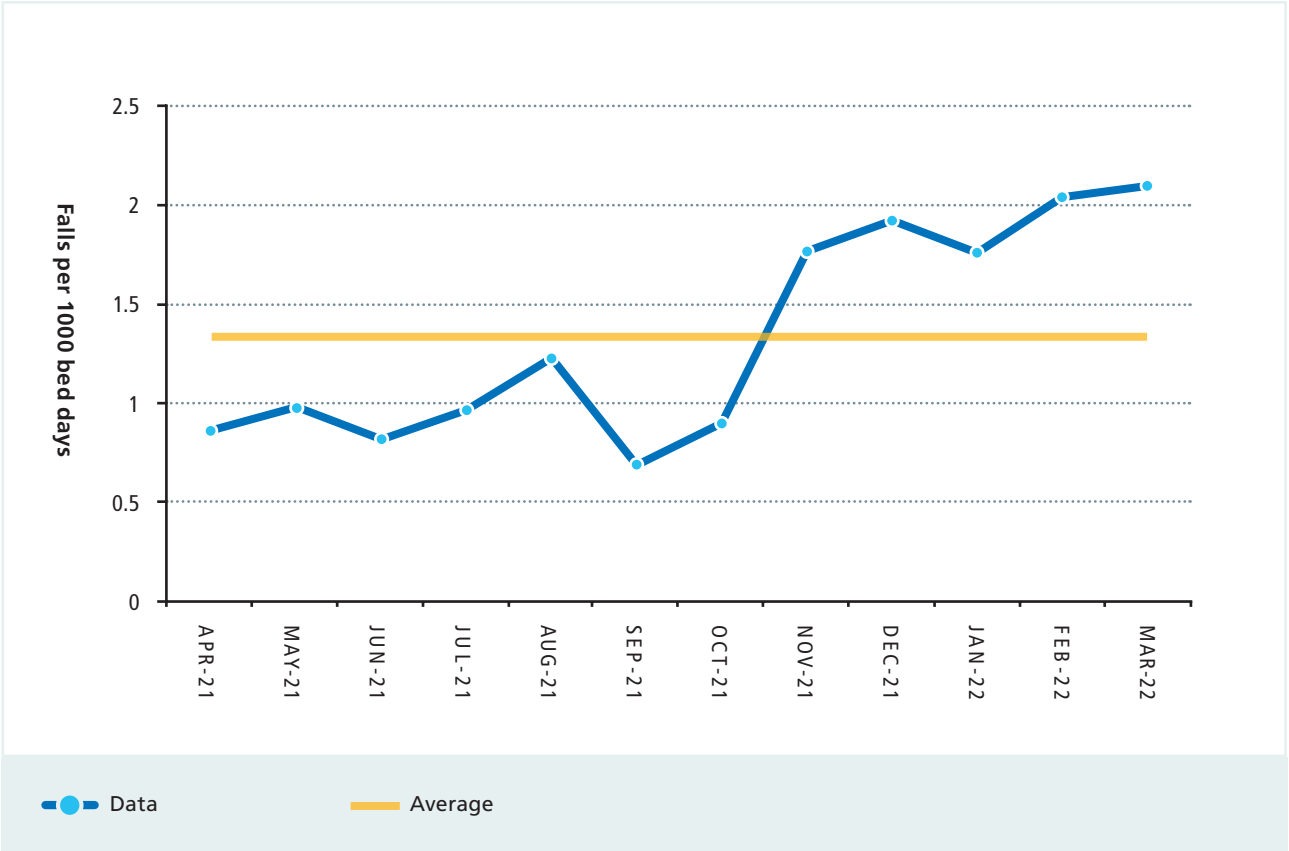
A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful.

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.

Fig. 5: Hospital acquired pressure ulcers (2–4 and unstagable) per 1000 bed days



How we have performed 2021/22

Preventing pressure ulcers is a key priority and the number of hospital acquired pressure ulcers is a measure of the quality of care being delivered to our community. The Tissue Viability service provides specialist evidence-based advice on caring for skin and the management of wounds that are complex in nature and are failing to respond to treatment. The team provide advice to patients; families, care givers and healthcare professionals. All patients are eligible for referral to the Tissue Viability service.

The chart below shows our current data for category 2-4 and unstageable Hospital Acquired Pressure Ulcers/1000 bed days

There are two main contributory factors to this reported increase in the number of Hospital Acquired Pressure Ulcers in 2021/22. The incidence of pressure damage in hospital is sensitive to nurse staffing levels, including safe Registered Nurse (RN) to Healthcare Assistant (HCA) ratios. Increases in pressure ulcers correlates with increased absence levels and use of temporary staffing, and we know from our data that wards with adverse RN to HCA rations are associated with a higher incidence of pressure damage. The Tissue Viability Team as a matter of course review and validate reported category 2 pressure ulcers however this work has been disrupted to absence in the team during the winter, including long-term sickness.

All of cases of unstageable pressure ulcers are presented by ward leaders to the Preventing Harm Improvement Hub (PHIH) where rapid feedback is given on the results of the investigation. Themes from that process are late identification of pressure damage leading to possible progression to this later stage and incomplete or missing documentation. Although not identified through the review of cases at PHIH, the Tissue Viability Team have received reports of equipment access delays and have taken actions to address this.

There are a number of actions and workstreams in progress as part of the Pressure Ulcer Prevention Improvement plan, including:

- Rapid dissemination of learning from Preventing Harm Improvement Hub.
- Pressure Ulcer Prevention training (PUP), formerly React to Red training, attended by 286 members of staff since 2020 and a further 174 booked for year 01/04/22- 31/12/23 to date.
- Increase in offerings of PUP training from 4 times yearly to 15 times a year, to increase awareness of clinical risk assessment and SSKIN bundle completion.
- 636 views of the React to Red videos "The Skin and Pressure Ulcers".
- 62 link nurses for tissue viability identified across all divisions, Meetings in 2022
- #Stopthepressure 18th November 2021 (international pressure Ulcer awareness day)
- Continuation of the Shared Decision-Making Council for Pressure ulcers and falls
- Daily offering of spoke placements for clinical staff including, student Nurses, Dr's, TNA's, Dermatologists, Dieticians and HCA's.
- Bespoke monthly online PUP presentation for ED commenced February 2022.
- Tissue Viability News Letter (4 x yearly) with emphasis always on Pressure Ulcer Prevention.

- Gloucestershire Hospitals Pressure Ulcer Prevention Guidance updated and now live.
- Clinical review of all patients with a hospital acquired pressure ulcers.

There are also a number of improvements in progress, including:

- Extra support for teams as required for pressure ulcer prevention when identified at the learning and preventing harm hub.
- Gloucestershire Hospitals Pressure Ulcer Prevention curriculum is being developed as a new initiative to raise awareness and reduce pressure ulcers within the Trust. This is a whole package of training to include certificate on completion and induction into pressure ulcer hero's hall of fame
- Audit of hospital mattresses to assure quality and ongoing procurement.
- Delivering a bespoke tissue viability conference for midwives and children's nurses with emphasis on pressure ulcer prevention.

Plans for improvement 2022/23

The continuation of a comprehensive Pressure Ulcer Prevention Program for 2022/2023 provides an operational framework for achieving progress with our pressure ulcer improvement agenda. The approach is multi-faceted with leadership from across nursing and allied professional. There has been an increase in our deep tissue injuries and unstageable pressure ulcers which has prompted further improvement focused in the areas that require this. The themes emerging are lack of pressure ulcer prevention awareness from staff, evidence of which is seen in the documentation in EPR. Factors in particular include lack of appropriate risk assessment and completion of the SSKIN bundle. This work will continue as a Quality Priority for 2022/23 as part of a wider preventing harm focus, incorporating both Falls and Pressure Ulcers, echoing the shared decision making council approach we are taking.

9. 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 2021/22

Covid 19 has continued to delay progress against the Falls Prevention Improvement plan. During the first wave the falls specialist nurse was redeployed, and staffing issues and increased work load on all staff, including the challenges of wards changing specialty and being flipped from green to red to manage the increase in Covid cases, has also hindered progress.

Work has continued however, and where there have been wards with high levels of falls identified, ward action plans have been produced and regularly reviewed with support of the Falls Specialist Nurse. Following this intervention, two wards that made significant improvements in their falls prevention work. Ryeworth ward saw a reduction of 15% in falls and 40% in falls with harm, and on AMU there was a reduction of 11% in falls and 14% in falls with harm.

Another example of where intervention had an impact was where a surgical ward turned to a medical ward, and had a large increase in falls during August, September and October 2021 (totalling 61). Specific

Fig. 6: Number of falls per 1000 bed days

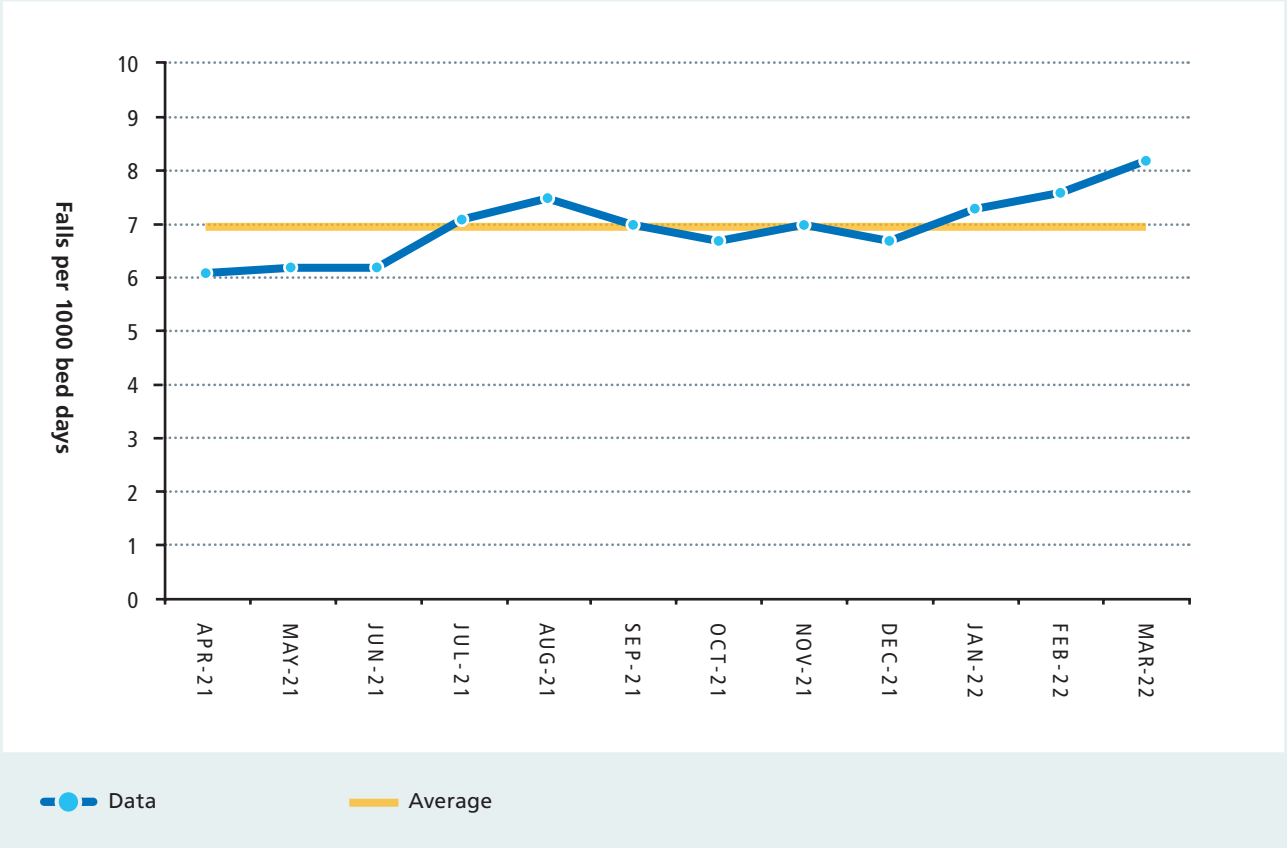
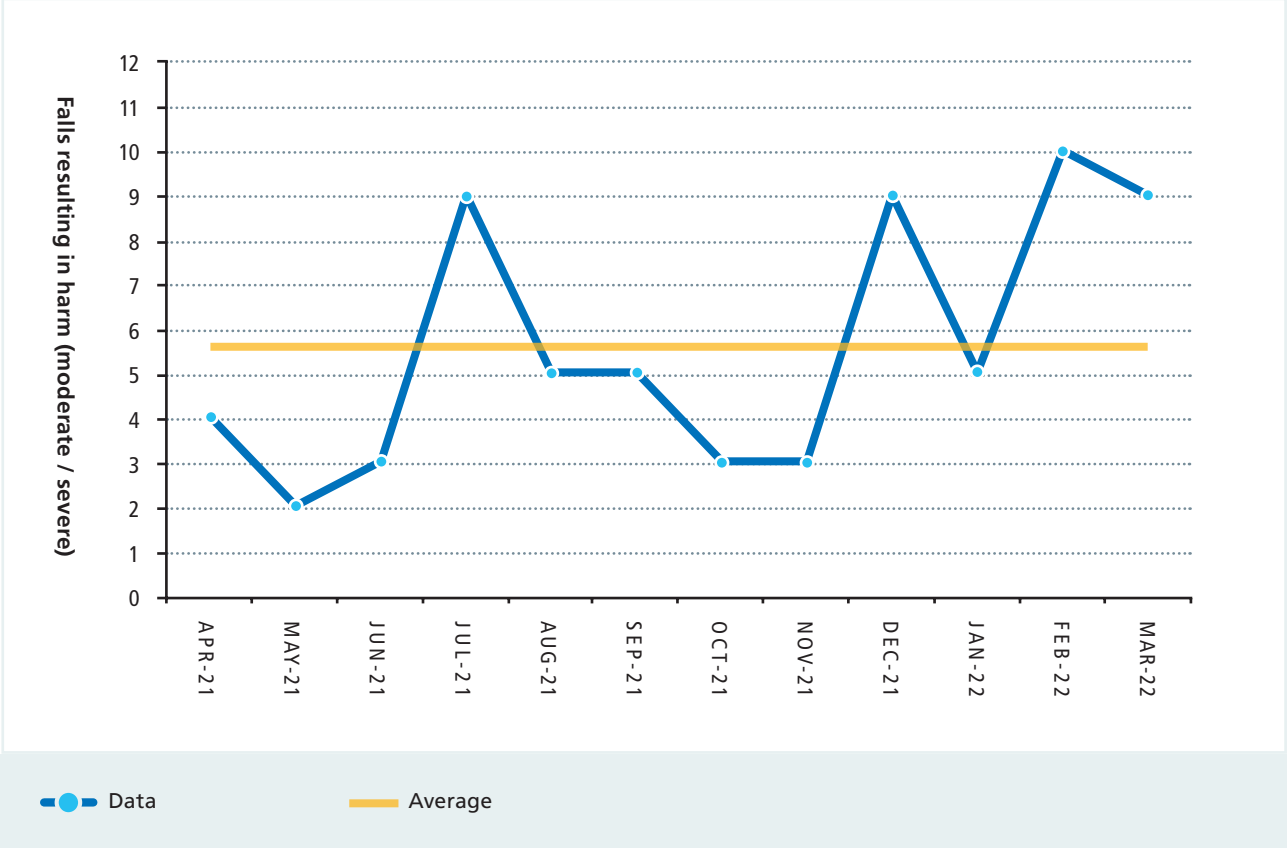


Fig. 7: Number of falls resulting in harm (moderate / severe)



ward training was put in place, with the support from the CPD team. During November, December and January the falls totalled 21, a reduction of 34%.

Overall, falls per 1000 bed days have remained within normal variation levels between April 21 and March 22, as seen in the graph below. We are around the same level as trusts of the equivalent size around the southwest. We have seen an increase overall in the number of falls with harm reported this year, as seen in the graph below, although these still fall within normal levels of variation.

There are several reasons as to why falls with harm have been so variable during the year:

- The acuity of the patients is higher and older people are more deconditioned as result of the pandemic
- Patients who are medically 'fit for discharge' are waiting for availability from the community for either assessment of their ongoing needs, awaiting placements or an increase in a package of care
- Enhanced care shifts not always being covered
- Staff fatigue

A number of improvement projects have been in progress this year to support our falls prevention programme, including:

- Monthly falls prevention training has commenced trust wide. Numbers currently restricted due to Covid restrictions. Numbers will increase as restrictions are lifted
- In ED – use of red blankets (now yellow) for identification of people identified as at risk of falls. This is also rolled out to the COTE and Stroke wards. Too early to see any results at present due to ED capacity
- Following audit of falls assessment documentation on EPR for ED, education sessions around the falls risk identification and the completion of the documentation due to commence, for a period of 6 months, to improve awareness and completion
- End PJ paralysis, is a trust wide initiative, to aid in the reduction of deconditioning
- Engagement with falls links on wards escalated to Divisional Directors and Ward managers to allow protected time for links to attend meetings and to instigate falls prevention on their wards

Improvements that have been achieved 2021/22:

- Ward based education and trust wide education has taken place following actions identified following Preventing Harm Hub investigations. Between April 2021 and Jan 2022 – total 192 registered, non-registered and therapy staff have had attended falls prevention training.
- Improvement and understanding of EPR data collected by Business Intelligence has led to an improvement in the completion of the falls documentation on the Electronic Patient Record (EPR)
- Safety briefings embedded on COTE and Stroke wards to enable ongoing identification of patients who are at increased risk of falls
- Since November 2021 the falls team has expanded to 2 full time members, a nurse and a therapist. All patients who have sustained a 2nd fall during an admission have been reviewed and recommendations made. Total number of 2nd falls was 69. Only 13 patients went on to have further falls. Therefore 81% of the patients did not go on to have any further falls during their admission. Those who went on to have further falls were most likely to continue to fall regardless of interventions
- Themes from harm hub are presented at the Shared Decision Making Council for Falls Prevention and Tissue Viability, with wards presenting and celebrating their success at this council

Plans for improvement 2022/23

A focus on preventing harm will continue as a Quality Priority for 2022/23, focusing on how we reduce the number of both falls and pressure ulcers, and the harm they cause patients.

10. To improve our care of patients whose condition deterioriates

Background

Patients who are admitted to hospital believe that they are entering a place of safety, where they, and their families and carers, have a right to believe that they will receive the best possible care. They feel confident that, should their condition deteriorate, they are in the best place for prompt and effective treatment. Yet there is evidence to the contrary. Patients who are, or become, acutely unwell in hospital may receive suboptimal care. This may be because their deterioration is not recognised, or because – despite indications of clinical deterioration – it is not appreciated, or not acted upon sufficiently rapidly. Communication and documentation are often poor, experience might be lacking and provision of critical care expertise, including admission to critical care areas, delayed (NICE, 2007).

Sometimes, the health of a patient in hospital may get worse suddenly (this is called becoming acutely ill). There are certain times when this is more likely, for example following an emergency admission to hospital, after surgery and after leaving critical care. However, it can happen at any stage of an illness. It increases the patient's risk of needing to stay longer in hospital, not recovering fully or dying.

Monitoring patients (checking them and their health) regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems.

We require that all adult patients in hospital have:

- a clear written monitoring plan specifying which vital signs should be recorded (and at what frequency),
- their severity of illness measured using the physiological National Early Warning Score (NEWS2) and
- a graded response strategy (NICE CG50 2007).

The NEWS2 was created to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients. The NEWS2 was founded on the premise that (i) early detection, (ii) timeliness and (iii) competency of the clinical response comprise a triad of determinants of clinical outcome in people with acute illness. When patients first arrive on the ward – either as a new patient or from a critical care area such as the intensive care unit – a healthcare professional should:

- measure the patient's pulse, blood pressure and temperature, how fast they are breathing, and the amount of oxygen in the blood
- look at how alert the patient is and whether the patient is aware of what is going on around them

The staff should write a plan for which of the patient's vital signs should be monitored and how often. The plan should take into account:

- why the patient is in hospital
- any other illnesses or health problems the patient has

- what the patient has agreed about your treatment.

If patient's vital signs show that health might be getting worse, or if a healthcare professional has concerns, the staff should respond according to how serious the problem is.

The ward/area should have a plan for the response, which should consist of three levels.

- For a minor problem (low NEWS2 score group), the nurse in charge should be told and the patient should be monitored more often to keep a closer watch on their condition.
- For a moderate problem (medium NEWS2 score group), the patient's consultant's team should be called urgently and healthcare professionals trained in assessing and treating patients whose health has become suddenly worse should be called at the same time (Acute Care Response Team (ACRT)).
- For a serious problem (high NEWS2 score group), there should be an emergency call to the Resuscitation Team (this team should include a critical care doctor trained in resuscitation).

If the problem is moderate or serious, the patient's healthcare team should review their condition and make the necessary changes to treatment. They should revise the care plan and consider whether the patient should be cared for in another unit, such as the **critical care area**.

Our electronic observation system - eObs

The NEWS2 can be readily transported into an electronic health system. There are potential advantages of automated calculation of the NEW score and automated alert systems. The standardised scoring systems and alert thresholds that underpin the NEWS should remain unaltered. In March 2020, we rolled out an e-Observation system that enables clinical staff to record their patient observations digitally as well as calculating the National Early Warning System (NEWS2) score. The NEWS2 calculates and reflects whether a patient's condition is improving or deteriorating and the appropriate escalation policy is presented to the clinician with a set of resulting actions. The eObs system has many benefits which have helped staff manage the care of the patient including: -

- Reducing cross infection as clinicians are using a digital system to input and retrieve information
- Tracking patients, and
- For the ACRT being alerted to patients who have deteriorated

How we have performed 2021/22

Our Electronic Vital Signs (eObs)

The general wards are now using electronic vital signs across the Trust and following further analysis around compliance minor modifications are being made to the system to ensure it is a better fit for the users.

The Acute Care Response Team (ACRT) is using the information generated every shift and it has proved enormously useful for practitioners to prioritise their workload.

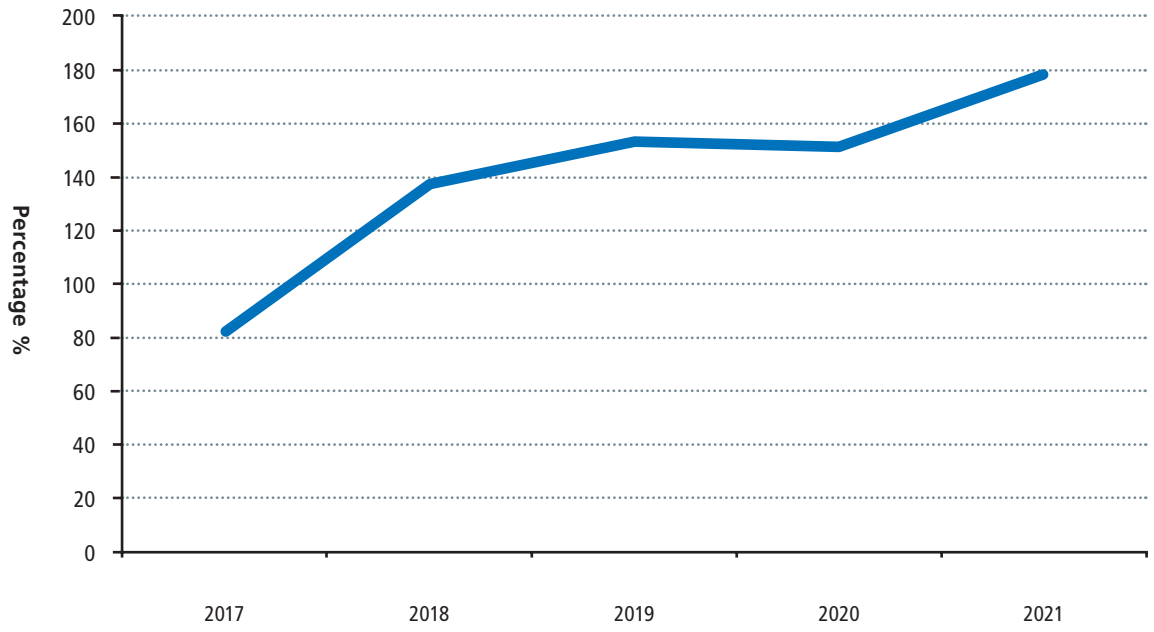
Acute Care Response Team (ACRT) involvement prior to DCC admission

If a patient deteriorates on the ward and is moved to critical care their chances of survival are significantly improved if they have 'optimal' ward based care prior to critical care admission. (McQuillan et al)

The involvement of ACRT in patients prior to admission to critical care has increased significantly in the last 5 years.

Year	No. of Patients
2017	82
2018	137
2019	153
2020	151
2021	178

Fig. 8: Involvement of ACRT prior to critical care admission



Plans for improvement 2022/23

- Staff are recording observations on paper prior to the data being entered on to the electronic system and the reasons for these behaviours need to be explored.
- NEWS2 excels at identifying those who are deteriorating due to serious infections such as sepsis, and enhances the timeliness of the identification. The sepsis toolkit has recently been launched in order to immediately flag up to staff what actions to take when they enter observations with a high 'NEWS' score. The ACRT are tracking its use and will work with Business Intelligence to ensure useful and timely data is maximised.
- Areas without electronic observations remain on the paper systems (including Critical care, Recovery, Paediatrics) and these areas will migrate to electronic systems in time.
- The direction of travel is that any patient who is deteriorating is referred to the ACRT even if there are ward doctors present. The future plans are for the ACRT to lead the care/management of all deteriorating patients but at present the service is not sufficiently resourced for this to be enacted.
- Staff surveys carried out by the ACRT suggest at present that 80% of staff would directly contact the ACRT regarding deteriorating patients.
- The sepsis toolkit has recently been launched in order to immediately flag up to staff what actions to take when they enter observations with a high 'NEWS' score. The ACRT are tracking its use and will work with Business Intelligence to ensure useful and timely data is maximised.
- The ACRT is exploring the value in supporting / managing vulnerable patient groups even before they deteriorate. The principle being that at admission it is known that certain patients are high risk or 'vulnerable' ACRT can potentially add an extra layer of protection for them.
- We will be taking part in the Commissioning for Quality and Innovation (CQUIN) scheme for 2022/23 for recording of NEWS2 score, escalation time and response time for unplanned critical care admissions. The NEWS2 protocol is the RCP and NHS-endorsed best practice for spotting the signs of deterioration, the importance of which has been emphasised during the pandemic. This measure would incentivise adherence to evidence-based steps in the identification and recording of deterioration, enabling swifter response, which will reduce the rate of cardiac arrest and the rate of preventable deaths in England. As many as 20,000 deaths in hospitals each year could be preventable and this CQUIN aims to reduce that figure by 4,000. Deterioration is linked to 90% of NHS bed days. Reducing the need f or higher levels of care will free up capacity particularly in ICU by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts.

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

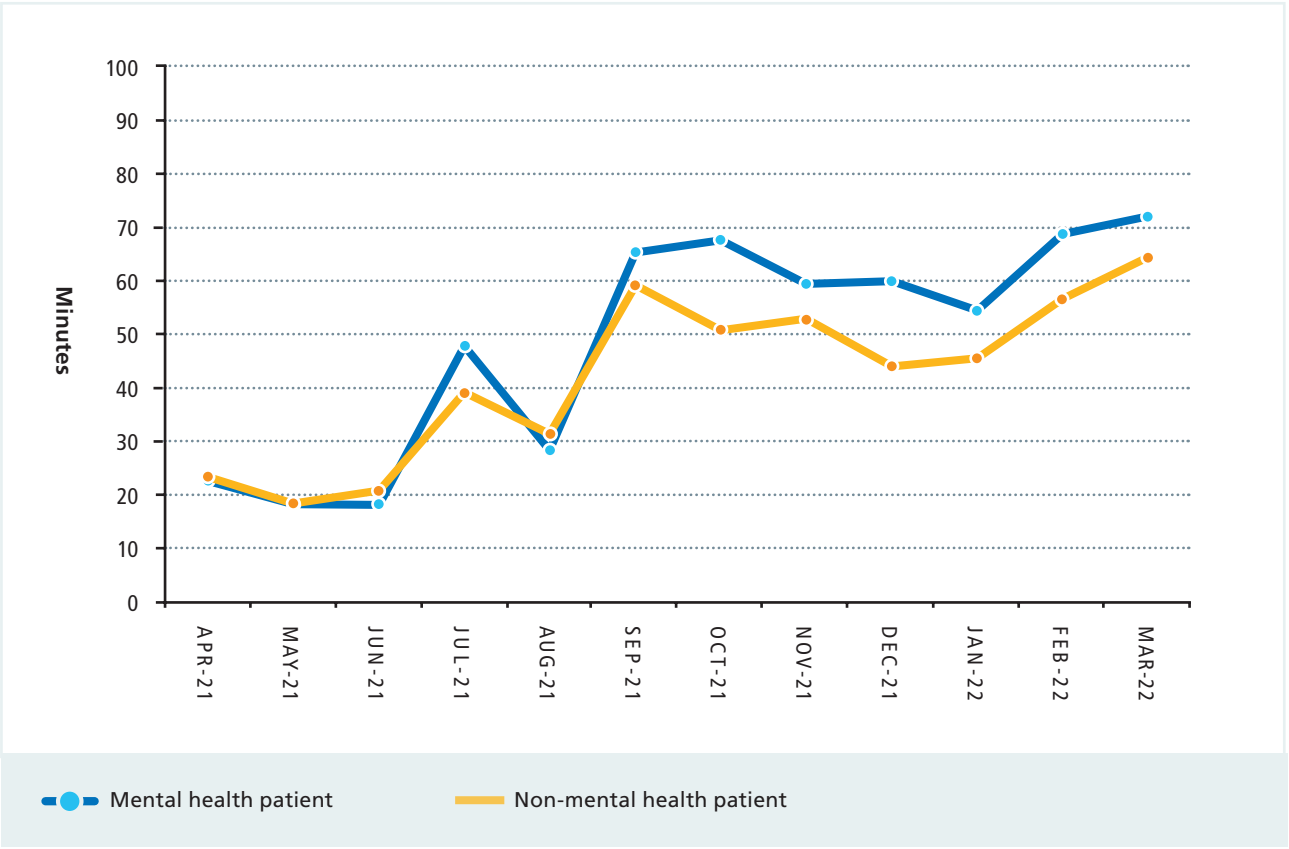
Background

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 2021/22

Leading on from the work of 2021, the Mental Health Working Group has continued its focus across the four main workstreams but also as a driving force behind the development of a trust mental health strategy. Although progress has been made in areas, in the

Fig. 9: Average time to triage for mental health patients compared to non-mental health patients



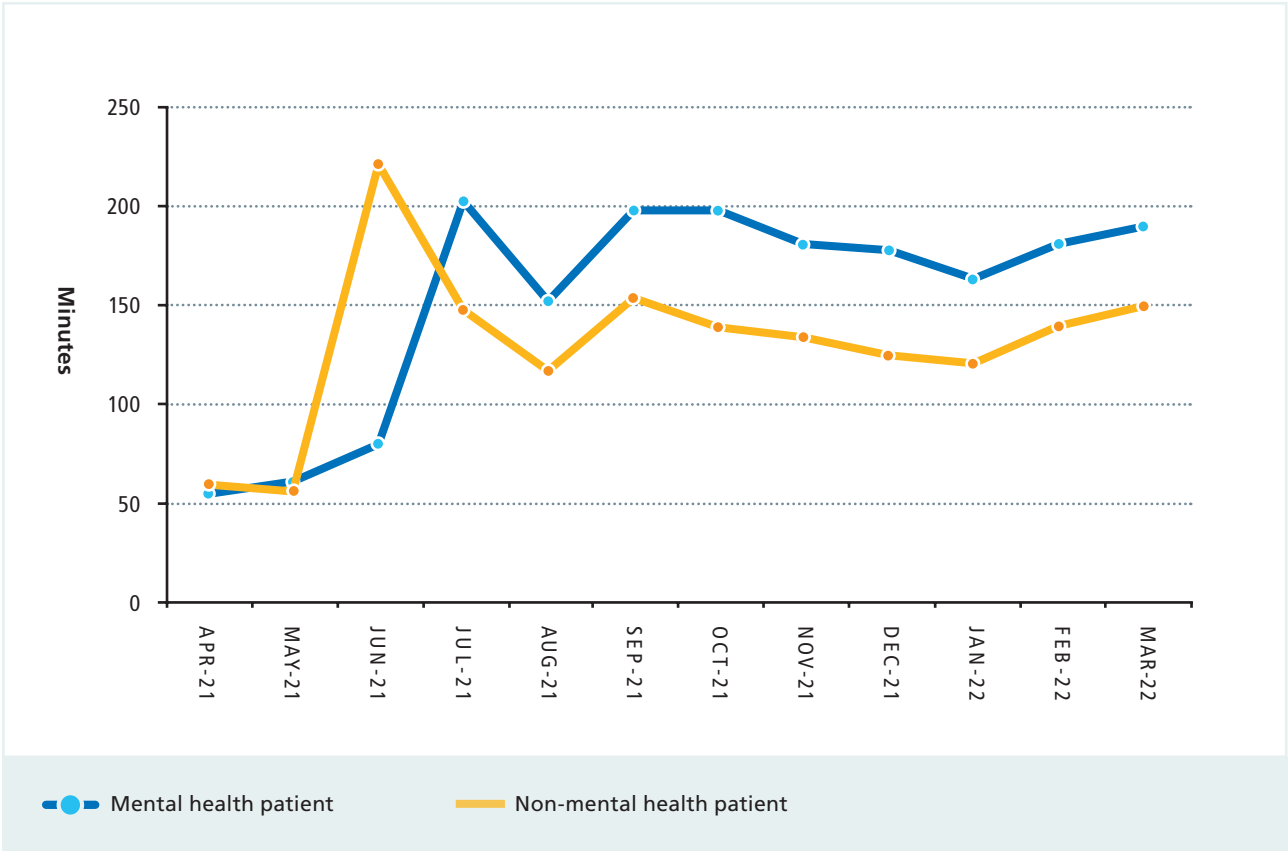
domain of performance we continue to see increasing disparity between mental health and physical health in the metrics, with all Urgent and Emergency Care metrics worsening due to multiple factors (increasing volume, acuity and overcrowding in particular). This has had a disproportionate impact on mental health presentations and consequently we continue to see a widening of time to see clinician time metric and now time to triage metric, which previously had always been fairly well maintained (please see charts below).

There has been progress on a number of areas in our Mental Health improvement plan in our emergency departments, including:

Physical estate and Signposting

- Completion of improvements made to Mental Health Assessment room including soft furnishings and artwork developed and co-created by experts by experience and staff
- Similar improvements to be made to Cheltenham General Hospital assessment space also
- A number of bids have been made to charitable funds for further more comfortable soft furnishings, mobile phone chargers specific

Fig. 10: Average time to clinician for mental health patients compared to non-mental health patients



Patient Flow and patient experience:

- Addressing long delays in a number of ways:
  - Review of risk assessment process and standard operating procedures
  - Co-streaming of patients by members of the liaison psychiatry team directly within the emergency department itself. Allows swift and early identification of those who need specialist mental health input. Particularly beneficial for vulnerable individuals who may not be able to wait.
  - Funding obtained for new role – "Emergency mental Health Practitioner" - The clinician will be based entirely within the emergency department and is a mental health specific practitioner whose only focus is to see and assess patients with mental health presentations. This new dedicated role will result in improvement across all unscheduled care metrics.
- Skill mix and staffing
  - Ongoing local training initiatives on shop floor for all clinicians
  - Foundation doctor shadowing Mental Health Liaison Team for the day – just about to start
  - Training offer from Gloucestershire Mental Health Crisis Care Workforce Development Group for multi-agency training (comprehensive package – online and face to face)
  - Identified requirement for a training needs analysis work which will be subsumed under the mental health strategy workstreams

Specialist services

- Drugs and alcohol:
  - Ongoing work with the drugs and alcohol teams to ensure locally responsive service within the emergency department.
  - Particular focus on opiates with the development of an emergency department specific guideline and the application for naloxone rescue treatment to now be included on the trust formulary.
- Eating disorders:
  - Huge focus of work in this area due to the rapid and huge increase in this presentation
  - Working group has been developed including stakeholders from GHT, GHC and Community eating disorders team
  - Working at pace to launch regular clinical multidisciplinary meeting, develop resources and guidance and systemwide work in place to consider future service models and provision.

High Impact Users Service development

- High impact users – disproportionate accumulation of health inequality, and the majority of these patients involve mental health issues and social isolation
- First Trust in the South West to launch a new monthly MDT clinic – coproduction of personal support plans with patients and clinicians
  - MDT includes: physical health consultant, Pain consultant, Safeguarding specialist, social prescriber, drug and alcohol practitioner and Homeless specialist nurse

- Immediate benefits to patient experience and outcomes including reduction in attendance and admission

In addition to the improvement plan progress, the Trust have been developing a Mental Health Strategy. This work has been co-produced with a cross section of people, including those with lived experience, staff and other key stakeholders.

A steering group was formed to enable clinical and strategic leaders in this trust and partner organisations to oversee and shape the development of the strategy, and a stakeholder reference group was established to provide objective and independent quality assurance of our approach to embedding stakeholder engagement throughout the development of the strategy.

A series of five bespoke engagement events were held between November 2021 and January 2022 to engage a cross section of stakeholders in developing the priorities and content of the strategy. More than 60 individuals participated in the events and shared their own experience and perspectives on the priorities that we should focus on to achieve the aims of this strategy.

Representatives from the steering group and stakeholder reference group have participated in a number of engagement events held in the One Gloucestershire Integrated Care System over the past 6 months, to listen to and understand the views and perspectives of a range of partner organisations and community groups.

The draft strategy has been tested with a small number of key reviewers and focus groups to ensure we have sufficiently considered views of specific groups and taken into account all equality, diversity and inclusion perspectives. Following this engagement, there has been a move away from a Mental Health specific label, to a broader approach about personalised and responsive care.

Plans for improvement 2022/23

This will continue as a Quality Account Indicator for 2022/23, with work continuing against the following areas:

- Within unscheduled care align mental health specific standard operating procedures for both trusts (GHC and GHT) to ensure processes working best for patients – current piece of work
- Operational priority to focus on young person's mental health
- Launch of unscheduled care specific social prescriber
- Look to involve our partners within voluntary and charitable sectors in providing support to patients and staff while in the Emergency Department ie Samaritans and Peer Supporters
- Approval and implementation of the new strategy:

12. 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.

In 2020/21, investment in inpatient diabetes specialist nursing correlated with an increase in the number of medication error incidents being reported. 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.

How we have performed 2021/22

Following from the work in 2021 to build the team, the Trust has invested in our diabetic specialist nurse team and have successfully recruited 2 Band 6 Posts, one of which was a development post from a Band 5.

Initial funding from NHS England has now been successfully converted to substantive establishment which was our ambition set out from the previous year. We still have 2.55 WTE Band 6 to recruit to.

The Benefits realisation of making the Diabetes inpatient service more robust includes:

- Reduced length of stay
- Education of ward staff (both Nursing and Medical)
    - E-learning for diabetes, which although not compulsory is encouraged to be completed by such initiatives such as Insulin Safety week, Hypo awareness week, Diabetes awareness week and World Diabetes Day.
- Reduced prescribing and medication errors
- Emergency admission avoidance
- Retention of existing staff
- Career development opportunities
- Point of contact/advice for urgent discharge reviews
- Ultimately a weekend morning attendance on Wards

The number of medication incidents reported each month can be seen in the table below. Since the introduction of the remote monitoring and additional inpatient nurse workforce implementation the number of reported incidents has continued to increase.

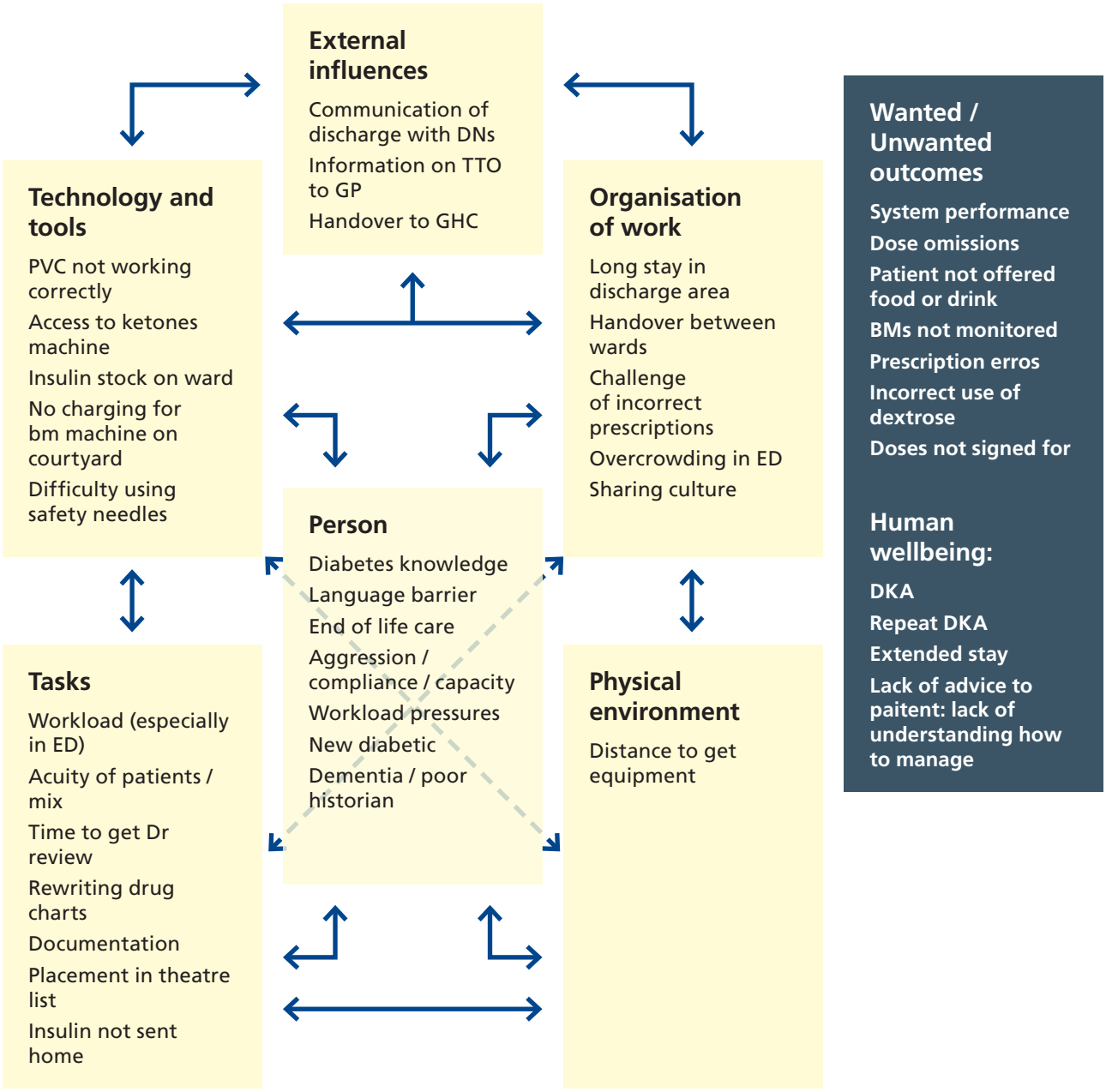
Medication Incidents by date (2021–22)	
Month	**Number**
Feb 2021	25
March 2021	25
April 2021	18
May 2021	28
June 2021	23
July 2021	13
August 2021	9
September 2021	19
October 2021	28
November 2021	17
December 2021	15
January 2022	15

A review of medication incidents in diabetes has highlighted contributory factors and areas where improvements can be made, which will continue to be a focus for improvement in 2022/23.

In 2021/22, a CCG Funded Review was commissioned across the whole service, focusing on identifying and repatriating type-2 patients who could be best managed in the community. This collaboration is ongoing and we are working towards re-assigning approximately 600 patients back to primary care, therefore freeing up opportunity for the specialist team within the acute Trust to focus on inpatients, patients managed with pump-therapy, transitional patients and the increasing antenatal service. Traditionally services such as Pump-therapy require 12 hours of Diabetes Specialist Nurse Contact time and safely commence treatment. With new Libre devices, this requires an hour-long face to face contact with patients in a 1-1 appointment.

The repatriation of Patients to primary care will free up valuable time to manage patients on the GDM App. This allows us to monitor Amber as well as Red measurement patients via text commentary/dashboard, reducing telephone calls and the need for face-to-face appointments, as well as enable greater focus on supporting our inpatients and the improvement programmes in our hospitals.

Medication incidents in diabetes



Plans for improvement 2022/23

This work will continue as a Quality Account Indicator for 2022/23, as a Trust priority, with a focus on continuing to grow and develop the diabetes inpatient service and the improvement programme to reduce the number of medication incidents in diabetes.

- With a more robust staffing structure, the team can target another key area for improvement – the antenatal diabetes service
  - Reduction in pre-term births- reduction in NICU admissions
  - Reduction in women transitioning to pharmacological treatment
  - Significantly higher patient satisfaction with care
  - Significantly better compliance with blood glucose monitoring increased
  - Significant reduction in caesarean sections unless clinically appropriate for other reasons
  - Enhanced education of those women with Diabetes who are considering pregnancy pro-actively

13. To improve our care of patients with dementia

Background

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 and the development of a Dementia Improvement Plan.

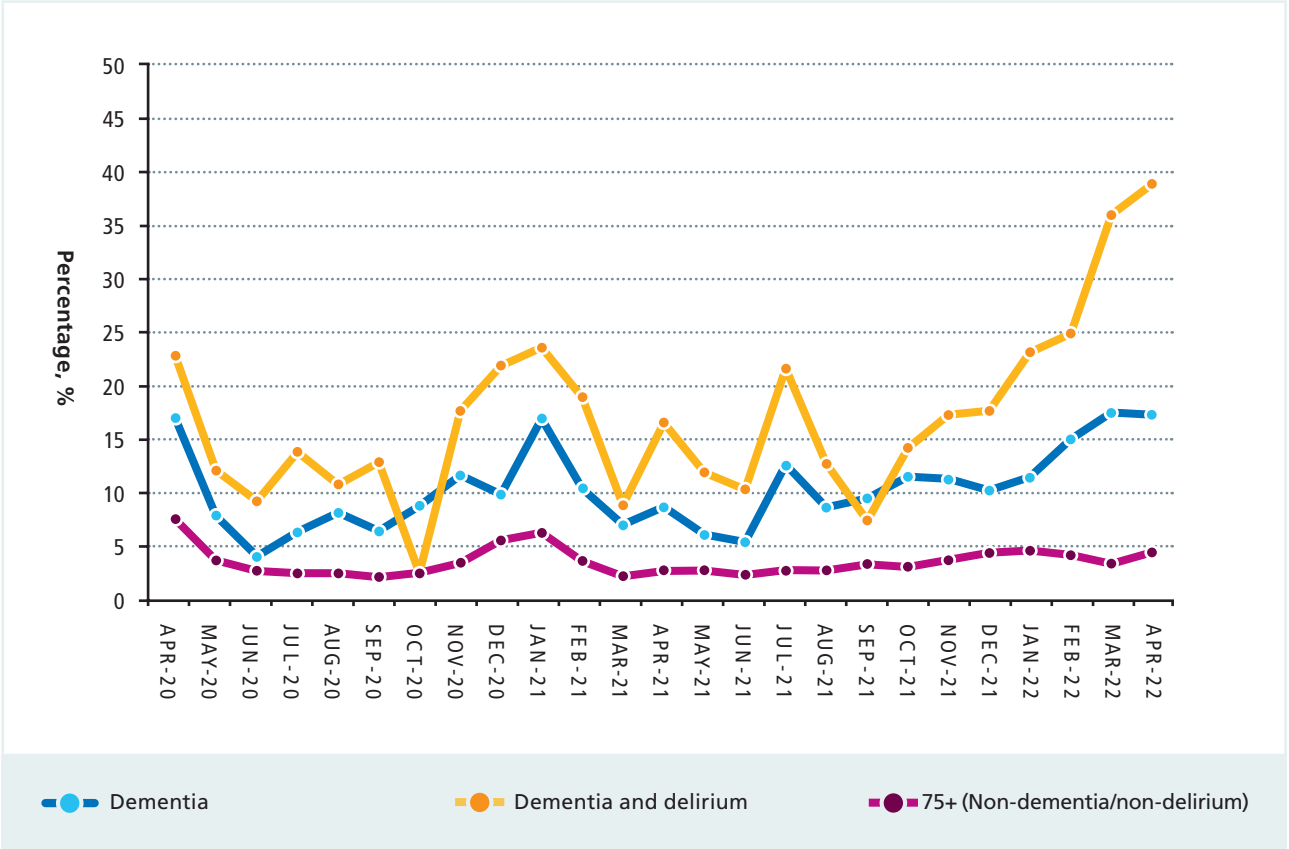
How we have performed 2021/22

Over 2021/22 work has continued to address the 3 priorities set out in the Trust's Dementia Improvement Plan (DIP):

- Improve the Trust's performance in national dementia quality indicators and audit

During 2021 NHSE suspended the Dementia Assess Refer (FAIR) quality indicator, confirming its retirement in September 2021. However aspects of the indicator are relevant to the DIP, such as delirium screening and assessment and are included in the Dementia Dashboard.

Fig. 11: In hospital mortality rate



The RCP's National Audit of Dementia (NAD) is a biennial audit that was last completed in 2018. The NAD team paused the 21/22 Round 5 audit, instead testing data collection and audit tools. Previous NAD audits were challenging in terms of the resources needed to collect the data manually from patient records, and separately for both hospitals. Business Intelligence (BI) analysts have worked hard to improve electronic data extraction for the NAD audit, successfully reducing the manual audit component and NAD have agreed to accept a single submission.

BI have further developed the Dementia Dashboard so that it is accessible on Insight and updated monthly. The Dementia Dashboard underlines the significantly poorer outcomes for 75+ with dementia and delirium (as seen in the graph below), experiencing more bed moves and longer length of stay. It is also worth noting that bed moves can lead to delirium, further compounding the issues.

- Develop a delirium pathway that aligns to an ICS approach

The 2019 Get It Right First Time (GIRFT) review recommended that the Trust develop a delirium clinical pathway and Mental Health Liaison Team's (MHLT) have produced both dementia and delirium clinical pathways available on the intranet. Work is continuing to include delirium screening & assessment tools on the Electronic Patient Record (EPR) system.

We have also worked with ICS partners to raise the profile and impact of unrecognised delirium by championing the need for a system-wide approach to delirium. GHT engaged in a delirium awareness raising campaign and contributed to a One Gloucestershire Delirium guide for family/friends.

An effective partnership has been established between Admiral Nurse (AN), MHLT and Care of The Elderly to reduce duplication of referrals, improve consistent communication with wards and families, and provide quick access to specialist advice. This way of working led to a Dementia & Delirium MDT proposal to case find patients with dementia and those with delirium or at risk of delirium on admission. The MDT would either allocate & case-manage complex patients or direct support to the ward. The additional resources in the team would offer:

- AN cover at both sites
- Health Care Assistant (HCA) support to ANs for both sites
- dedicated MHLT support
- Access to specialist support out of hours and weekends.

The proposal needs a decision on whether/how to progress but in the short term, Dementia UK (Admiral Nurse) have secured a non-recurring grant of £50K to fund a second AN for 1 year and the Trust 3 months funding for the HCA posts.

- Develop a Trust Dementia Training Pathway to improve workforce awareness and skills

Trust dementia training was offered by a number of practitioners so a mapping process was undertaken by setting up a Dementia Training Community of Practice (CoP) with ICS training partners. Outcomes include:

- improved record of training delivered
- training content is up to date/consistent and includes signposting to AN and carers organisations
- aligns with county Dementia Training & Education Strategy (DTES)

- Included in Ward Managers and Porters training requirements.

The Trust's online dementia and delirium training modules are now revised and updated, with the dementia modules reduced from two to one.

The AN continues to deliver face to face training to support staff need and supports teams/departments to address specific issues. The AN also works closely with community partners such as Community Dementia Nurses, Complex Care @ Home Team and Dementia Advisors.

Plans for Improvement 2022/23

Work will continue in 2022/23 on the dementia improvement plan, with a particular focus on reducing multiple bed moves for patients 75+ with dementia and/or delirium. A pilot study of an approach documenting RAG risk to the patient from move was tested, providing additional data on falls and delays to discharge. Omicron has delayed next steps to date but work will continue in 2022/23.

14. 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 four priority standards. Trusts were required, each year, to complete 7 Day Service self-assessments to understand if these standards were being met.

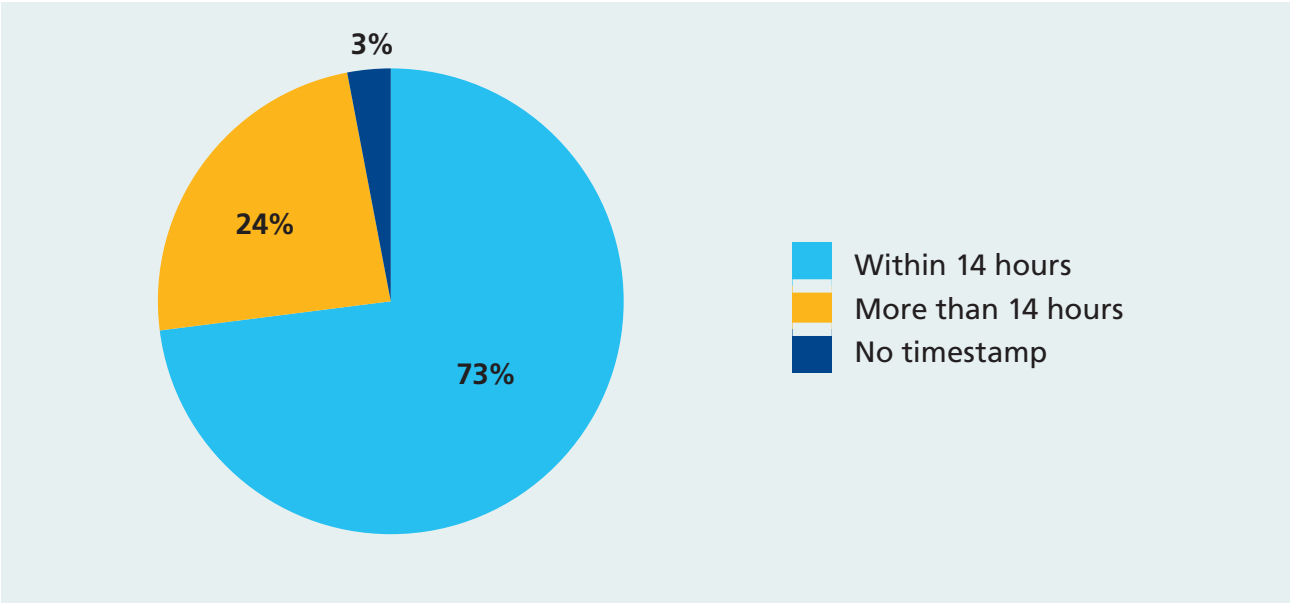
An audit of the ten clinical standards took place in July 2019 and the audit evidenced that two standards were not being met:

- 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.

Amount of time between deciding to admit and post take ward round



How we have performed 2021/22

This work has been led by the current chief registrar (Dr Giovanna Sheiybani) with support from Prof Mark Pietroni. The last audit was from 2020 and the re-audit for 2021 was unfortunately delayed due to Covid.

The focus of the re-audit was on time to first consultant review within medicine to keep the scope focused, and to allow PDSA cycles to be tested here which can be rolled out. The decision to admit time to consultant review was measured.

The main conclusion is that we are still falling below the national standard for medicine (our current position is at 73% vs national standard of 90%) and this varies depending on weekdays vs weekends and what time of the day the patient was clerked (see graph above).

This is not directly comparable to the previous audit as the time was measured from front door rather than decision to admit.

The team involving the Chief Registrar, a group of SHOs and input from acute medical consultants, have completed process mapping exercises as part of their QI work and developed a driver diagram.

From this work, one of the biggest issues identified was not having a proper take list or post-take list that has patients in time order. The first PDSA cycle coincided with the launch of the electronic clerking and take list (both of which the Chief Registrar has inputted in due to the results of this QI work).

As part of this QI work, the following measures have been identified:

- Outcome measure:
- Time from DTA to first consultant review
- Process measures:
- Time taken to clerk patients
- Time from clerking to first consultant review
- Balancing measures:
- Time of seeing patients of NEWS >4

Once launched, these measures will be tracked using SPC charts, and the team are aiming for three PDSA cycles focused on the take list and the process of post taking patients. Reporting will be supported by the EPR team.

Plans for improvement 2022/23

This work will continue in 2022/23, led by the Chief Registrar, supported by the Medical Director and our EPR teams. The PDSA cycles will be evaluated, and reporting developed, and work continuing on the wider quality improvement programme.

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 2021/22 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 2021/22 financial year.

Information on participation in clinical audit

From 1 April 2021 to 31 March 2022, 50 national clinical audits and 3 national confidential enquiries covered relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 96% national clinical audits and 100% national confidential enquiries which it was eligible to participate in. Participation was suspended or delayed for some audits due to ongoing Covid recovery, in line with national agreements. 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 were appropriate to Gloucestershire Hospitals NHS Foundation Trust during 2021/22 are as follows:

	Eligible	Participated	Status
Case Mix Programme (CMP)	Yes	Yes	Ongoing
Chronic Kidney Disease registry	Yes	Yes	Ongoing
British Spine Registry	Yes	Yes	Ongoing
Elective Surgery (National PROMs Programme)	Yes	Yes	Ongoing
Emergency Medicine QIPS (RCEM): Pain in Children (care in Emergency Departments)	Yes	Yes	Ongoing
Emergency Medicine QIPS (RCEM): Severe sepsis and septic shock (care in Emergency Departments	No	N/A	Cancelled
Falls and Fragility Fractures Audit programme (FFFAP): Fracture Liaison Service Database	No	N/A	N/A
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	Yes	**Yes**	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	Yes	**Yes**	Ongoing
Inflammatory Bowel Disease (IBD) Audit	Yes	No	N/A
LeDeR - Learning Disabilities Mortality Review	Yes	Yes	Ongoing
Maternal, Newborn and Infant Review Programme Clinical Outcome	Yes	Yes	Ongoing
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death)	Yes	Yes	Ongoing

	Eligible	Participated	Status
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Transition from Child to Adult services	Yes	Yes	Ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Epilepsy	Yes	Yes	Ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Crohn's Disease	Yes	Yes	Ongoing
National Asthma and COPD Audit Programme (NACAP) - Adult asthma secondary care	Yes	Yes	Ongoing
National Asthma and COPD Audit Programme (NACAP) - Paediatric asthma secondary care	Yes	No	Ongoing
National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Ongoing
National Audit of Cardiovascular Disease Prevention	No	n/a	n/a
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Completed
National Audit of Dementia (NAD)	Yes	Yes	Completed
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

	Eligible	Participated	Status
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	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
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Yes	Yes	Ongoing
National Child Mortality Database	Yes	Yes	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Ongoing
National Comparative Audit of Blood Transfusion - 2021 Audit of Patient Blood Management & NICE Guidelines	Yes	Yes	Completed
National Comparative Audit of Blood Transfusion - 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	No	N/A	N/A
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Ongoing

	Eligible	Participated	Status
National Gastro-intestinal Cancer Programme - National Oesophago-gastric Cancer	Yes	Yes	Ongoing
National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	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 Paediatric Diabetes Audit (NPDA)	Yes	Yes	Ongoing
National Perinatal Mortality Review Tool	Yes	Yes	Ongoing
National Prostate Cancer Audit	Yes	Yes	Ongoing
National Vascular Registry	Yes	Yes	Ongoing
Out-of-Hospital Cardiac Arrest Outcomes Registry	No	N/A	N/A
Respiratory Audits - National Outpatient Management of Pulmonary Embolism	No	N/A	N/A
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	Ongoing
Serious Hazards of Transfusion (SHOT)	Yes	Yes	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	Complete

	Eligible	Participated	Status
Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Yes	Yes	Ongoing
The Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing
UK Cystic Fibrosis Registry	Yes	Yes	Ongoing
Urology Audits - Cytoreductive Radical Nephrectomy Audit	No	N/A	N/A
Urology Audits - Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Yes	Yes	Complete

Ongoing – relates to continuous data collection, or data collection where the deadline has not yet ended

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Case Mix Programme (CMP)	The CMP is an audit of patient outcomes from adult, general critical care units covering England, Wales and Northern Ireland. 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. Specific COVID reports and rapid mortality meetings continue. The reports provide information on mortality rates, length of stay, etc. and provide the Trust with an indication of our performance in relation to other ICUs. Where trends are identified, these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society. Standardised mortality rates in both units remain below 1 over the year. Despite the exceptional year in relation to the continued pandemic, both units are performing above national standards in areas assessed. Separate COVID reports suggest both units are meeting standards with similar admission demographics – with better survival outcomes than national average. The Trust also demonstrated the local model of running a RHC worked exceptionally well in only admitting sicker patients to ICU. This also resulted in better outcomes; with less elective surgery cancellations, low numbers of capacity transfers.
Chronic Kidney Disease registry	The UK Renal Registry (UKRR) collects and reports data annually on approximately 70,000 kidney patients on renal replacement therapy (RRT) in the UK. The Trust continues to participate in the registry. Data is submitted via the renal data system with a quarterly annual validation and query resolution. The 2021 report is due to be discussed summer 2022. Registry data also feeds in to other audit / QI activity and is discussed in other meetings, such as GIRFT, regional Kidney Quality Improvement Partnership, renal regional network. The audit publication is mainly reviewed as a quality assurance exercise to ensure Trust compliance. Local audit activity (alfacalcidol use and parathyroid hormone levels, line infection rates, PD tube complications) is often driven by registry report findings.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
British 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.
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, which are used as part of their appraisal.
Emergency Medicine QIPS (RCEM) - Pain in Children (care in Emergency Departments)	The purpose of this Royal College of Emergency Medicine (RCEM) QIP is to improve patient care by reducing pain and suffering. The RCEM will identify current performance in EDs against nationally agreed clinical standards and show the results in comparison with other departments. Data collection continues until October 2022.
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient	The National Audit of Inpatient Falls (NAIF) is a national clinical audit and part of the Falls and Fragility Fracture Audit Programme (FFFAP) managed by the Royal College of Physicians. This audit measures compliance against national standards of best practice in reducing the risk of falls within acute care. In this reporting period there has been an interim and final report. These reports are reviewed at Quality Delivery Group every 3 months. The falls annual plan has been updated to include recommendations following report publication.
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	The National Hip Fracture Database (NHFD) was established to measure quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform. The Trust completes online viewing as soon as the report is released (Dec 2021). Improvement work continued around consolidation and embedding of previous years' actions, together with looking at additional theatre availability. This year saw the continued 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	The Trust submit data annually to the NHSI Learning Disability and Autism Benchmarking Audit. A patient survey is also sent out to every patient with a learning disability who has used Trust services during the year being audited, and it is a requirement to ask staff to complete a parallel survey. For the 2020/2021 survey, QR code posters were put up around the whole Trust to capture staff from all areas of work. Following previous patient survey feedback, Best Interests leaflets are now used and are likely to be used countywide by other providers, as the quality has been appreciated by everyone. Changing Places toilets were opened during the last year, offering the same level of privacy and dignity for severely disabled visitors to our hospitals as those without disabilities can expect. The NHSEI Benchmarking audit results were taken to the LD Steering Group and then reviewed at Safeguarding Strategy Group and thence to Quality and Performance Committee. An improvement plan was written based on the deficits and monitored by this same governance structure. The Trust was not a national outlier, but as the Trust is not exclusively a Learning Disabilities healthcare facility, it should not be expected to be in the top centile. Data for the 2020/2021 survey was submitted on time and is being analysed, but it has been identified that the Complaints and Adverse Incidents data needs to be disaggregated, so a change request has been put in for Datix and Datix Cloud.
Maternal, Newborn and Infant Review Programme Clinical Outcome	The Trust continues to participate in MBRRACE-UK data reporting. This report includes surveillance data on women who died during or up to one year after pregnancy between 2017 and 2019 in the UK. In addition, it also includes Confidential Enquiries into the care of women who died between 2017 and 2019 in the UK and Ireland from mental health-related causes, venous thromboembolism, homicide and malignancy. The report also includes a Morbidity Confidential Enquiry into the care of women who gave birth aged over 45 years. Surveillance information is included for 495 women who died during or up to one year after the end of pregnancy between 2017 and 2019. The care of 37 women who gave birth aged over 45 years was reviewed in depth for the Confidential Enquiry chapter.

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 Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The reports for this year's studies have not yet been published. Previous years' reports for the Pulmonary Embolism Study and the Time Matters, Out of Hospital Arrest Study were disseminated and reviewed at the appropriate team meetings.
National Asthma and COPD Audit Programme (NACAP) - Adult asthma secondary care	NACAP aims to improve the quality of care, services and clinical outcomes for patients with asthma and COPD. NACAP includes strong collaboration with asthma and COPD patients, as well as healthcare professionals, and aspires to set out a vision for a service which puts patient needs first. The adult asthma clinical audit is a component of the National Asthma and COPD Audit Programme (NACAP) There have been a number of periods where the Trust's work on the asthma part of the audit has had to be paused because of COVID, winter pressures and lack of resource and time to enter cases. This has reduced the number of cases entered. The intention is to start up data entry again now things are settling down. This may be impacted by limited resources including staff sickness.
National Asthma and COPD Audit Programme (NACAP) - Paediatric asthma secondary care	The children and young people (CYP) asthma audit is a component of the National Asthma and COPD Audit Programme (NACAP). The Trust did not have capacity to participate in the audit until this year. In terms of Quality Improvement, the Trust now has a local Paediatric Asthma Lead. Time has been spent working with the CCG on the CYP Asthma care Bundle. Bristol Children's Hospital are in the process of developing a regional Asthma network.
National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	NACAP is a programme of work that aims to improve the quality of care, services and clinical outcomes for patients. NACAP includes strong collaboration with asthma and COPD patients as well as healthcare professionals, and aspires to set out a vision for a service which puts patient needs first. In relation to COPD, the Trust has made improvements in our discharge bundle completion, which now sits above the regional and national average. The workforce has undergone a lot of change and the IT infrastructure still limits our ability to identify patients, but improvements are continually being made.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Audit of Breast Cancer in Older People (NABCOP)	NABCOP is a national clinical audit run by the Association of Breast Surgery (ABS) and the Clinical Effectiveness Unit (CEU) of the Royal College of Surgeons of England (RCS). The aim of NABCOP is to support NHS providers to improve the quality of hospital care for older patients with breast cancer by publishing information about the care provided by all NHS hospitals that deliver breast cancer care in England and Wales, and looking at the care received by patients with breast cancer and their outcomes. The NABCOP audit pulls the anonymised data it requires automatically. The Trust reviews cases and reports at specialist departmental meetings. The NABCOP Patient information sheet for >70s is now used within clinics.
National Audit of Care at the End of Life (NACEL)	The Trust participated in round 3 NACEL 2021 and is currently awaiting the publication of the report. NACEL is designed to measure the experience of care at the end of life for dying people and those important to them, and to provide audit outputs which enable stakeholders to identify areas for service improvement.
National Audit of Dementia (NAD)	The National Audit of Dementia (NAD) measures performance of general hospitals against standards relating to care delivery which are known to impact people with dementia while in hospital. NAD introduced a pilot audit of electronic data collection in which the Trust participated. Not all data was captured due to the electronic data collection, so NAD and the Trust are looking at different ways to capture data. Although NAD did not release a report last year, the following initiatives have been set up in the trust: 1: Purple protects in ED (an initiative set up to help identify people with cognitive impairments and thus to use purple items as a way of keeping them safe) 2: All about Me boards - on CoTE wards - a quick and easy way to communicate needs of people with dementia (this is due to be rolled out to other medical wards) 3: QI work on environmental changes that can be made to keep our hospitals safe - dementia friendly wards / spaces 4: Dementia and Delirium e-learning packages for staff have been reviewed and updated 5: Work is ongoing to try to reduce ward moves for people with dementia

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. The Trust continues to provide data and but some data collection deadlines have been missed due to clinical commitments and staff absences. The Trust are meeting with the Royal College of Paediatrics and Child Health who organise the audit to agree the best way forward. Reports are reviewed at the epilepsy multi-disciplinary team meeting, to review the recommendations and outcomes.
National Bariatric Surgery Registry (NBSR)	The National Bariatric Surgery Register is a comprehensive, prospective, nationwide analysis of outcomes from bariatric surgery in the United Kingdom and Ireland. It contains pooled national outcome data for bariatric and metabolic surgery in the United Kingdom. All cases performed in Gloucester are submitted to NBSR. These are then reported on the NBSR Website. The results are presented at the SQAG (Surgical Quality Assurance Group) Meeting and at the Upper GI Surgical Governance Meeting.
National Cardiac Arrest Audit (NCAA)	The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland. The aims of the audit are to: improve patient outcomes; decrease incidence of avoidable cardiac arrests; decrease incidence of inappropriate resuscitation; and promote adoption and compliance with evidence-based practice. All reports are reviewed as a department as well as within the Deteriorating Patient & Resuscitation Committee quarterly. The reports have also been made available on the Deteriorating Patient & Resuscitation Committee drive so that they can be accessed and be reviewed by appropriate clinicians who require access. The Trust also publishes the results quarterly in a newsletter that is made accessible on the Intranet as well as staff notice boards, and shared with department heads for dissemination. The Trust continues to share the results at Induction sessions. Any inappropriate CPR attempts are highlighted and reviewed, and if appropriate, simulated to help focus teaching and lessons learned. The Trust is in the process of using data to further investigate situations prior to the event by working closely with the Acute Care Response Team.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	The NACRM report details activity in cardiac rhythm management (CRM) device and ablation procedures for England and Wales and, where possible, Scotland and Northern Ireland in 2019/20. The Trust continues to participate in the NICOR programme. The report is seen by Specialists, Clinical Leads and all members of the pacing sub- speciality. It is discussed weekly at the Gloucestershire Arrhythmia Group (GAG) meeting. The NICOR data has a focus on numbers and the completeness of the data. It is acknowledged that the numbers for the centre are low. A local complications audit is also carried out and presented at the GAG alongside the countywide audit.
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	The data is used centrally to produce an annual NCAP report and also presented at the annual meeting of the representative specialist body, the British Cardiovascular Intervention Society. A local audit is produced on an annual basis also, presented at one of the departmental audit meetings. The Trust is an outlier in that we do not provide a 24/7 PPCI service as recommended by BCIS and, more recently, GIRFT. The principal reasons for this are shortages in certain staff groups (radiographers) that we share with other specialities and also inability to manage our speciality bed base.
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	The Myocardial Ischaemia National Audit Project (MINAP) was established in 1999 to examine the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales. The Trust continues to enter all patients who are admitted with Acute coronary syndromes onto both our sites (GRH & CGH) using NICORs web portal. The current data and report will be reviewed at the Cardiology Audit meeting at the end of Q1 2022. The reports will be used to inform Quality improvements. The Trust continues to work on improving its data completeness and timeliness of entering the information.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	The National Heart Failure Audit is part of the National Cardiac Audit Programme (NCAP), the audit aims to improve the quality and outcomes of care for patients with unscheduled admission to hospital with heart failure. It captures data on clinical indicators which have a proven link to improved outcomes and encourages the increased use of clinically recommended diagnostic tools, disease-modifying treatments and referral pathways. The report was reviewed at the Cardiology audit meeting in December 2021, with a presentation on the report and the current year's progress. The Trust is compliant with the required data entry and in addition to the annual report review, a quarterly analysis is performed.
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Audit Harms (NaDIA-Harms)	The National Diabetes Inpatient Audit (NaDIA) –Harms is designed to help reduce serious inpatient harms identified by the NaDIA snapshot audits. This helps to enable NHS trusts to identify and analyse local occurrences of these key inpatient harms, supporting local quality improvement (QI) work. The Trust has continued to participate in the NaDIA alongside the core National Diabetes Audit. A seminar has recently taken place as a collaborative approach to review the most recent publications with a view to looking at improved ways of reviewing key life-threatening diabetes specific inpatient events (harms) and understanding why they have occurred. Across the Trust there have been updates to the inpatient prescription charts and updated protocols for managing hyperglycaemia on the wards. Other initiatives have included development of an e-learning package and enteral feeding charts being trialled, applicable to the surgical wards.
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	The National Pregnancy in Diabetes (NPID) Audit measures the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes. The report aims to support local, regional and national quality improvement in relation to diabetes in pregnancy. Data has been submitted for all T1/T2DM pregnancies managed in the Trust. Data is published nationally and usually reviewed at annual Diabetes in Pregnancy conference. There is an ongoing focus on diabetes care in pregnancy in the department. Because of evidence of poor pre-conception care nationally for the audit, the Trust has provided training to primary care and now has a pre-conception case load managed by our specialist team.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	The National Diabetes Audit (NDA) provides a comprehensive view of diabetes care in England and Wales. It measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards. The Type 1 Diabetes report details the findings and recommendations relating to diabetes care process completion, treatment target achievement and structured education for people with Type 1 diabetes. The Trust participates in the NDA and reviews recommendations that are applicable, alongside the National Diabetes Inpatient Audit Harms (NaDIA-Harms) audit.
National Child Mortality Database	National Child Mortality Database (NCMD) publications provide the Trust with recommendations to support improvement to services based on national review data. Publications are reviewed and actioned as appropriate.
National Early Inflammatory Arthritis Audit (NEIAA)	The National Early Inflammatory Arthritis Audit (NEIAA) is looking in detail at what happens to patients over 16 years of age in England and Wales with suspected early inflammatory arthritis (EIA) when they are referred to a rheumatology service. Timelines to referral and being seen in a specialist service are collected for all patients with suspected inflammatory arthritis; more detailed information is collected over a 12-month period for all patients with a confirmed rheumatoid arthritis (RA) pattern of inflammatory arthritis. The Trust has continued to participate in this audit for the 2021/22 period.
National Comparative Audit of Blood Transfusion - 2021 Audit of Patient Blood Management & NICE Guidelines	The 2021 Audit of Patient Blood Management (PBM) & NICE Guidelines audit is part of the National Comparative Audit of Blood Transfusion (NCABT) programme. It provides the opportunity to: evaluate local evidence of compliance with the four quality statements in the NICE Quality Standard for Blood Transfusion, to provide data to hospital teams to allow their understanding of what steps they can take to implement PBM, to measure their effectiveness in improving patient care, and to allow the transfusion community to benchmark the progress of PBM and its effect on improving patient outcomes. The report was reviewed and identified good practice regarding clinical review and potential improvement opportunities relating to documentation of blood transfusion consent. A new transfusion care record was introduced in December 2021 and this should significantly improve consent documentation. The Trust also plans to repeat the PBM audit against the NICE standards locally on an annual basis.

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 Emergency Laparotomy Audit (NELA)	Data continues to be uploaded to the NELA website, with quarterly joint surgical and anaesthetic NELA meetings to review results. Improvement projects and data reviews looking at pre-op sepsis, post-op delirium and the introduction of 'dignity boxes' with the aim of keeping glasses, hearing aid etc. with the patient ongoing.
National Gastro-intestinal Cancer Programme - National Oesophago-gastric Cancer	The Trust submits data for the NOGCA. The reports are reviewed at the appropriate specialty and governance meetings when they are published.
National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	The Trust continues to submit data to NBOCA to assess the quality of care and outcomes of patients diagnosed with bowel cancer in England and Wales. NBOCA highlighted GHNHSFT as a potential negative outlier for 18-month stoma rate after major resection. Following a local review of cases submitted, it was found that due to various factors, a proportion of cases should not have been included within the results. Reducing the impact of any patients waiting longer than necessary for stoma closure is an area of focus in improving our overall colorectal cancer care
National Joint Registry (NJR)	The National Joint Registry (NJR) collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery. The results of the NJR are shared with the Medical Director and Chief Executive, and are discussed at hip and knee MDT meetings amongst all hip and knee surgeons. Individual reports are used as part of the appraisal process. New implants have been introduced to improve periprosthetic fracture rate. This year's National report has not yet been released but will be discussed alongside the Trust Annual report when published.
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.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
National Maternity and Perinatal Audit (NMPA)	Maternity and perinatal services in the UK are currently subject to a number of maternity and neonatal review programmes, including quality monitoring and improvement initiatives. These programmes focus attention on the quality of care provided by maternity services in the UK at both a national level and the individual trust or board level. The Trust has continued to participate in data collection for the National Maternity and Perinatal Audit (NMPA), which uses the data to produce information that can support the improvement of maternity and perinatal care
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care	The NNAP assesses whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high quality care, and identify areas for quality improvement. The Trust reviews the report during the year, with quarterly reviews of data, so it can be seen where improvement is needed. Posters are provided for dissemination of results to staff and parents. Usually, the Trust is above National levels in most of the key areas. Where the Trust falls below, the causes are looked into, and Quality Improvement Initiatives are set up to help – for example, with admission temperatures. It should be considered, that the data in the NNAP report is not always in alignment with what it is felt that the Trust has submitted. The Trust has been positive outliers in some areas and negative in others. The pandemic contributed to this, especially with 2yr follow-up data, as so many face-to-face clinics were cancelled.
National Paediatric Diabetes Audit (NPDA)	The NPDA is delivered by the Royal College of Paediatrics and Child Health (RCPCH). Data is submitted by Paediatric Diabetes Units (PDUs) in England and Wales about the care received by children and young people with diabetes using their service. The annual report published this year (data April 2019 - March 2020) showed GHNHSFT to have results within the national average for responses, whilst HbA1c, BMI, thyroid testing, blood pressure and eye screening are above National average for England/Wales (nearly 100%). The result for foot exam screening of 84.3% is consistent with the national average and has been found to relate mostly to DNA/recording.

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 Perinatal Mortality Review Tool	The Trust continues to participate in data collection for the National Perinatal Mortality Review Tool (PRMT). The PMRT's third annual report shows there have been modest improvements in the way hospital reviews have been undertaken across the UK over the 12-month period spanning the pandemic. These improvements have been made against the backdrop of extreme pressures on the NHS during an unprecedented global health crisis. While progress has been made in reducing the number of baby deaths in the UK, 14 babies still die every day, and many of these deaths remain potentially preventable. Robust implementation of the PMRT is key in addressing this.
National Prostate Cancer Audit	The National Prostate Cancer Audit (NPCA) is a national clinical audit assessing the process and outcome measures from all aspects of the care pathway for men newly diagnosed with prostate cancer in England and Wales. The findings help to define new standards and help NHS hospitals to improve the care they provide to patients with prostate cancer. The Trust submits data for NPCA and reviews the reports at the appropriate specialty and governance meetings when they are released. There is a clear improvement between the 2020 and 2021 data for the Trust. The improvements and developments made in service delivery has moved the Trust from an outlier to comparable and potentially better than the national average.
National Vascular Registry	The NVR data entry system is a secure online database where vascular specialists working in NHS hospitals in the UK can enter their data for vascular procedures they carry out. 100% of data is extracted from the NVR database. The reports are reviewed at the specialty meetings and there are no reported actions.

Audit title	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 report is reviewed in Stroke Monthly business meetings. 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. With a system of Score A (best) to E (worst), the Trust scored B for the first 3 quarters, and D in the last, challenged by bed pressures and difficulties due to accessing stroke beds and Covid issues. The Trust has redesigned the stroke service and moved HASU to CGH from 1st February, so is intending to see improvements.
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 ongoing with particular focus on identifying potential improvements to ensure transfusion delays are avoided.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
Society for Acute Medicine Benchmarking Audit (SAMBA)	The Society for Acute Medicine Benchmarking Audit (SAMBA) 2021 provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 17th June 2021. This report is written for the benefit of all those involved in acute medical care, including healthcare professionals, healthcare commissioners, all UK governments and, most importantly, patients and public. This was the first clinical data collection for SAMBA since the start of the Covid-19 pandemic. Since the last round of SAMBA in January 2020, acute medicine services have worked through periods of intense pressure, rapidly adapting to changes in service pressures, clinical need, and measures for patient safety that have often required widespread physical reconfiguration of services. The Trust was a participant in the 2021 audit.
Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment (RESECT)	RESECT aims to conduct a retrospective and prospective, multicentre, international study of urological practice of the management of non-muscle-invasive bladder cancer (NMIBC). The primary objective is to determine if audit and feedback can improve the quality of TURBT surgery and reduce early recurrence rates. The Trust is participating but no report has been published as yet.
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 measures.

Audit title	Details of the audit, and where the report was reviewed, and what actions were taken as a result of audit/use of the database?
UK Cystic Fibrosis Registry	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. The CF Registry provides data used by the Trust to compare as a site against either Bristol or nationally. Bristol is in line with most data sets published in the summary for example BMI, mean FeV1, IV courses. The Trust completed data submission for 2021 with a total of 37 patients. The report from the previous year is published in early summer and is usually shared at the AGM in July. It is also disseminated by the CF Registry team to data managers/ centre/site leads. The Trust is significantly above average for use of mucolytic nebulisers, due to having very proactive doctors and physio team. The Trust is lower than average in chronic pseudomonas infection. A main goal at present is the rollout of CFTR modifiers.
Urology Audits: Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Management of the lower end of ureter in nephroureterectomy varies widely because there is no clear evidence as to which procedure offers the best cancer control. The aims of this audit are: to determine which surgical technique offers the best cancer control in terms of survival and recurrence; to capture patient profiles at entry; to determine whether the different procedures are performed without significant morbidity; and to establish the recurrence and survival rates of patients who underwent procedures between 1 January 2017 and 31 December 2019. The Trust participated in this audit and currently awaits the report. The local data was presented and reviewed at the Urology QI meeting January 2022.

Local clinical audits

The reports of 120 local clinical audits were registered in 2021/22 and these are reviewed and actioned locally.

This includes 13 'Silver' quality improvement projects which graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2021/22 (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?
Improving Postnatal Bladder Care	Bladder care is an important aspect of management in the postpartum period. Postpartum voiding dysfunction occurs in a significant number of women, which can potentially cause permanent damage to the detrusor muscle and long-term complications when left undetected or untreated. Previously once midwives were qualified, they had very little to no training on postnatal bladder care. The Urogynaecology Department would frequently be asked for advice and guidance and the postnatal bladder care pathway could be hard for midwives to interpret without any guidance or training. A QIP was introduced to ensure that all midwives have bladder care training as part of their mandatory training. The changes have made a benefit in improving documentation of postnatal bladder care and confidence of midwives treating these ladies postnatally. In order to ensure this improvement is sustained, there will be continuation of Postnatal Bladder Care to Midwives on mandatory training and a review of midwives' confidence and knowledge scores. It is also planned that Bladder Care "Champion" midwives will be present on wards to offer additional support and to be trained further in teaching of intermittent self-catheterisation (ISC).
Traction Removal of PEG tubes in Outpatients for Head & Neck Cancer Patients	Following treatment for head & neck cancer, patients are keen to have their PEG tubes removed as soon as possible when they are no longer required. As this is classed as a non-urgent procedure by Endoscopy, they often have to wait a long time, which can cause psychological distress and potential physical complications. The Head & Neck Dietitian and CNS looked at ways of being able to offer this service in an ENT outpatient setting. New ways of working needed to be introduced, such as sourcing a suitable clinic room, establishing clinic codes and getting clinic built on Trakcare. A competency needed to be developed as none existed in the Trust (or nationally that could be sourced). Once competency had been approved, CNS commenced training by Gastroenterologists. A patient feedback questionnaire was developed and implemented, showing patients' satisfaction with the new service and reduced waiting times There was an 81.5 % reduction in average waiting time for PEG removal by the end of 6 months with a range of 8 - 29 day wait, once the backlog of patients waiting for removal was cleared. There was a 100% Satisfaction with the PEG removal procedure by CNS. This QIP resulted in an improved patient quality of life and satisfaction in waiting times as well as offering cost savings.

Participation in clinical research

The number of patients receiving relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 3347.

Commissioning for Quality and Innovation (CQUINS)

Due to the pandemic, in 2021/22, 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 2021/22

The CQC carried out a pilot system inspection focussed on Urgent and Emergency Care and Medical care services between 8 and 10 December 2021. The inspection report was published on 3 March 2022.

Secondary uses services data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2021/22 to NHS Digital for Commissioning Data Sets (CDS) 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: 99.7%) for the report period APR 2021 to MAR 2022
- 100% for outpatient care (national average: 99.8%) for the report period APR 2021 to MAR 2022
- 99.5% for accident and emergency care (national average: 98.2%) for the report period APR 2021 to MAR 2022. Please note we are missing part of this financial years data which is currently being investigated by NHS digital.

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

- 100% for admitted patient care (national average: 99.7%) for the report period APR 2021 to MAR 2022
- 100% for outpatient care (national average: 99.6%) for the report period APR 2021 to MAR 2022
- 100% for accident and emergency care (national average: 99.2%) for the report period APR 2021 to MAR 2022. Please note we are missing part of this financial years data which is currently being investigated by NHS digital.

Information Governance Incidents

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

Six incidents have been reported to the ICO during the 2021/22 reporting period. This compares to ten reported in the previous period.

Summary of incidents reported to the Information Commissioner

Month Incident Reported	Nature of Incident	Number Affected	How Patients informed
May 2021	Patient discharge information given to wrong patient upon discharge. **Lessons learnt:** Human error. Staff reminded to double check discharge summary and TTO before sending / giving it to patient.	1	Patient contacted by the clinical team
July 2021	Member of staff accessed health records of a relative when there was no legitimate work related reason to do so. **Lessons learnt:** Managed through human resources process. Staff reminded of their responsibilities and code of confidentiality	2	Written communication following patient raising concerns
October 2021	Printout from one patient's medical records were accidentally included with printout from a second patient's records and filed in the patient's hand held record. Printout contained medical history and obstetric history of each patient. **Lessons learnt:** Reminder to the Community Midwives to check that when they generate multiple printouts they ensure they are separated before putting with patient proformas for filing.	2	Patient who wrongly received information telephoned the Patient whose records she had. Staff also phoned once they were aware and apologised.
January 2022	Employee left work and personal bags in car after shift. Car was stolen from outside employee's home. Contents containing patient identifiable information included pregnancy cards, booking forms, antenatal notes. **Lessons learnt:** Update sent out to all staff re confidential information not to be left in cars and paperwork to be transported in confidential carry bags.	24	All patients affected received written or verbal apology.

Month Incident Reported	Nature of Incident	Number Affected	How Patients informed
February 2022	Member of staff (A) left shift early with health issues. Colleague looked at the staff member's records on the Trust's Patient Administration System with a view to verifying or checking whether there was any record relating to the issue.	1	Investigations ongoing as part of HR process
	Lessons learnt – Investigations ongoing as part of HR process		
February 2022	A member of staff has accessed health records of former partner without apparent authority	1	Patient instigated. Investigations ongoing as part of HR process.
	Lessons learnt – Investigations ongoing as part of HR process		

Summary of confidentiality incidents internally reported 2021/22

All of these incidents have been now been closed by the ICO with the ICO expressing satisfaction with the steps taken by the Trust to mitigate the effects and minimise the risk of recurrence, and requiring no further action, unless new matters came to light. With respect to the number of incidents of inappropriate access by staff there will be a further communications exercise to remind staff of the requirements of the Code of Confidentiality.

A large number of the 259 near miss reported incidents (185) relate to lost SmartCards which are disabled when reported as missing.

Reportable breaches	(detailed above) 06
Number of confirmed Non-reportable breaches	161
Number of no breach / Near miss incidents.	259
Total number of confidentiality incidents internally reported	436

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

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 different 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 2019 to March 2020, the percentage of records which included a valid patient NHS number was:
  - 99.8% for admitted patient care (national average: 99.4%)
  - 100% for outpatient care (national average: 99.7%)
  - 99.1% for accident and emergency care (national average: 97.7%)
- The percentage of published data which included the patient's valid GP practice code was:
  - 99.9% for admitted patient care (national average: 99.7%)
  - 99.8% for outpatient care (national average: 99.6%)
  - 99.9% for accident and emergency care (national average: 97.9%)
- A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly
- These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as: -

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

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

Audit trails are used to identify areas of 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 2021/2022

During 2021/2022 2281 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:

- 471 in the first quarter
- 552 in the second quarter
- 616 in the third quarter
- 642 in the fourth quarter

These quarterly results are broken down by Division below:

- The total number of deaths across all Divisions for the reporting year 2021/2022 is 2281 of which 100% are reviewed by the Medical Examiner as per Trust policy.
- Of these 2281 deaths 510 have been triggered for an investigation by structured judgement review
- Of these 2281 deaths, 335 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 2281 deaths 21 have been reviewed by other means (harm review/ investigation, PIR, complaint)
- Of these 335 SJRs carried out, 3 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 or serious complaint) (Additional deaths awaiting 2nd review or scoping for serious incident panel)

Number of patient deaths

Division	Q1 Total	Q2 Total	Q3 Total	Q4 Total	Divisional Year Total
Surgery	68	75	105	104	352
Medicine	374	445	476	509	1804
D&S	29	29	35	29	122
W&C	0	3	0	0	3
Total	**471**	**552**	**616**	**642**	**2281**

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

- The percentage of deaths which were selected for SJR=22%
- 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 335 SJRs conducted (up until 20/04/2022), the percentage of deaths identified as having sub-optimal care as a contributing factor to the death = 0%
- 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)= 0.9%

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:

- Mortality stats report on the BI tool – Insight;
- SJR stats taken from Datix;
- Quarterly Learning from Deaths Reports authored by the Medical Director and taken through Quality & Performance Committee and then on to Main Board;
- Outcomes from the monthly Hospital Mortality Group, chaired by the Medical Director.

Additional information is provided in the supporting tables:

- Table 1 – breakdown of above data
- Table 2 – Summary of Learning Themes to come out of the SJR process
- Table 3 – Learning from Deaths – Using the SJR methodology

Table 1: 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	68	68	9	0
Q2	75	75	10	0
Q3	105	105	20	0
Q4	104	104	15	0
Year Totals	**352**	**352**	**54**	**0**
Medical division				
Q1	374	374	138	3
Q2	445	445	129	6
Q3	476	476	85	0
Q4	509	509	95	2
Year Totals	**1804**	**1804**	**447**	**11**
D&S Division				
Q1	29	29	3	0
Q2	29	29	4	0
Q3	35	35	1	0
Q4	29	29	1	0
Year Totals	**122**	**122**	**9**	**0**
W&C Division (Paediatrics follow their own review process)				
Q1	0	0	0	0
Q2	0	0	0	0
Q3	3	3	1	0
Q4	0	0	0	0
Year Totals	**3**	**3**	**1**	**0**

2021/22 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	352	352	54	0%
Medicine	1804	1804	447	0.6%
D&S	122	122	9	0%
W&C	3	3	1	0%
Total	**2281**	**2281**	**510**	**0.4%**

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	352	15%	0%	0%
Medicine	1804	25%	2%	0.6%
D&S	122	7%	0%	0%
W&C	3	33%	0%	0%
Totals	**2281**	**22%**	**2%**	**0.4%**

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 (2021/22)

We continued to review and analyse our data to provide early indicators of our issues which were hampered by ongoing COVID absences through our staff groups. In 2021/22 we took the following steps to make improvements:

- 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.
- Regular meetings continued with the Medicine Division Rota leads to discuss known issues and discussing ways of reducing gaps, along with an increase in overseas doctor recruitment to support known gaps
- 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 (2022/23)

In 2022/23, we will see an increase in our training numbers from Health Education England to re-balance the number of trainees that we are allocated, along with our continuation of overseas doctor recruitment to support the known gaps in our workforce.

We will maintain development of processes to support the ongoing delivery of our 5-year People and Organisational Development Strategy, to provide a robust picture of rotas and ensure that early intervention for service provision is agreed to mitigate gaps within the rota.

We will look to build on the 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.

Veteran Aware Trust

The Trust was accredited by the Veterans Convenance Healthcare Alliance (VCHA) in 2019 in recognition for the work and relationships undertaken with the local Armed Forces Community.

NHS Providers that have been accredited demonstrate themselves as exemplars of the best care for veterans, helping to drive improvements in NHS care for people who serve or have served in the UK armed forces and their families.

Veteran Aware Trusts will:

- provide leaflets and posters to veterans and their families explaining what to expect
- train relevant staff to be aware of veterans' needs and the commitments of the NHS under the Armed Forces Covenant
- inform staff if a veteran or their GP has told the hospital they have served in the armed forces
- ensure that members of the armed forces community do not face disadvantage compared to other citizens when accessing NHS services
- signpost to extra services that might be provided to the armed forces community by a charity or service organisation in the trust
- look into what services are available in their locality, which patients would benefit from being referred to

Over a 12 month period the Trust had 1388 Veteran inpatients, however with EPR compliance to record this on admission at only 75.7%, the Veteran inpatient population within this 122 month period is likely to be considerably higher.

Figure 1: Veteran attendance and EPR compliance from March 2021-2022

Armed Forces Breakdown by Month

Month	Year	Armed Forces	Admission Documents	Completed	Compliance
March	2021	99	3462	2501	72.2%
April	2021	123	3922	2933	74.8%
May	2021	149	4320	3367	77.9%
June	2021	151	4341	3442	79.3%
July	**2021**	**127**	**4375**	**3373**	**77.1%**
August	**2021**	**142**	**4264**	**3253**	**76.3%**
September	**2021**	**110**	**3856**	**2899**	**75.2%**
October	**2021**	**114**	**3887**	**2955**	**76.0%**
November	**2021**	**109**	**3724**	**2872**	**77.1%**
December	**2021**	**103**	**3420**	**2533**	**74.1%**
January	**2022**	**71**	**3178**	**2288**	**72.0%**
February	**2022**	**90**	**3189**	**2433**	**76.3%**
Total		**1388**	**45938**	**34849**	**75.7%**

During the Covid-19 Pandemic the usual military dates normally celebrated within the Trust had to be recognised on social media and there was little activity undertaken by the Armed Forces Champions and the Operational Lead for the Armed Forces due to government restrictions.

Main points to note for 21/22

- Multi-faith Armistice Day in the Garden of Remembrance at Gloucestershire Royal Hospital
- Armistice Day cards sent to all Veterans on our wards to thank them for their service
- 3 year re-accreditation submission due by June 2022 to retain Veteran Aware status for 2022-2025
- Recruitment of two Armed Forces Advocates sponsored by the Armed Forces Covenant Fund Trust for a 2 year period.
- The Armed Forces Act 2021 was amended to include the Armed Forces Covenant as a Statutory requirement within the Private Sector
- Participant in the Veteran in an Acute Setting Programme, sponsored jointly by Armed Forces Covenant Fund Trust and NHSE/I

Objectives for 22/23

- Educate Trust workforce in relation to the Armed Forces Covenant and EPR compliance.
- Embed Armed Forces Covenant Training in to the Trust Induction Programme.
- Armed Forces Advocates to represent Gloucestershire Hospitals at Gloucester Armed Forces Day on 25 June 2022.
- Develop partner working across the ICS
- Trust representation at the SW NHS Challenge hosted by 243 Field Hospital.
- Continue to collect and submit data as part of the Veterans in an Acute Setting Programme

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: 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	2021/22 data period: Apr21 - Dec21 (latest published data as at 03/04/21)	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		
	2021/22	1.0237	1.0001	1.1860	0.7193		
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%	2021/22 data period: Apr21 - Dec21 (latest published data as at 03/04	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%		
	2021/22	37%	39.52%	64%	11%		

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. 2021/22 data period: Apr21 - Dec21 (latest published data as at 03/04/21)	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		
	2021/22	14,882 / 36	24,805 / 58.4	37,572 / 50.7	3,169 / 27.2		
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. 2021/22 data period: Apr21 - Dec21 (latest published data as at 03/04/21)	
	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		
	2021/22	59.9 / 0.3	58.4 / 0.5	118.7 / 1.8	27.2 / 0.1		

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 29/03/22	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		
	2021/22	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%	2021/22 data period: Apr21 - Dec21 (data as at 03/04/21)	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%		
	2021/22	89.4%		92.3%	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 29/03/22	
	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		
	2021/22	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 29/03/22	
	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		
	2021/22	n/a	n/a	n/a	n/a		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	GHT considers that this data is as described for the following reasons.	GHT intends to take or has taken the following actions to improve this percentage/proportion/ score/rate/number, and so the quality of its services, by these actions listed.
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	As at 29/03/22	
	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		
	2021/22	not available	not available	not available	not available		
Staff Friends & Family Test Q12d (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2015/16	69.0%	65.0%	85.4%	46.0%	2021/22 data period: Survey in Oct21-Dec21 (as at 04/04/2022)	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:

- groin hernia surgery
- varicose vein surgery
- hip replacement surgery and
- knee replacement surgery during the reporting period.

	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	2021/ 2022	National target (if applicable)	Notes/ Other information
Maximum 6-week wait for diagnostic procedures	0.28%	0.45%	3.16%	19.48%	**18.27%**	<1%	Mar 21 snapshot
Clostridium difficile year on year reduction	56	56	97	75	**95**	2019/20: 114	Total Apr 20 – Mar21
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	4	6	2	0	**2**	0	Total Apr 20 – Mar 21
MSSA	100	80	18	18	**31**	<=8	Total Apr 20 – Mar 21
Never events	6	2	6	8	**11**	0	Total Apr 20 – Mar 21
Risk assessment for patients with VTE	87.03%	93.20%	93.19%	91.2%	**89.4%**	>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%	**1.46%**	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%	**73.81%**	>=95%	Total Apr 19 – Mar 20
No. of ambulance handovers delayed over 30 minutes *(<=1hr)	506	666	1,177	2,151	**3,481**	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	**3,171**	0	Total Apr 20 – Mar 21
Emergency readmissions within 30 days: elective and emergency	6.9%	6.9%	7.0%	8.0%	**3.36%**	<8.25%	Total Apr 20 – Mar 21
% stroke patients spending 90% of time on stroke ward	88.2%	90.8%	87.70%	83.5%	**82%**	>=80%	Total Apr 20 – Mar 21
% of women seen by midwife by 12 weeks	89.50%	89.80%	88.90%	92.8%	**91.3%**	>90%	Total Apr 20 – Mar 21

Indicator	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021	2021/ 2022	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%	**92.7%**	>=93%	Total Apr 20 – Mar 21 (unvalidated)
2 week wait breast symptomatic referrals	90.40%	95.90%	97.50%	92.5%	**91.2%**	>=93%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (first treatments)	96.30%	94.60%	93.40%	97.9%	**97%**	>=96%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – surgery)	94.80%	95.30%	93.60%	95.2%	**92.3%**	>=94%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – drug)	99.80%	99.90%	99.40%	99.4%	**99.8%**	>=98%	Total Apr 20 – Mar 21 (unvalidated)
Cancer: 31 day diagnosis to treatment (subsequent – radiotherapy)	99.10%	99.30%	94.90%	98.0%	**99.1%**	>=94%	Total Apr 20 – Mar 21 (unvalidated)
Cancer 62-day referral to treatment (urgent GP referral)	75%	74.80%	73.10%	83.3%	**72.3%**	>=85%	Total Apr 20 – Mar 21 (unvalidated)
Cancer 62-day referral to treatment (screenings)	92.20%	96.50%	95.40%	90.8%	**85.9%**	>=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%	**72.15%**	92%	Mar 21 snapshot
Delayed Transfer of Care rate	2.39%	3.15%	2.96%			<=3.5%	Mar20 snapshot
Number of delayed discharges at month end	34	43	15			<=38	Mar20 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 (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2021-22. 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 times. 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.

The CCG would like to thank the Trust for all the continuing efforts, dedication and hard work over the past year in dealing with the ongoing COVID-19 pandemic. The CCG have continues 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 remained a priority area.

Over the past year the Trust has undergone a number of CQC visits and inspections, the CCG has good visibility of the Trust's response to the unannounced visits and CQC action plans, it further notes the plans for improvement in 2022/23. The CCG is also pleased to see that improving the Urgent and Emergency Care patient experience remains a priority for 2022/23 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. In light of the recently published final report of the Ockenden review the CCG is keen to support the Trust with their work on improving maternity experiences and working in partnership with the Gloucestershire Maternity Voices. The CCG also recognises the importance of improving quality and experience for inpatients and are pleased to see this listed as a priority, as well as the focus on better discharge and work on the criteria to reside agenda. As per the previous year's report, the importance of the safety strategy and safety culture features heavily. The implementation of the new National Patient Safety Strategy, sitting alongside the ICS Journey for Quality will support this area of work and remains a key component of the operational planning.

The CCG endorses the Quality priorities that the Trust have selected for 2022/23 and are particularly pleased to see work to include the focus on falls prevention. Also the focus on the prevention of pressure ulcers, together with improved mental health care and addressing the health inequalities agenda, with improved engagement with ethnic minority communities in the development of services are to be commended. The CCG is also pleased to see the ongoing work around improving care for patient with diabetes and the deteriorating patient workstreams, with the introduction of new digital systems and enhanced technology to support sepsis management.

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. The CCG are also keen that there is wider system learning and development through shared 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 form the CCG and members of the Learning Academy, maintain a clear and robust system for ongoing monitoring of all action plans and recommendations. The high number of recent Never Event declarations at Gloucestershire Hospitals Trust was flagged as a concern by the Regional and National Quality Teams at NHSEI and as part of an additional support offer the CCG has met with colleagues from the Clinical Quality Team at NHSEI and the Patient Safety Lead for Never Events and regional learning has been shared. The Trust have worked incredibly hard in producing a robust programme of improvement and the team have demonstrated commitment to improving safety and enhanced staff engagement.

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 with good outcomes for the people of Gloucestershire. The report is a clear, transparent and comprehensive document which demonstrates the Trust's commitment to continuous quality improvement. The CCG confirms that to the best of our knowledge we consider that the 2021/22 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 this summer.

Dr Marion Andrews-Evans
Executive Nurse and Quality Director

Statement from Healthwatch Gloucestershire (HWG)

2021/22 has been another challenging year for the Trust in Gloucestershire, as for others around the country. We understand that pent up demand and the scale of the backlog created by Covid have led to extraordinary pressures. The current challenges in staffing and for staff have also been significant and the focus on staff wellbeing by the Trust is welcome. We know that a good working experience for staff leads to a good experience for patients.

We have been following the progress of the Trust's Mental Health Strategy with interest. We have welcomed the positive environmental changes made in A&E and the inclusion of people with lived experience in co-design. Although there is some distance to travel in rolling out the strategy, we believe that the Trust's approach of partnership working within the ICS and VCSE sector alongside public and patient involvement aims to achieve the best outcomes for people. We are also pleased to note the focus on service improvement for people with Learning Disabilities and Autism. We look forward to being able to test this out and contribute to continued improvement through our own work with people with autism in the coming year.

Healthwatch Gloucestershire has also received feedback about Maternity services that reflects experiences reported directly to the Trust and maternity services across the nation. We know that Maternity Voices is the expert in women's voices and will be watching closely to ensure that the local arrangements are effective.

We believe that the two main areas of significant pressure, those of A&E and delayed discharge with its associated risks around deconditioning, speak to the wider pressures within the system. We acknowledge and welcome the resources allocated and service improvement measures enacted by the Trust in helping to improve experiences of A&E. We also welcome the focussed attention on improving care for patients whose condition deteriorates, who develop pressure ulcers and who fall in hospital alongside the work on inpatient experience. However, we believe that action by the wider health and care system can help with long term solutions. We are hopeful that the Trust will be able to see positive change in their own services in part through the effectiveness of the Integrated Care System. Healthwatch Gloucestershire will continue to champion the experiences and positive outcomes of those using the system's services.

We are pleased to note that the Trust sets out its priority to improve safety and to foster a learning culture. Our own experience of the Trust at management and governance levels shows it to be an organisation with a constructive culture of honesty and active focus on the outcomes and experiences for patients. We are continually impressed by the Trust's constructive attitude to working with Healthwatch Gloucestershire and look forward to a continued strong relationship.

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 Quality Account Report 2021/22.

In particular, I note and value the hard work and commitment of the Trust to review and make improvements to the delivery of services during and following the COVID-19 Coronavirus Pandemic.

I'm pleased to have this opportunity to publicly thank the senior management team at the Trust for the courteous and respectful way in which they engage with the Committee. I'm proud of the way in which the Committee and Trust work together to ensure that effective scrutiny of the Trust is able to be carried out and that there are no 'no go' areas.

I'm especially grateful that the Committee is kept fully up to date on the ongoing Fit For the Future plans, which are wide ranging. The regular updates are most welcome and useful. Together with our NHS Reference Group meetings, the regular updates ensure the Committee is never taken by surprise by any 'out of left field' decisions. It's vital that this close working relationship continues .

It's important, too, that we look at what is working well and to recognise where the Trust is at the cutting edge of advanced medicine. As we slowly emerge from the pandemic there will be issues arising which we cannot foresee and which will require us to be flexible in the way in which we scrutinise the work of the Trust .

Having thanked the senior management team at the Trust, I'd also like to thank every single member of staff at the Trust for the dedication to their vocation. I, personally, have benefitted hugely as an outpatient on both sites from their skills, knowledge and care. I hope I've been a good patient!

Cllr Andrew Gravells MBE (Chair of the Gloucestershire Health Overview and Scrutiny Committee)

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 20 May 2022

Our Governors have contributed to identifying the priorities for next year 2022/23 and have also provided us with feedback on this year's Quality Account.

- feedback from local Healthwatch organisations dated 16 May 2022
- feedback from overview and scrutiny committee dated 27 May 2022
- the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated TBC https://www.gloshospitals.nhs.uk/contact-us/feedback-and-complaints-pals/
- the 2020 national patient survey published by CQC 28/01/2022 https://www.cqc.org.uk/provider/RTE/survey/3
- the 2021 national staff survey published March 2022 https://www.nhsstaffsurveys.com/results/local-results/
- CQC inspection report dated 07/01/2019 and 23/04/2021 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.

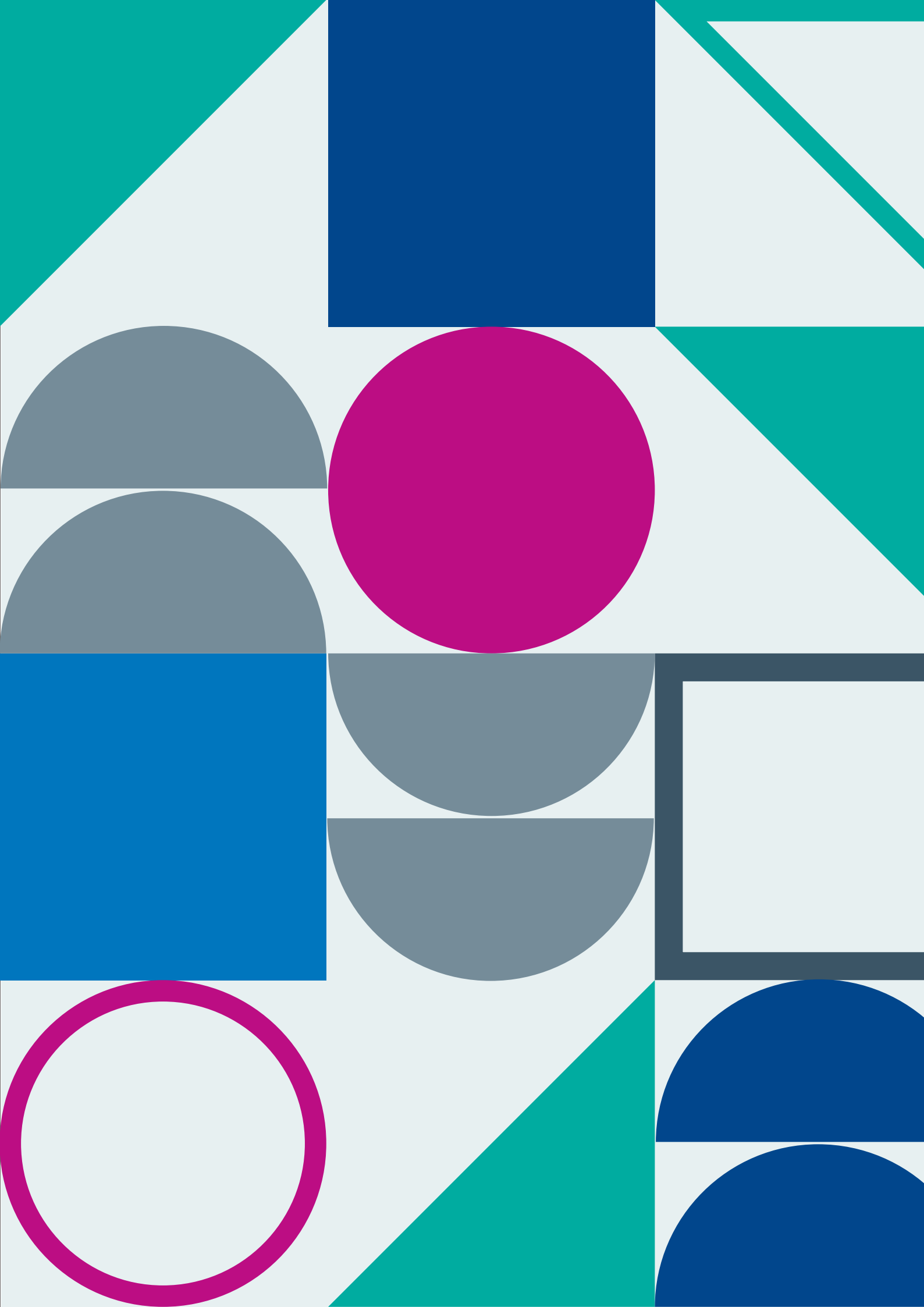
The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

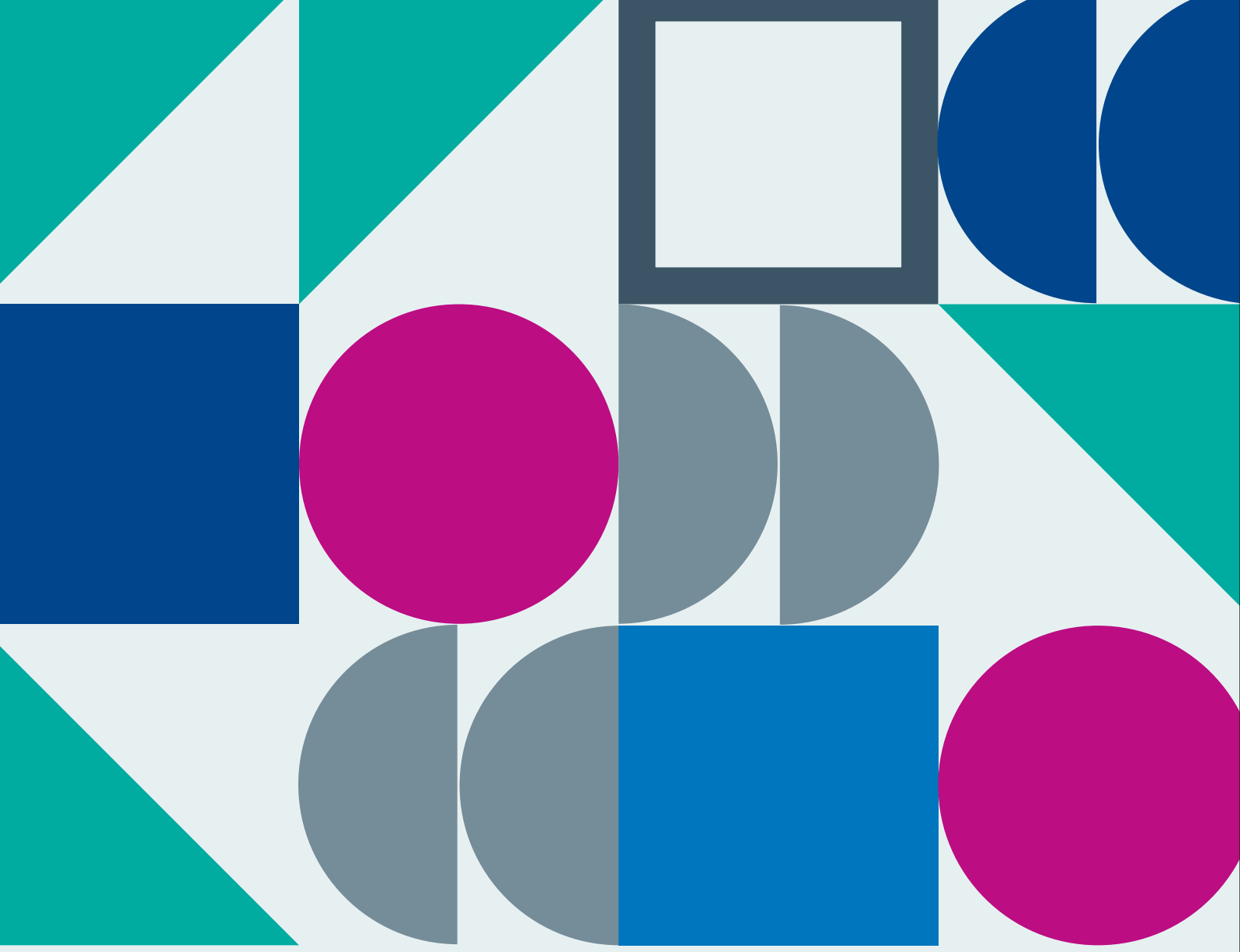
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Chairman

Chief Executive





Quality Account 2021–2022