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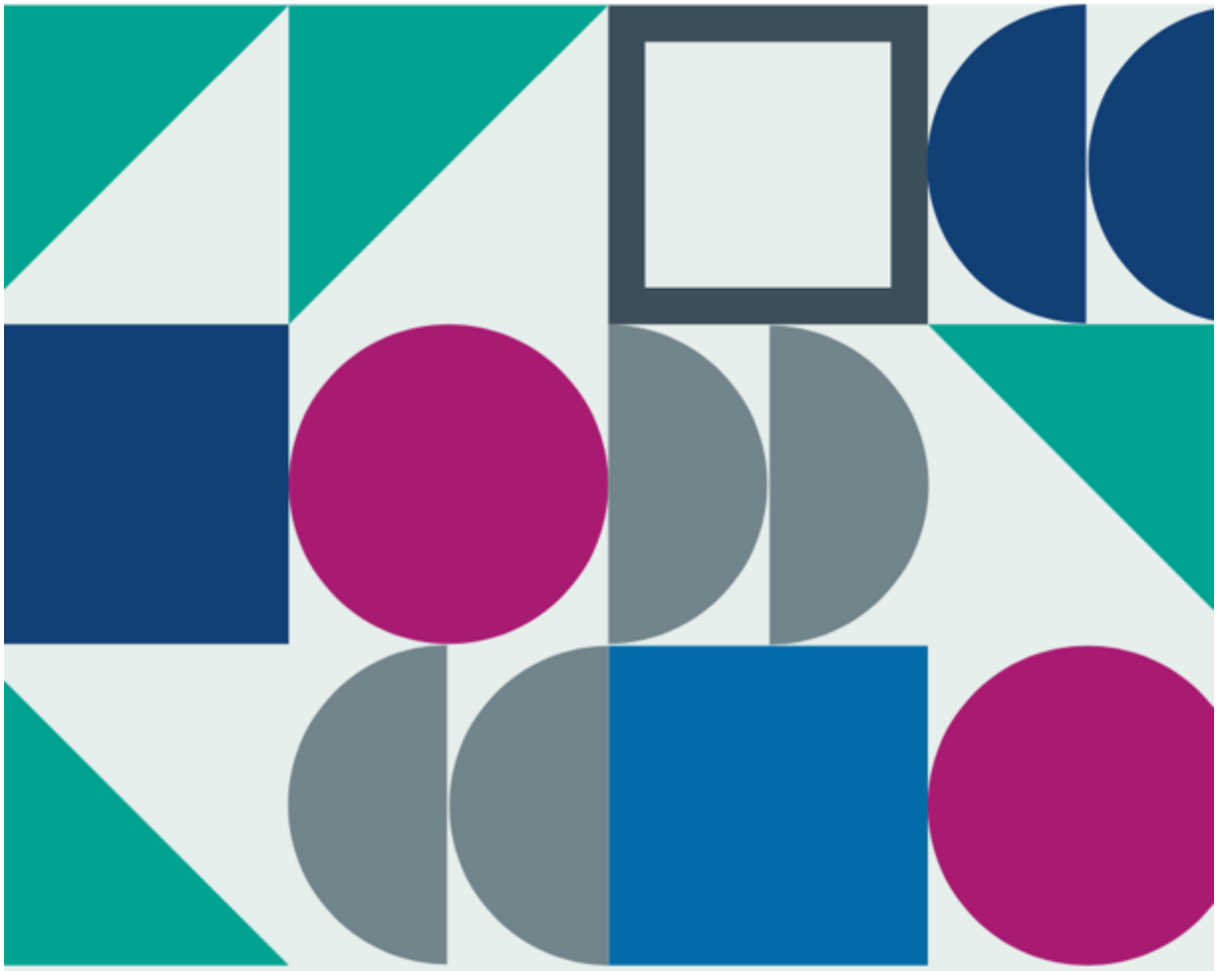
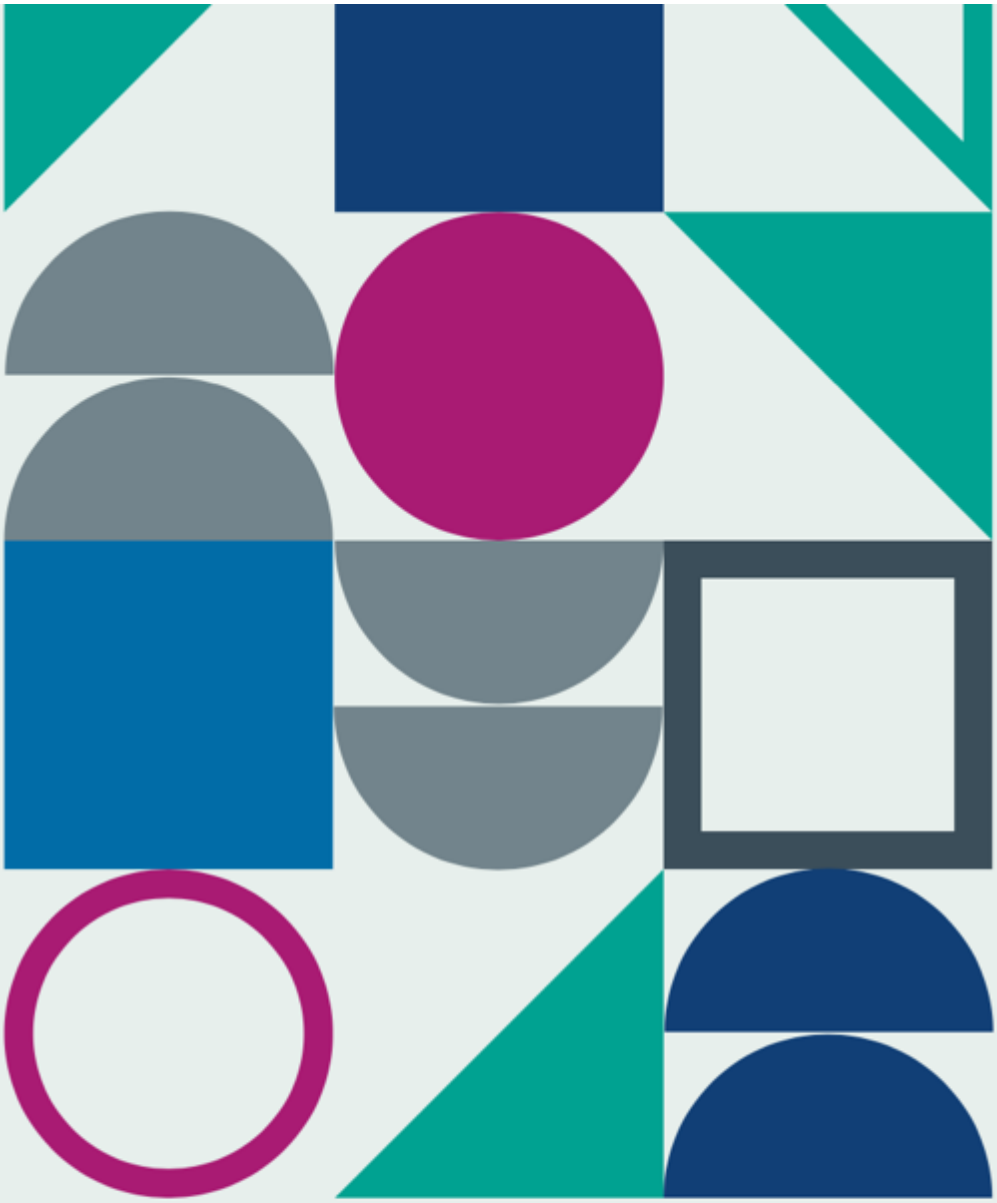
NHS Foundation Trust



Quality Account

2022/23



Our Quality Account

2022/23

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

As we come to the close of the year, my key reflections are firstly upon the unrelenting and unprecedented operational pressures in all of our services and secondly, the incredible way in which my colleagues have risen to that challenge in their determination to deliver the very best quality of care, albeit in very difficult circumstances.

The Year Just Gone

The last year has been characterised by some great successes but equally some significant challenges. The Care Quality Commission's (CQC) inspections and subsequent findings into the standard of care provided in our surgical and maternity services were a sobering read for all of us and especially difficult for the staff working in these services. I am, however, very proud of the way our leaders and their teams have risen to these insights and are addressing, with rigour and enthusiasm, the actions required to ensure our patients and their families get the quality of care we strive to deliver. The vast majority of the actions required following these visits are now completed and we look forward to welcoming CQC back when they re-inspect the services later this year.

Two of the key concerns reflected by the CQC in our surgical services were the number of Never Events in our theatres and the use of our theatre recovery to care for patients overnight. Colleagues have embraced a quality improvement approach to addressing these issues with startling results. From a mean of one Never Event every 59 days, the service has not had a theatre Never Event for 442 days. Similarly, following change to practice in theatres, no elective patient has stayed in theatres overnight since June 2022.

Recruitment remains a challenge for our maternity services and regrettably, temporary changes to services in Stroud and Cheltenham are ongoing. However, our commitment to the future of these services remains as strong as ever and I look forward to them re-opening in the coming year. We are fortunate to have recruited into many of the leadership vacancies in our maternity services and our midwife vacancies continue to reduce.

Our patients continue to reflect very positive experiences of care in both of these services and this has been a huge boost to the morale of colleagues striving to ensure the best possible patient experience. In August 2021, the Trust received its best ever Cancer Patient Experience Survey results and in January 2022, the Trust was ranked 7th out of 121 Trusts in the CQC National Maternity Patient Survey and Gloucestershire was voted the best place in England to give birth!

We know that the quality of both patient and staff experience is closely linked to the environment in which they work and are cared for, and we recognise the disruption caused

by the developments on both of our hospital sites in the last year. Many of these developments have come to fruition this year including the fabulous new Gallery Wing Ward at Gloucestershire Royal (GRH) and state of the art Day Surgery Unit at Cheltenham General Hospital (CGH). Later this year we looking forward to opening two new theatres at CGH and a significantly expanded Emergency Department at GRH both of which will provide another opportunity to improve the experience of patients and staff.

Finally, we know that for many patients they judge the quality of their care by their waiting experience and this has never been more so given the impact of the pandemic on waiting times. As a result of some of the choices and decisions that the Trust made during the pandemic, the Trust started the year with fewer patients waiting for elective care and outpatients, compared to others the South West Region, and has maintained this very strong position. By the end of March 2023, no patient had waited more than 78 weeks for their care, from the point of referral; one of only a handful of Trusts in this position. The picture in respect of cancer is more mixed with more patients waiting beyond the 62-day standard than previously, although the Trust remains the strongest performer with respect to the 28 Day Faster Diagnosis Standard – this is a key indicator for patient experience as it measures the interval from referral to the point at which cancer is confirmed or excluded; 90% of patients will have cancer excluded at this point bringing huge relief to them and their families.

The Year Ahead

The quality and safety of the care we provide to our patients is inextricably linked to the experience of our staff. It's easy to get caught up in thinking that 'this year has been like no other' and in many ways, that's true - the combined effects of the Covid-19 pandemic and the resulting operational pressures have had, and continue to have, a significant impact on all staff. However, the operational pressures don't explain fully the current staff experience. We know from a wide range of sources that colleagues and patients who identify with minority groups continue to have a worse experience than their counterparts. This is not, and never will be, ok. The latest staff survey and race equality statistics continue to paint a concerning picture which means we must increase our focus on, and change our approach, if we are to improve not only the experience of staff, but also the patient experience that flows from having an engaged, valued workforce. Our vision of 'the best care for everyone' can only be achieved with this focus.

Of course, culture takes time to change, there will be bumps along the way, and it'll be some of the hardest work we ever do, but it's absolutely critical that each and every-one of us embrace this work. More than this, it is a moral imperative.

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

Parts 2 and 3

Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following 2 sections are divided into parts:

- Part 2
    - Part 2.1
        - 2.1.1 What our priorities for 2023/24 are
        - 2.1.2 How well we have done in 2022/23
    - Part 2.2: Statements of assurance from the Board
    - Part 2.3: Reporting against core indicators
- Part 3: The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

Part 2

Part 2.1

2.1.1 Our priorities for 2023/24

Our Quality Account is an important way for us to report on the quality of the services we provide and show our improvements to our services that we deliver to our local communities. The quality of our services is measured by looking at patient safety, the effectiveness of treatments our patients receive, and patient feedback about experiences of the care we provide. The quality priorities, detailed in this report, form a key element of the delivery of the Trust's objective to provide the "Best Care for Everyone".

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

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

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

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 data, PALs concerns, Compliments, feedback from the Friends and Family Test (FFT), and local survey data, focus groups and experience stories to our 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 and outcomes data.
- Staff, key stakeholders and public engagement – throughout the year seeking the views of people at engagement events.
- Engaging directly with our Governors on our quality priorities (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.
- 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 (Governors are members of our Quality and Performance Committee).

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

Our Priorities for improving quality for 2023/24

No.	Priority for 2023/24	Why we have chosen this priority
1.	To improve maternity safety/ experience	The priority for 2023/24 will be focused on delivering the 10 safety standards within the NHS Resolution **Maternity Incentive Scheme (MIS)**.
2.	To improve emergency department (ED) care safety/ experience	One of our programmes of work we have chosen to report on will be delivering the Commissioning for Quality and Innovation indicator (CQUIN 05) **"Identification and response to frailty in emergency departments".**
3.	To improve adult inpatient safety/ experience	Our adult inpatient Friends and Family feedback tells us that patients do not like to be cared for **in non-designated bed spaces**, including boarding, and therefore our focus will be on monitoring and then reducing/eliminating our use of escalation beds.
4.	To improve experience of discharge	In order to release beds for waiting patients we will have an improvement programme focused on **"simple" discharges**.
5.	To enhance and improve our safety culture	To enhance and improve our safety culture we will be implementing the **National Patient Safety and Incident Response Framework (PSIRF)** which will bring a change to our safety investigation work and we will be **focusing on staff being able to raise their concerns (Staff Survey questions 19a, 19b, 23a and 23f).**

6.	To improve our prevention of harm (pressure ulcers and falls)	The priority for 2023/24 will be to improve our risk assessment, prevention and management of harm in relation to **pressure ulcers and falls.** This will include the delivery of the CQUIN (CQUIN 12) assessment and documentation of pressure ulcer risk assessments.
7.	To improve our care for patients whose condition deteriorates	We are one of 7 Trusts who have been chosen by NHS England to implement improvement work in the area of including patients/carers and their families in identifying deterioration – our "**Worries and Concerns Programme**" of improvement work.
8.	To improve mental health care for our patients coming to our acute hospital	We will be continuing the implementation of the Trust's Mental Health Strategy – **Whole Person Care Strategy**.
9.	To improve our care for patients with diabetes	Our focus will be on carrying out improvement work in response to the national **diabetes** audit findings (children and adults).
10	To reduce health inequalities	We will continue to deliver the Core20Plus5 health inequalities programme focused on **tackling tobacco dependency** for colleagues, inpatients and in maternity.
11	Surgical experience	Our focus will be delivering on the Commissioning for Quality and Innovation Indicator (CQUIN 02) **supporting patients to drink, eat and mobilise (DrEaMing) after surgery.**
12	Equality, diversity and inclusion – equality priorities	The Patient Experience Team will be enabling the delivery of **2 equality priorities** by improving our translation and interpretation services and focusing on the accessibility of our services.
13	Commissioning for Quality and Innovation (CQUINs)	We will be focused on delivering our 5 CQUINs – **CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery** (TARGET - 80% of patients within 24hrs) – **CQUIN04:** Prompt switching of intravenous to oral antibiotic (TARGET 40% of fewer) – **CQUIN05: Identification and response to frailty in emergency departments** (TARGET 30% receiving clinical frailty assessment) – **CQUIN07: Recording of and response to NEWS2 score for unplanned critical care** (TARGET 30% having timely response Early Warning Score (EWS) 5-6 60-minute response and EWS 7+ response time 30 min)

		– **CQUIN12: Assessment and documentation of pressure ulcer risk assessments (**Target: 70% to 85%).
14	Caring for people at the end of their lives	We will support the improvement of our compliance with national guidance on care at the end of life (One Chance to Get It Right, NICE guidelines and the Quality Standards for end of life care). (NB The NACEL Audit is paused in 2023.)

2.1.2 How have we done with our priorities for improving quality 2022/23

1. Quality priority

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

Background

Making the move from children to adults' services can be a difficult period in young people's lives. Adults often see children and young people as passive recipients of healthcare. This can lead to children and young people not being listened to, having a lack of understanding of their own condition and may lead to problems that can affect future care (for example, finding it difficult to trust healthcare professionals or feeling very anxious before procedures). However, having a positive experience can make a child or young person feel confident, empowered and supported to manage decisions about their own health and healthcare, and can improve their perception of their diagnosis and treatment.

The aim of healthcare transition at the Trust is to enable the child/ young person and their family/carer have the right information to allow for a smooth process when moving to adult services. The transition process is aimed to enable the young person to understand why they attend hospital and what they can do to manage their own conditions as they become more independent.

Whether a patient transitions to adolescent or adult services or is discharged from hospital care, we want to provide them the tools to understand their condition and empower them to manage it through planning and preparation, to ensure that their processes is as smooth as possible. Transition is a gradual process of change, which gives everyone time to ensure that young people and their families are prepared and feel ready to make the move to adult health care.

How we have performed 2022/23

A loss of continuity in care can be a disruptive experience, particularly during adolescence, when young people are at an enhanced risk of psychosocial problems. The National Institute for Clinical Effectiveness (NICE) produce guidance on Transition, the components of good patient experience in adult NHS services and guidance for babies, children and young people experience of care. All healthcare professionals in the Trust should follow the NICE recommendations. As part of our personalisation work with Gloucestershire Integrated Care Board we have been working this year to embed the NICE recommendations of embedding shared decision making at an organisational level.

Shared decision making
Shared decision making is a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care. Over this last year, we have continued to use the "**Ready Steady Go Hello**" transition programme principles however due to the operational pressures and a lack of dedicated senior leadership, transitions have not always been as personalised for the young person as we would like it. However, we have updated the transition leaflet and have included the personalisation shared decision making questions which we plan to roll out and have within every leaflet.

Paediatric diabetes service
The Trust has participated in a pilot project for a transition service for adolescents and young adults living with type one diabetes in 2021/22 which continued into 2022/23. The pilot project was focused on improving care for people with Type 1 Diabetes who are transitioning from paediatric to adult services. This pilot has now concluded, and we are using the learning to identify opportunities to develop services and improve patient outcomes.

As part of this pilot, the service has been able to improve the administration processes which support care and treatment and test a new youth worker role to support young people through the transition. The team hope to retain the youth worker to continue to provide additional support as patients reported this to be supportive. 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 adult's services.

Paediatric endocrine service
Within our endocrine services, we cover anything endocrine related so lots of different conditions. Young people with growth hormone issues are currently transitioned to Bristol Adult Endocrine Team as there is no service here in Gloucestershire. The Specialist Nurse is working with the adult Endocrine Consultant to set up this service here in Gloucestershire. There may be around 500 patients that would access this service and we would transition 5 young people per year approximately. Many of our children who are growth hormone deficient as children do not need follow up as an adult so are discharged at the end of their growth period. Our patients with thyroid issues are transferred back to General Practitioner led care after they complete puberty and growth. Complex pituitary deficient patients are transitioned to the adult team here and we have a transition clinic twice a year for this. Approximately 15 patients per year transition and any young people that also have a learning disability we work closely with the Learning Disability Team to make the experience as joined up as possible. We had a very successful patient transition just this month as a result of collaborative working.

Paediatric epilepsy service
The Epilepsy Service run 4 transition clinics a year. Two on our Gloucester site and two in Cheltenham. The transition clinics happen around the spring and autumn time. We invite the adult epilepsy nurse, adult hospital liaison nurse, a representative from Community Learning Disability Team (CLDT), Paediatric Neuro-disability Nurse, Paediatric Epilepsy Nurse and Paediatrician to attend. We try and book 6- 8 patents in each clinic and keep the first 2 slots

for our Profound and Multiple Learning Disability (PMLD) patients. We have been running this for 6 years and therefore transition approximately 24-32 young people a year.

Leadership
A new post of Director of Quality and Nursing for Paediatrics and Gynaecology has been created and we have recruited to the position. A key priority for the post holder is progression of a consistent and clear pathway for young people transitioning to adult services and within the new post there will be the leadership capacity to do this as well as the wider experience of care agenda.

Plans for improvement 2023/24
This improvement work will continue and will be reported on within the Division's programme.

Plans

- There will be focused leadership from the Divisional Director to support this programme of work.
- Links will be developed on our Trust website to the **Ready Steady Go Hello** transition programme resources which are available in easy read format and other languages.
- We will support further roll out of the "Ask 3 questions" shared decision making approach across the organisation.

2. Quality priority

To improve maternity experience

Background

Patient experience feedback provides a clear measure of the quality of service we are providing for women, their families and babies 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.

Care Quality Commission (CQC)
As a healthcare provider, we hold registration with the Care Quality Commission (CQC). CQC monitor, inspect and regulate all of our services and in April 2022 they carried out an unannounced inspection of our Maternity. The inspection resulted in an overall inadequate rating for the service and we also received a Section 29A Warning Notice as they had concerns about the culture, safety, and quality of the maternity services.

Table: Core maternity service ratings (July 2022)

Service	Safe	Effective	Caring	Responsive	Well led	Overall
Maternity	Inadequate	Not rated	Not rated	Inadequate	Inadequate	Inadequate

As this was a focused inspection, CQC only inspected the safe, well-led and parts of the effective key questions. Following their inspection they published a Report, and advised us that although the service receives lots of patient experience data we needed to have a greater focus on demonstrating learning and improvement.

CQC National Survey Programme – Maternity Survey 2023
In addition, as a Trust, we take part in the CQC National Surveys every year. The Care Quality Commission (CQC) use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England.

How we have performed 2022/23

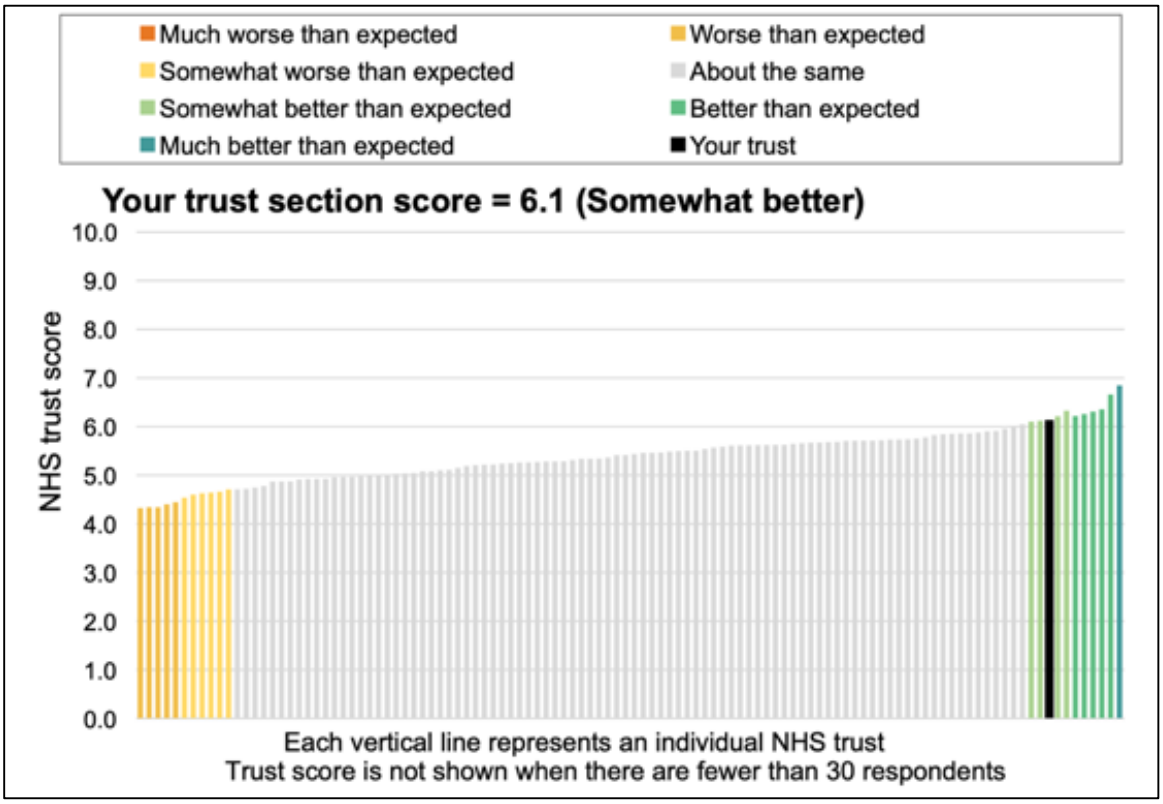
CQC and our improvement plan
Since the Trust was issued a Section 29A Warning Notice there has been extensive focus on improving the services with a robust improvement plan and progress has been shared with the Integrated Care Board and CQC representatives on a 6-weekly basis since the notice was issued May 2022.

CQC National Survey Programme - Maternity Survey
As an organisation, we took part in the 2022 CQC NHS Patient Survey Programme Maternity Survey. This survey looks at the experiences of women across the Maternity

Pathway. Our survey results reveal the responses from women who had given birth during February 2022. Given the considerable challenges that our maternity services have faced over the last year (midwifery staffing challenges, temporary closure of beds/units, an inadequate rating by CQC with a S29a warning notice, entry onto the NHSE Maternity Safety Improvement Programme), we are delighted that our maternity service has been benchmarked and ranked 7th out of 121 Trusts providing maternity services. It is wonderful to see the many areas where we are delivering great care, which is clearly valued by women and families in Gloucestershire. This feedback is exceptional and everyone delivering maternity care should feel extremely proud of these results, and we would like to extend our congratulations to everyone involved.

The Maternity Survey Report uses an 'expected range' analysis technique which has been improved this year to include more nuanced categories to determine if our trust is performing better, worse, or about the same when compared with most other Trusts. Importantly, this is a national comparison with all other Trusts who took part in the survey.

Graph: CQC National Maternity Survey results benchmarking score



Primarily we use our survey data to monitor change over time and compare our performance with other Trusts. The questions which our trust has performed better compared with most other Trusts are listed below. Within the full report the benchmarking section used the 'expected range' analysis technique to show how our Trust scored for each evaluative question in the survey compared with other Trusts that took part. This enabled us to see the range of scores we achieved and can provide us with an indication of where we perform

better than the average, and what we should aim for in areas where you may wish to improve.

In summary: -

- We had no questions where we benchmarked “Somewhat worse than expected”.
- We had 12 questions where we benchmarked “Somewhat better than expected”.
- We had 10 questions where we benchmarked “Better than expected”.

List: Benchmarking data

Below is a summary of our top five and bottom five questions for our Trust (comparing our results to the Trust’s average) enabling us share a simplified summary of our results.

Table: CQC National Maternity Survey things to celebrate and things to improve

Results for Gloucestershire Hospitals NHS Foundation Trust

Where mothers' experience is best

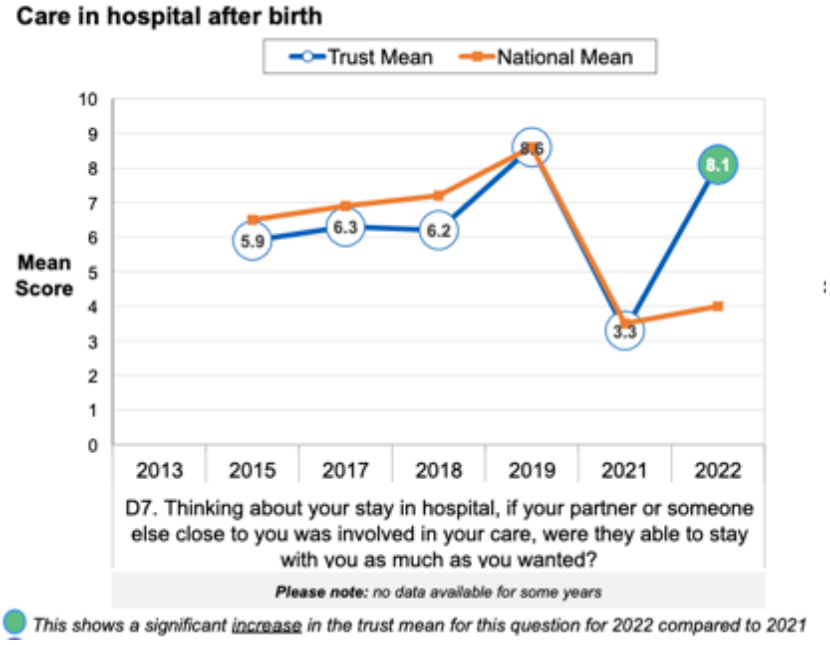
- ✓ Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- ✓ Mothers being able to see or speak to a midwife as much as they wanted during their care after birth.
- ✓ During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.
- ✓ Mothers (and / or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.
- ✓ Mothers being offered a choice about where to have their baby during their antenatal care.

Where mothers' experience could improve

- ○ The midwife or health visitor asking about mothers' mental health during their care after birth.
- ○ Mothers receiving help and advice from a midwife or health visitor about feeding their baby in the six weeks after giving birth.
- ○ Midwives providing mothers with relevant information, during their pregnancy, about feeding their baby.
- ○ At the start of their pregnancy, mothers being given enough information about coronavirus restrictions and any implications for their maternity care.
- ○ Mothers being treated with kindness and understanding while in hospital after the birth.

We had one particular question which showed a significant increase from 2021 to 2022, which was enabling partners to stay as much as women wanted. We were well above the national average and this demonstrates our person-centred approach to care.

Graph: Question D7 National Survey showing significant increase in reporting for partners being able to stay over



The CQC Maternity Services Survey has been an annual survey since 2019 and to monitor our patient experience data in between the national Surveys we run the Maternity Friends and Family Test Survey and the results are presented to Trust Board on a monthly basis within our Quality and Performance Report (link).

Learning and improvement

The service has been working closely with the Patient Experience Team, the Maternity and Neonatal Voices Partnership (MNVP – link) and colleagues across the Local Maternity and Neonatal System (LMNS) to identify key themes emerging from our feedback, and prioritise areas for improvement. From our data in the Trust, from Friends and Family Test (FFT), PALS, Complaints, 15 Steps and also from the feedback gathered by MVP, the key themes

have been focused on the ward experience, particularly around environment, information and interactions with staff.

A co-production workshop was held on 2 November facilitated by MVP, with members of maternity services, health visiting, women, birthing partners and other stakeholders to review data and themes from across the system to ensure we are prioritising the right areas and co-producing our improvement programme.

NHS Resolution
In Feb 2023, we were able to submit compliance with NHS Resolution Maternity Incentive Scheme Year 4 standards for Safety Action 7 – Service User Feedback (submitted February 2023). We were able to demonstrate that we had mechanisms for gathering user feedback, and that we worked with service users through our Maternity Voices Partnership to co-produce our service.

Plans for improvement 2023/24

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

In addition, we will:

- Continue to deliver improvements in relation to the CQC section 29A warning notice, must do and should do improvement plan.
- Support the delivery of the Maternity and Neonatal Voices Partnership patient experience improvement plan.
- Continue a specific quality improvement (QI) project focusing on delays to the induction of labour pathway.
- Focus on improving the experience of our Maternity Ward in line with feedback and as a result of our prioritisation approach with the MVP.
- Introduce a Patient Experience Coordinator post with Maternity Services to enable a dedicated resource to triangulate insight data and support quality improvement initiatives.

3. Quality priority

To improve Emergency Department (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. From April 2022 – March 2023 79.3% of patients reported, through the FFT that they rate the quality of their care positively. FFT feedback provides us an opportunity to improve the quality of care that we deliver for our patients.

How we have performed 2022/23

The Friends and Family Test is an important feedback tool that support the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how. From April 2020, a new question replaced the original FFT question and the replacement question invites feedback on the overall experience of using the service. FFT provides a mechanism to capture both good and poor patient experience. The graph below shows the Emergency Department FFT positive score.

Graph: Friends and Family Test Emergency Department positive scores March 2023

The main theme emerging across the comments which is impacting the Emergency Department (ED) positive score has been wait times due to operational pressures in the Trust. To identify other areas in feedback, where experience improvements can be made, the ED Team decided to receive their FFT data weekly, so that trends in comments could be analysed and reviewed along with Patient Advice and Liaison Service (PALS) themes and feedback, and actions taken quickly to improve experience for our patients.

Through the role of a Patient Experience Lead within the service a number of priority areas were identified as part of an ED patient experience improvement plan, with progress this year in the following areas:

Communication within the department with patients and relatives

- Information slide deck in the waiting area of Department with relevant information
- Patient information leaflet and poster (with QR code) providing information regarding triage and managing expectations of timings and treatments.
- Patient experience lead role in the department who updates and communicates with patients and relatives.
- You said we did boards for the department – using FFT comments to improve services.
- ED journey road map developed similar to the one on the Surgical Assessment Unit to support managing expectations around wait times.
- Working with the ICB and GHT comms team to help inform and shape the wider patient information that is on offer to our patients.
- Implementation of pocket guide for staff detailing how to access an interpreter to enable improved communication with our patients where English is not a first language including British Sign Language.

Volunteer support

- Recruited and trained volunteer team for patient facing roles in the department – supporting with refreshments / communication.
- Volunteer coordination managed by Patient Experience Lead to ensure needs of patients and the service are met.
- 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.
- More tailored activity boxes in development with service users to support specific conditions e.g. autism.
- Introduction of Samaritans volunteers service to our patients requiring support with their mental health.
- New build plans.
- Working to ensure accessibility of new site build, working with colleagues, patients, carers and arts coordinator.
- Ensuring dementia friendly signage throughout the new department.

- Development of mental health room artwork for the new build to ensure a calming environment
- Work programme with Arts Coordinator to improve environment including waiting areas, mental health rooms and bereavement room

Plans for improvement 2023/24

One of our programmes of work we have chosen to report on for 2023/24 will be delivering the Commissioning for Quality and Innovation indicator (CQUIN 05) "**Identification and response to frailty in emergency departments".**

We are also looking to continue to work to improve the experiences and accessibility of our services for our more vulnerable patients. There will be several projects including: -

- Working alongside the Arts Coordinator and clinical teams to improve the new build space to ensure it is more dementia friendly.
- Entering into a research project with "Squid Soup", looking at installing a large interactive sensory piece into our new build mental health area to help with the overall experience of patients presenting to the department in a mental health crisis.
- Further working with the ICB and the system flow team to improve patient experience throughout ED (Newton).
- Engagement with NHS England to further develop and support patient experience throughout Unscheduled Care.
- Implementation of "social prescribers" throughout the department to support our vulnerable patients.
- Supporting the recruitment and management of "care navigators" within ED. This will help support flow and redirection throughout the department and also improve the experience by ensuing patients are seen in the correct care setting.
- Launching a new patient information campaign in the form of quick and informal videos informing patients of different areas and processes within the department.
- Fully implementing "What matters to me folders" into the department, currently socialising them amongst staff to ensure continued success of the project. This will support wider Trust and system work to deliver personalised care.
- Implementation of ask 3 questions to ED related patient information leaflets to support delivery of Shared Decision Making.

4. Quality priority

To improve adult inpatient experience

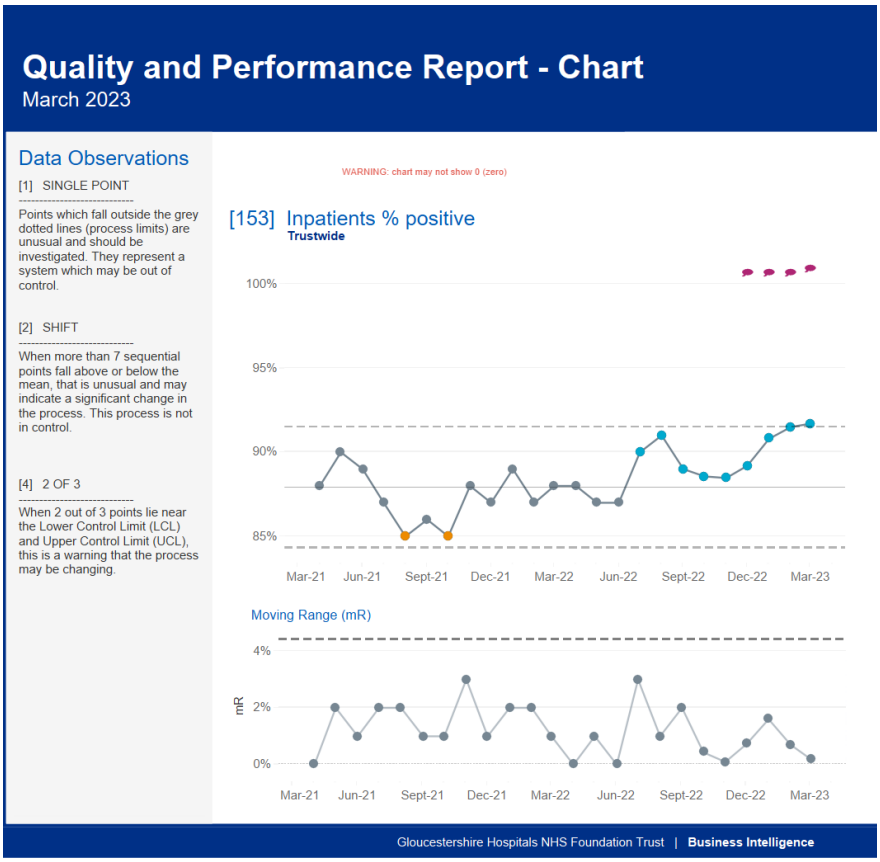
Background

Excellence in healthcare depends on the quality of relationships with patients and families – really listening to what they want and need – and remembering the values that led to healthcare professionals working in the NHS. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

How we have performed 2022/23

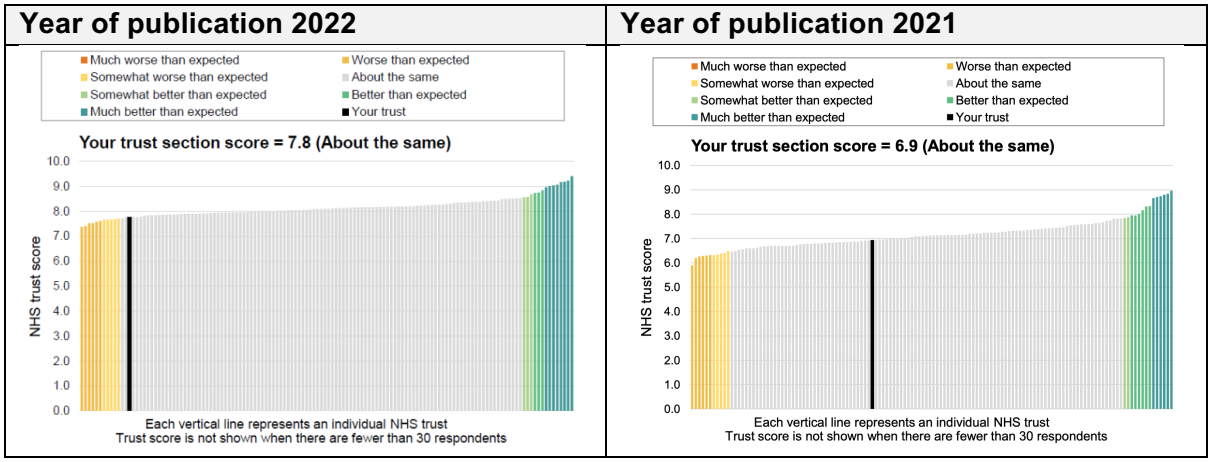
Overall, our patients report a mostly positive experience of our inpatient services, with an average of 89.1% of patients recommending our services through the Friends and Family Test (FFT) from April 2022 – March 2023. While this provides reassurance that we get it right for the majority, 10.9% of our patients are consistently not receiving a positive experience, and this feedback provides us an opportunity to improve the quality of care that we deliver for our patients.

Graph: Inpatients % positive March 2023



In addition to collecting our FFT data, we also have our 2021 National Adult Inpatient Survey results, which give us insight into the areas that we should also be focusing on. These results were published online September 2022. The table below shows how we compare nationally for overall experience of our inpatient services. The Survey Report uses an 'expected range' analysis technique which has been improved this year to include more nuanced categories to determine if our trust is performing better, worse, or about the same when compared with most other Trusts. Importantly, this is a national comparison with all other Trusts who took part in the survey. Our overall Trust Score was 7.8 and so we benchmarked "about the same" as other Trusts taking part in the Survey. Our benchmark position has declined and we are no longer "middle of the pack" and this will need to be monitored over the next year.

Graph: CQC National Survey ED results benchmarking score 2022 and 2021



In summary, in 2022 we scored comparatively to other NHS Trusts

- 'about the same' in 43 questions
- 'somewhat worse than expected' in 2 questions
- 'worse than expected' in 2 questions

The areas experience is better and where we could improve is shown in the table below

Where patient experience is best

- ✓ Taking medication: patients being able to take medication they brought to hospital when needed
- ✓ Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- ✓ Including patients: patients feeling included in nurses' conversations about their care
- ✓ Answers to questions: hospital staff answering patients' questions before the operation or procedure
- ✓ Information about medicines to take at home: patients being given information about medicines they were to take at home

Where patient experience could improve

- ○ Noise from other patients: patients not being bothered by noise at night from other patients
- ○ Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- ○ Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital
- ○ Help with eating: patients being given enough help from staff to eat meals, if needed
- ○ Feedback on care: patients being asked to give their views on the quality of their care

These themes about concerns relating to discharge have been echoed in our Friends and Family Test and Patient Advice and Liaison Service (PALS) data. Through our PALS service

we have heard from carers and families with concerns about food for patients. We are pleased that patients have reported feeling involved in conversations about their care and their questions being answered prior to operations and procedures.

The Patient Experience team have implemented a number of initiatives to support divisional teams in using their experience data effectively to drive improvements:

- Reviewing our reporting into divisions, to provide more holistic patient experience reports that give themes across insight sources.
- We have streamlined our data collection and reporting within our PALS service to enable our reporting to be triangulated more efficiently and our priorities to be easier identified.
- Supporting teams with the patient experience improvement plans in divisions, providing Quality Improvement (QI) coaching support.
- Introduction of department specific translation and interpreting guides to enable staff to feel confident in arranging an interpreter.
- Introduction of support for teams in identifying and referring carers to our locally commissioned Carers support service.
- 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.
- Roll out of projects such as the Surgical Assessment Unit (SAU) journey poster which focus on informing patients and relatives, and improving communication of processes.
- Reviewing and refining our Patient Experience Quality Improvement training to build understanding of different tools and approaches that can be used to support patient experience improvement.

Plans for improvement 2023/24

Our adult inpatient Friends and Family positive feedback tells us that patients do not like to be cared for in corridors and therefore our focus will be on reducing/eliminating **Boarding** of patients on wards.

We will also be continuing our improvement work in these areas:

- Work in collaboration with safety and effectiveness colleagues to support a Quality Summit around providing care in corridors.
- Work in collaboration with safety and effectiveness colleagues to support a Trust-wide quality improvement project around simple discharges. This includes leading a piece to support criteria led discharge.
- Implement a volunteer role to support cognitive stimulation of our patients, specifically those in our hospitals with no criteria to reside (NCTR).
- Implement a volunteer coordinator role to enhance our offer to our patients and to support delivery of our NCTR project.
- Implement ‘ask 3 questions’ to our patient information offer to support our work to deliver shared decision making.
- Continue to work on delivering the Accessible Information Standard with improvements to the accessibility of our patient letters personalised to the patient requirements.

- Procure a new joint translation and interpreting contract across NHS providers in Gloucestershire to improve continuity of care for our patients.
- Support the roll out and implementation of the ‘what matters to you’ folders which support our commitment to delivering personalised care.
- Deliver a programme of arts projects which support the health and wellbeing of both our patients and staff.
- Increase the accessibility of our PALS service through implementation of a ‘Pop Up PALS’ service.
- Work with the team delivering virtual wards to ensure patient experience is captured and acted on.
- Deliver the Worries and Concerns Project which will enable patients and carers to have access to our Acute Care Response Team if they are concerned about deteriorating health.

5. Quality priority

To improve the experience of discharge

Background

Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. During 2022/23, there have been multiple work streams underway to support the reduction in delays to discharges and these can be categorised into four main work streams; Internal processes/improvement works, the system Sloman Plan, the national 100-day challenge and what was known as reset week at the beginning of October 2022.

How we have performed 2022/23

Internal processes/improvement works

The start of the year saw a strong focus on internal and system level processes to ensure they were lean and adding value to the patient journey. This was driven through the development of strong Trust and System data and digital operational platforms to support clinicians make better and more timely decisions. This was very much in keeping with the strong national drive to ensure improvement in patient flow is data enabled, clinically led and operationally embedded. Some of the specific work streams were:

- Agreeing and embedding a process to support conversations around the transfer of patients from the acute into community hospitals, reducing decision making delays and ensuring accurate information has been shared to support ongoing patient care.
- Change in process for the Home First pathway to manage all offers through Onward Care Team (OCT) for acceptance - enabling early identification, documentation of offer and any bridging conversation needed to enable earlier discharge, all helping patients and relatives to be kept informed and up to date with progress.
- Introduction of a planned discharges document sent through to OCT, Site, Operations and Urgent care teams twice daily for visibility and early 'readying' patient for discharge, avoiding on the day of discharge delays, whilst allowing earlier notification to patients and relatives of planned discharges.
- Introduction of a daily OCT Escalation Lead, enabling ward OCT staff to escalate barriers impacting on the discharge of same day/next day complex patient discharges, increasing senior support to staff, whilst helping avoid unnecessary delays to discharge. This included the creation of an escalation line and mailbox, which is now a single point of contact for OCT support, both internally and that of our partner organisations.
- Introduction of ward manager mobile phones, along with the distribution of these numbers to our partner organisations. This has significantly reduced delays associated with the challenge of getting through to a ward or being able to speak to a nurse looking after a patient when trying to facilitate a discharge.
- This has led to the creation of professional standards for communication/escalation between OCT and Brokerage, driving regular updates to both keep patients and

relatives informed, but also allow earlier identification of problems and subsequent mitigations to be put in place.

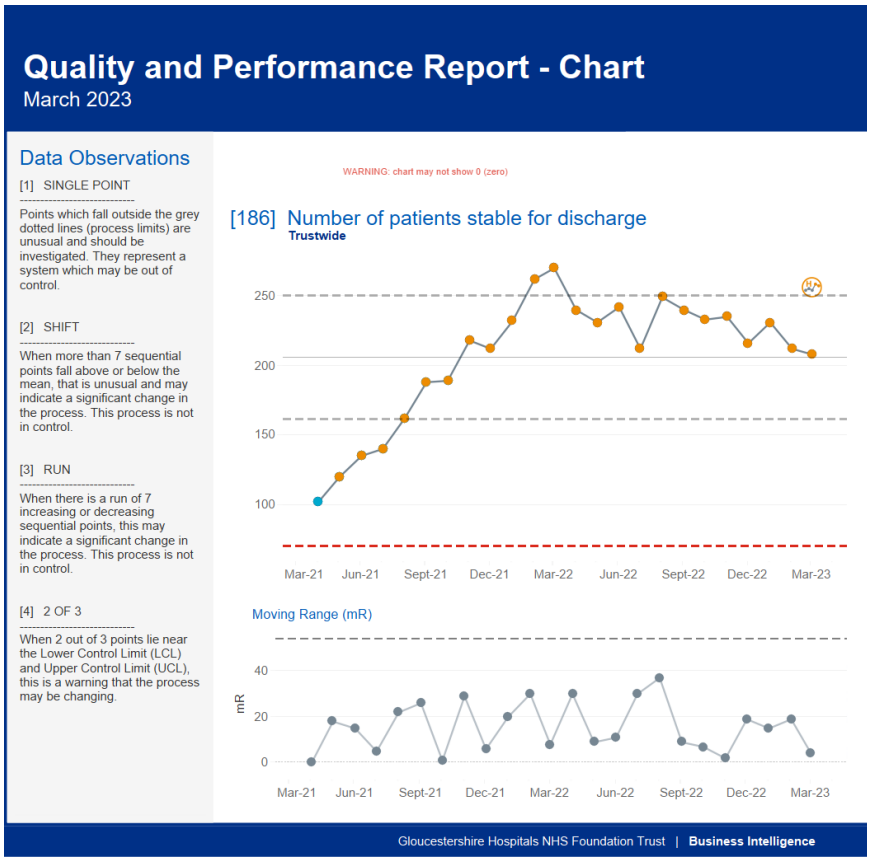
- A specific piece of work to review and target positive outcome for all patients who firstly have been waiting for discharge for more than 75 days, then subsequently moving down to 50+ days as we saw a positive reduction in the over 75 group, further reducing through 40+ to now focusing on patients at 30-40 days.
- Chairing Transfer of Care Bureau (TOCB) as part of the interim plan to enable pathway decisions for all complex patients requiring pathway 1 to 3 on discharge
- Introduction of 'remote' clinical reviews with Gloucestershire GHC patient flow team to identify most appropriate 'flex opportunity' and/or step down of patients as able. Ensuring all capacity has been utilised.
- Introduction of weekly reviews and updates on all patients waiting for Home First, OCT working alongside Therapy to consider as patients improve, whether we can consider alternative pathways to help patients return home sooner.
- Ongoing collaboration with the voluntary sector around enabling hospital discharge, but also now extending to post discharge follow up calls by both the Trust and voluntary sector staff. Working in collaboration to ensure as many questions or concerns can be managed without the need for referral into primary care, or readmission to hospital.
- Introduction of the virtual whiteboard (digital bed management system) to support daily operational knowledge of flow and discharges, whilst also providing a single point of communication and escalation of flow related issues.
- Introduction of an ‘Early Meds for Early Beds’ campaign to drive completion of To Take Out medication and help move discharges to earlier in the day, minimising the issues for those discharged later, whilst improving early flow within ED.
- Built and opened a new Discharge lounge which has enabled the ability to release specialty ward beds earlier in the day, whilst improving the experience of patients on the actual day of discharge. The recurrent staff has now been secured for 23/24 onwards, with plans to continue with the improvements being seen within the utilisation of the unit for the majority of discharges on the GRH site.
- Introduction of a Clinical Assessment and Decision Unit (CADU) to enable a 24hr approach to acute medicine, as well as providing an improved pathway for GP admissions by combining a clinical decision unit with GP assessment unit. This has seen a significant step improvement in our 0-1day LOS figures, supporting our overall reduction in LOS. But it has also provided a much better pathway for patients sent to hospital by their GP through the Cynapsis route, rather than being brought into and having to go through ED first.

‘The Sloman Plan’ (Link to letter July 2022) and Acute Hospital Discharge “100-day Challenge”

The Sloman Plan was a nationally mandated piece of work at a system level, designed to directly impact on and lead to an improvement in UEC performance. Each organisation had to identify key work streams to achieve an improved 4hour standard and reduction in ambulance handover delays within ED.

As a Trust, we identified 8 schemes which are now known as our Sloman Plan, having to report progress on the schemes every 2 weeks. These reports show a gradual improvement in Trust performance around ED and ambulance handovers through the driving of better decision making, improved hospital processes and thus allow ambulance offloads. What the report also shows is and ongoing need to continue work around community pathways to reduce the overall number of no Criteria to Reside (nCTR) patients. Although a Sloman plan has not been mandated for 23/24, as an ICS we have decided to continue with this approach as part of our yearly operational planning, and as such are currently finalising the 23/24 schemes.

Statistical Process Chart: Number of patients stable for discharge November 2020 - March 2023



Alongside this sat another nationally mandated piece of work, but with a more back door or discharge focus. 10 best practice descriptors were identified at a national level, with each system and Trust needed to RAG rate themselves and provide evidence against why they have rated themselves as such. Through meetings with NHS England (NHSE) a baseline was agreed, along with a clear action plan identifying the improvements required to improve flow and achieve a green RAG rating across all 10 descriptors within each organisation.

Below is our latest audit as a Trust, showing our RAG rating and the progression we have made over the year. It shows we have gone from a very much red/amber dominated picture to one that is now predominantly green, with a few remaining amber. Importantly none are now considered as red as agreed by the NHS E regional team, with the work ongoing into the 23/24 financial year, with regular meetings with regional NHSE teams to monitor progress and aim to have all rated as green.

Table: Sloman Plan (RAG ratings) and update

	Interventions	Jul 22	Sep 22	Oct 22	Feb 23	Mar 23	May 23	System feedback/comments (how did you get there, next steps and plans to progress or reasons not to implement the intervention)
1	Identify patients needing complex discharge support early							Redesign of Transfer of Care Bureau (TOCB) now an ICS function. Development of the Gloucestershire Hospitals NHS Foundation Trust (GHFT) whiteboard and internal bed management flow system, progression of the system wide flow tracker with Patient Tracking List (PTL) behind, roll out of LLOS predictor AI tool.
2	Ensure multidisciplinary engagement in early discharge plan							Relaunch of daily rhythm and board round red to green actions utilising the flow white board to collate actions for today and next 48hrs. Improvement still required in discharge before 5 and next 48 hr planning hence amber.
3	Set expected date of discharge (EDD), and discharge within 48 hours of admission							Expected Date of Discharge (EDD) set within 48hrs of admission – clinical accuracy is variable but will be superseded by LLOS predictor data which will give risk of long length of stay and EDD with proven accuracy.
4	Ensuring consistency of process, personnel and documentation in ward rounds							Roll out of EPMA has improved multiple components of WR safety and discharge-consistency of team membership at board rounds to include MDT still required in some areas.
5	Apply seven-day working to enable discharge of patients during weekends							Continued use of flow white board internally at Gloucestershire Hospitals NHS Foundation Trust (GHT) to plan weekend discharge in advance and criteria led discharge. System wide planning for discharge and sharing with all system partners EDD's for next 48hrs across home first brokerage and community services.
6	Treat delayed discharge as a potential harm event							Process remains in place.
7	Streamline operation of transfer of care hubs							TOCB and SCC working in alignment, TOCB operational development group established, referral processes under review including improved electronic referral-consistent ICS coordination of daily meetings aiming to improve processes.

8	Develop demand/capacity modelling for local and community systems							This will be realised through the Urgent and Emergency Care (UEC) and system flow transformation programme following Newton diagnostic 23/24.
9	Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges							Alignment of SPCA and rapid response teams to have a true single point of referral 1/4/23, linking in to TOCB to and brokerage to look at predicted demand across localities. Additional Dom care block sourcing in place to meet demand across the county with a focus on more difficult local areas to staff. Joint support for home first front door pathway through a combination of GHC and brokerage re-ablement capacity sourcing.
10	Revise intermediate care strategies to optimise recovery and rehabilitation.							In 2023/24, we will see further focus on reduction of bedded Discharge to Assess (D2A) pathways and increase in pathway 1 capacity. Reduction in total beds will enable reablement and workforce efficiency and allow a much more effective offer to be delivered with a shorter Length of Stay (LOS) and increased flow. D2A flow coordinator post to be recruited to JD in finalisation.

Alongside this each system had to also identify the 3 key standards that as an ICS we will focus our improvement work on. As a OneGlos system we agreed a need to focus on standards 2,5 and 8 as they offered the most likely biggest return in investment. We also asked for support and further clarity from the national team around delay related harm guidelines. This is something we measure well and report on, unlike many other systems, but as yet there is no formal direction on a standardised way to use this information or performance measure. This work is still ongoing and being played into the Newton diagnostic work, recognising that they include some more complex components to achieve at a system level.

Reset week

At the beginning of October, we, and the wider OneGlos system, entered into what we referred to as reset week. During this week, we stood down all normal activities and focused all energy and work on patients flow and ED performance. We have subsequently carried on the work streams we identified through new ways of working and the experiential learning which occurred. Some of this strengthened work already underway within our Sloman or 100-day challenge plans, whilst also identifying new work streams which could improve the experience and outcomes of our patients.

The main areas we have been focusing on are using digital technology to support operational performance and communication both internally and with our system partners. The introduction of a digital site management system has allowed better identification of potential discharges, allowing the wider MDT to ensure all discharge related processes have been completed, avoiding unnecessary delays. This along with the introduction of a boarding policy which allows the safe pre-empting of patients onto the wards, have been the main catalysts for a significant improvement in ED performance around ambulance handovers.

Part of this work was the setting up and running of a campaign to support people to stay at home once discharged from hospital with regular updates to #TheresNoPlaceLikeHome internet page with useful support and links to resources. This has been combined with wider work to educate both patients and staff around the risks as well as the benefits of being in hospital, recognising the balance and need to consider that staying in hospital may be more of a risk than going home. This is often the opposite of most people’s conscious or unconscious assumption that hospitals are safe places.

The second half of the year saw a continued programme of works focusing both on ED performance and an overall reduction in our nCTR numbers and improved patient flow. This has led to two successful quality summits, 1 based on TTOs and facilitating earlier discharges, the other focused on corridor care and wider flow and discharge components such as board rounds and alternatives to admission within ED. All has seen a significant improvement within our ED performance and wider flow outcomes. Whilst also helping identify and direct the continued improvement works taken into the 23/24 operational year.

The main highlights in improved performance within the 2022/23 work being:

- DTAs as at 8am typically in the 70s, now in the 40s
- Ambulance handover hours lost per day initially in the 200s in October, now in the 40-50s.
- 12hrs in department breaches have reduced from 1180 per month in Dec to 952 in Feb.
- nCTR numbers peaked at 272 in Dec/Jan, now @ 180 – equivalent to a 3 wards reduction in numbers at 92 beds released
- D2A patients waiting at 101 in Sept22, now at 28.
- 21+ days peaked at 268 (31%) in October, now at 190 (22%)
- Averaging 20 additional discharges per weekend since additional weekend processes put in place. Now 21% of weekday discharges – regional average 19%.
- Improved discharge profile with shift to earlier in the day, baseline 55% of discharges achieved by 5pm, now @ 66%, with peak of 70% at end of Jan.
- Simple discharges performance has been variable with periods of improvements at the end of 2022, but not sustained. Since January there has seen a sustained improvement with an upward trend peaking at 119 per day w/c 20th Feb.
- CADU operational within Courtyard space with significant impact on ED performance. 22% of patients managed through a short stay model (>72hrs), whilst an additional 29% were discharged within 24hrs. Trust data also showing improved 0 and 1 day LOS data with 26% of admissions managed since operational.

- Average LOS has seen a significant drop from 16.7 days in October 22 to now being 9days.
- Discharges through Discharge lounge struggled initially as the workforce recruitment was undertaken, but towards the end of the 22/23 year once staff we in post, the unit has been taken on average 24 patients per day, with a continued upward trajectory.

Plans for improvement 2023/24

Improvement plans surround hospital flow and discharge for 2023/24 have been group into 4 main work streams which have a number of individual projects within them. Having all been identified through the various work streams discussed above along with a recent discharge process audit we have undertaken with the support of an external auditing company, highlighting many of the same themes we had identified anecdotally.

1. **Alternative pathways** – This is where our work around providing alternatives to both ED attendances and admissions. This will pick up continued improvements in the CADU model, virtual ward implementation, better utilisation of Cynapsis and wider alternative pathways to getting specialist input when required, including community services.
2. **UEC processes** – This is the work related to the experiences and processes that occur within our ED and UEC attendance pathways. Continuing to improve on our ED 4hour performance, ambulance handover delays/cat 2 performance, 12 hours in ED and our decision to admit process and delays.
3. "**simple" discharges** – This is where we will continue to pick up the work identified through the QI approach we have taken to understanding ward level processes, along with the programmes which have come out of the quality summits and discharge audit. This focuses on our internal actions and processes, driving down LOS and improving both our number of discharges and the time of day we discharge our patients.
4. **"complex" discharges** – This is where we will continue both the internal, but also system work around improving the access and timeliness of accessing pathway 1-3 discharge routes, continuing to drive down our nCTR numbers. This will be where the ICS work around the implementation of the newton diagnostic will also be captured and monitored.

There are multiple meetings and teams involved in projects across all 4 of these areas, making oversight and governance challenging. We have as a result introduced a newly formed hospital flow and discharge steering group which meets on a monthly basis to monitor progress against these areas and provide an opportunity to raise concerns and requests for support. This meeting will then formally provide an update to DOAG, both for information and when formal sign off is required, leading up to TLT for ratification. Recognising that some projects will be of significant size, they will require their own individual governance process, or one that is more at an ICB level due to the cross system inter dependencies or impacts. This is still being finalised as it will need to be linked into the ICB transformation work being conducted alongside Newton Europe.

6. Quality priority

To enhance and improve our safety culture

Background

Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience. The safety culture context within the NHS Patient Safety Strategy defines a positive safety culture as one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all

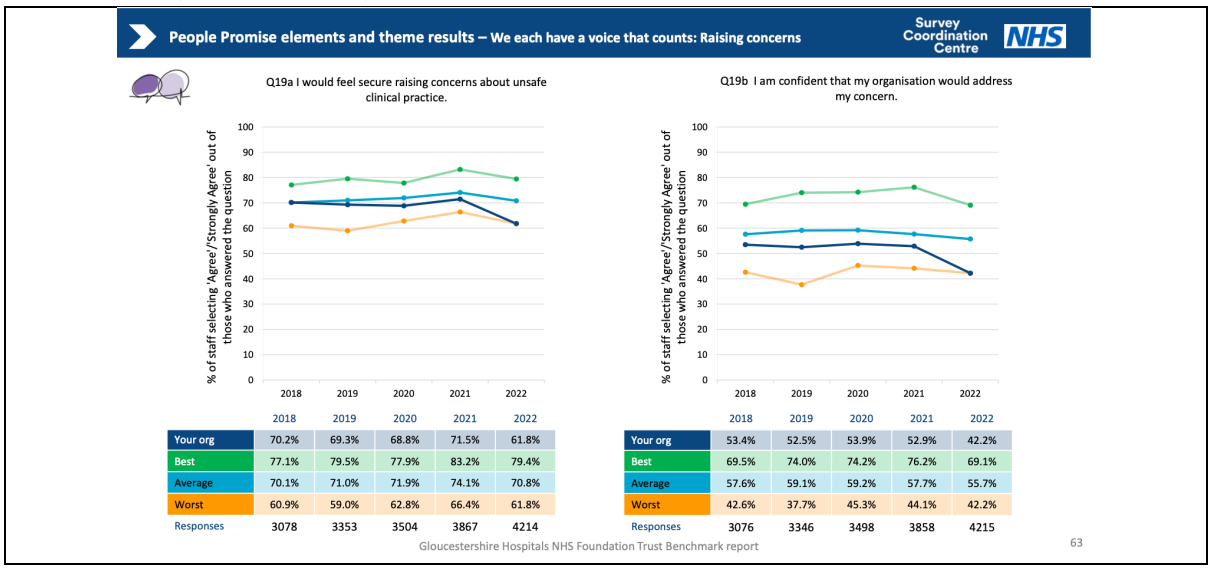
The NHS Patient Safety Strategy includes the introduction of the following:

- 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 2022/23

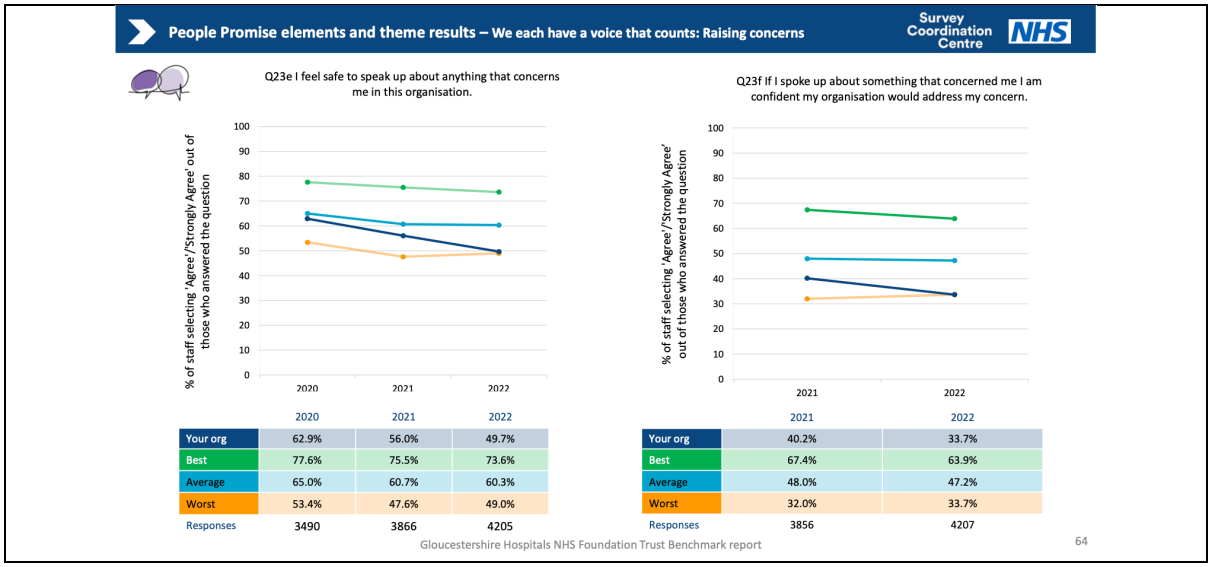
Measure = NHS Staff Survey question "I feel safe to speak up about anything that concerns me". Our scores have declined from 62.9% in 2020 to 56.1% in 2021 and are 49.7% in 2022.

Graphs: Gloucestershire Hospitals NHS Foundation Trust NHS Staff Survey Benchmark Report 2022 (9 March 2023)



	2018	2019	2020	2021	2022
Your org	70.2%	69.3%	68.8%	71.5%	61.8%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	3078	3353	3504	3867	4214

	2018	2019	2020	2021	2022
Your org	53.4%	52.5%	53.9%	52.9%	42.2%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	3076	3346	3498	3858	4215



Trying to understand, measure and improve safety culture can appear to be nebulous goal. However, it is one of the two key foundations of the NHS Patient Safety Strategy and in the delivery of our Trust's Quality Strategy 2019-2024 we chose to benchmark the progress of our safety actions against the NHS Staff Survey questions. Our ambition for safety is that people are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.

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

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

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

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

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents

3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute healthcare providers. Organisations are expected to transition to PSIRF within 12 months, completing by Autumn 2023.

Preparation and Implementation

PSIRF preparation has been split into six phases. The phases and transition timescales are shown below in figure 1 and their purpose in figure 2.

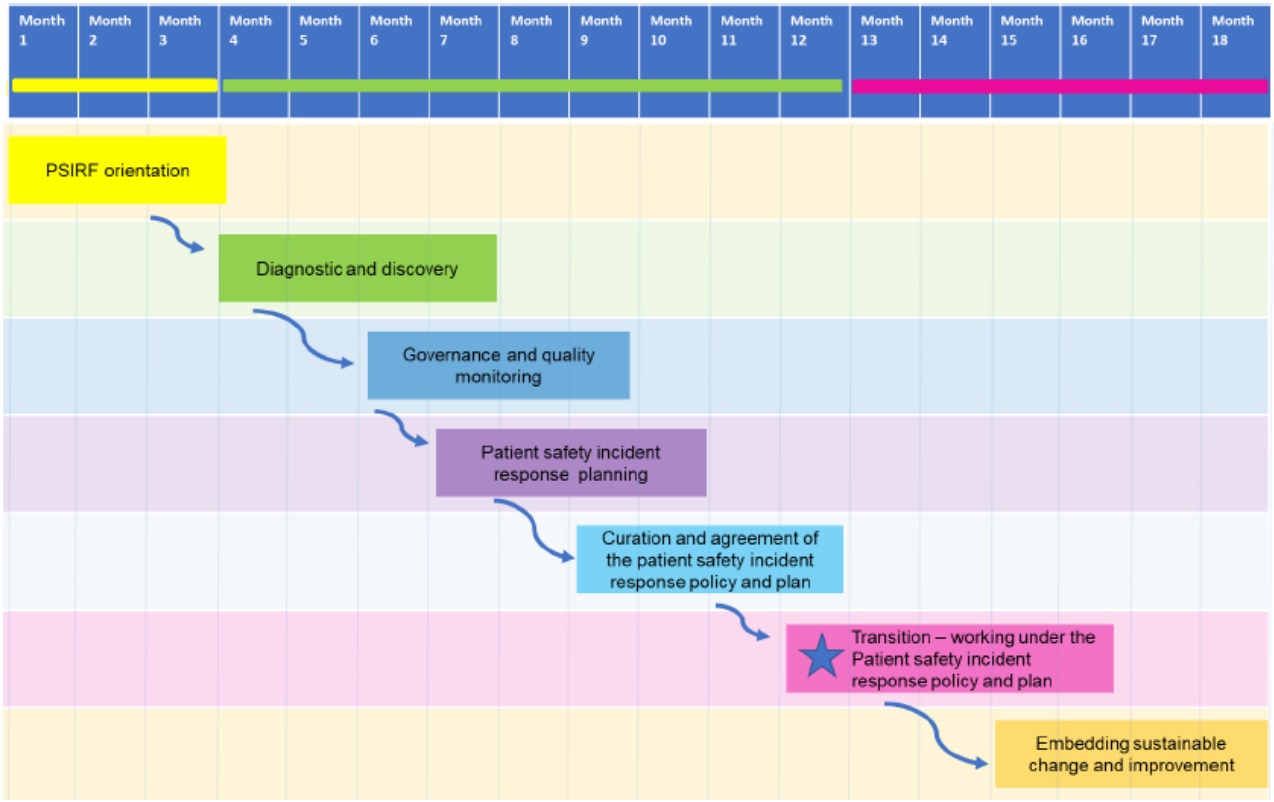


Figure 1. Transition time frames and phases.

Phase	Duration	Purpose
PSIRF orientation	Months 1–3	To help PSIRF leads at all levels of the system familiarise themselves with the revised framework and associated requirements. This phase establishes important foundations for PSIRF preparation and subsequent implementation.
Diagnostic and discovery	Months 4–7	To understand how developed systems and processes already are to respond to patient safety incidents for the purpose of learning and improvement. In this phase strengths and weaknesses are identified, and necessary improvements in areas that will support PSIRF requirements and transition are defined.
Governance and quality monitoring	Months 6–9	Organisations at all levels of the system (provider, ICB, region) begin to define the oversight structures and ways of working once they transition to PSIRF.
Patient safety incident response planning	Months 7–10	For organisations to understand their patient safety incident profile, improvement profile and available resources. This information is used to develop a patient safety incident response plan that forms part of a patient safety incident response policy.
Curation and agreement of the policy and plan	Months 9–12	To draft and agree a patient safety incident response policy and plan based on the findings from work undertaken in the preceding preparation phases.
Transition	Months 12+	Organisations continue to adapt and learn as the designed systems and processes are put in place.

Figure 2: Purpose of PSIRF preparation phases

In addition to the framework itself, a number of documents have been produced containing guidance and information related to the introduction of PSIRF. A summary of the available documents and the intended outputs is shown in figure 3, below.

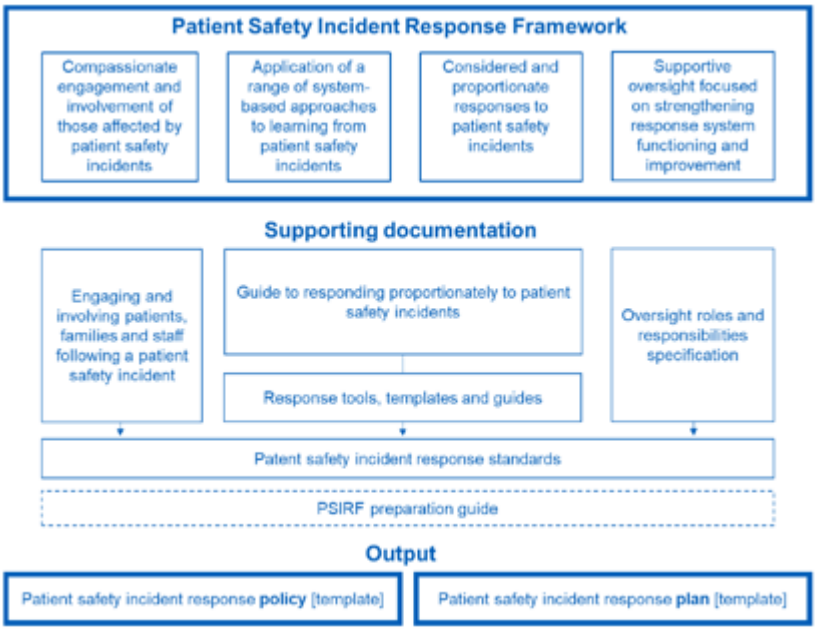


Figure 3: Overview of the PSIRF documentation and outputs

Fortnightly working group meetings have been set up from the 20th September, to plan and implement the introduction of PSIRF, project updates will be provided from this group to Quality Delivery Group QDG on a monthly basis.

Plans for improvement 2023/24

To enhance and improve our safety culture we will be implementing the **National Patient Safety and Incident Response Framework (PSIRF)** which will bring a change to our safety investigation work and we will be **focusing on staff being able to raise their concerns (Staff Survey questions 19a, 19b, 23a and 23f).**

7. Quality priority

To improve our prevention of harm (pressure ulcers and falls)

Background

Pressure ulcer prevention

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 (European Pressure Ulcer Advisory Panel (EUAP) 2019).

Pressure ulcers can affect anyone from new-borns 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. Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day. Finding ways to improve the prevention of pressure damage is therefore a priority for policy-makers, managers and practitioners alike (NHS, 2018).

Pressure ulcers and falls are one of our key indicators of the quality and experience of patient care in our Trust. This past year has continued to be challenging for everyone, none more so than health care workers. Despite this staff in the Trust continued their hard work and dedication to make improvements in pressure ulcer and falls prevention ensuring that patient safety is a priority.

Falls prevention

Falls are the most common reported type of patient safety incident in healthcare. Around 230,000 patients fall in acute and community hospitals each year (NHS England, National Reporting System 2013, 2014). Over 800 hip fractures and about 600 other fractures are reported as a result of a fall.

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 interventions
- Older patients are both more likely to fall and more likely to suffer harm – falls amongst 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

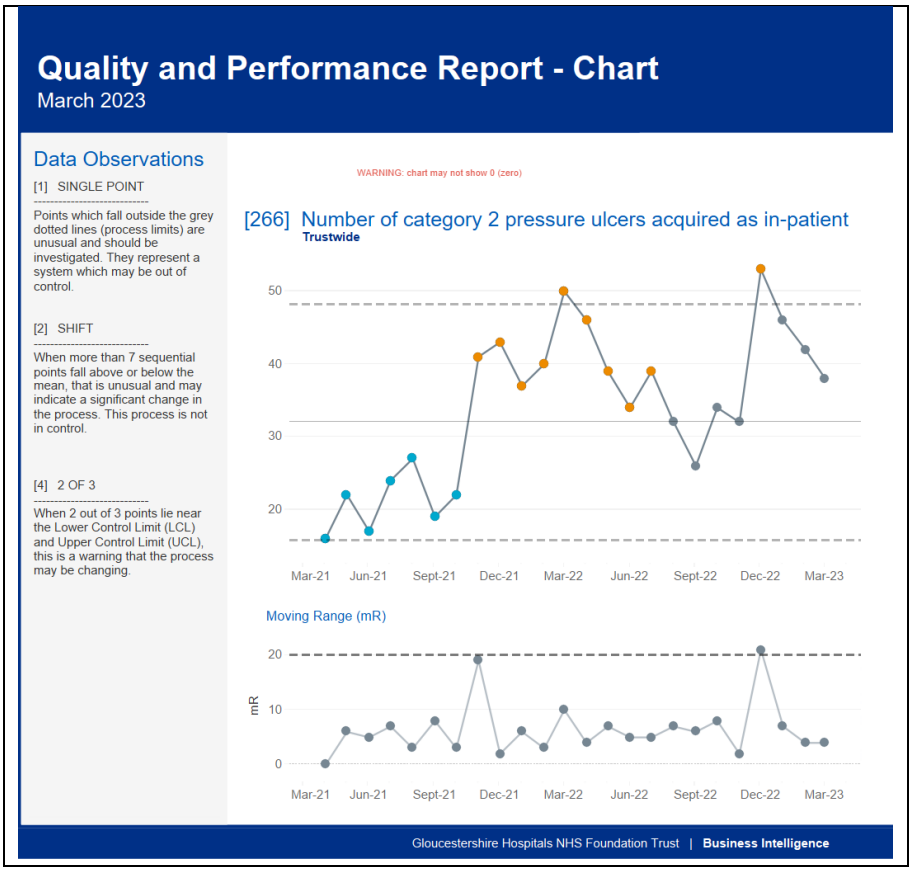
How we have performed 2022/23

The Trust set up the Preventing Harm Improvement Hub, with a focus on reviewing cases of pressure ulcers and falls and where rapid feedback is given on the results of the investigation.

Pressure Ulcers

The charts below show our current data for category 2, 4 and 4 and deep tissue hospital acquired pressure ulcers.

Graphs: Pressure ulcers – number of category 2, 3, 4 and deep tissue (March 2023)

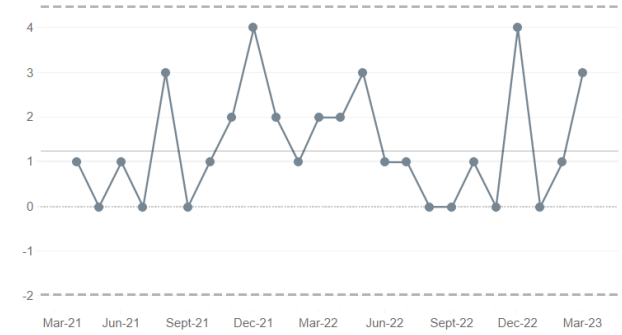


Quality and Performance Report - Chart
March 2023

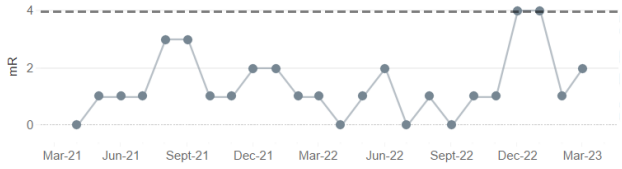
Data Observations

WARNING: chart may not show 0 (zero)

[267] Number of category 3 pressure ulcers acquired as in-patient
Trustwide



Moving Range (mR)



Quality and Performance Report - Chart
March 2023

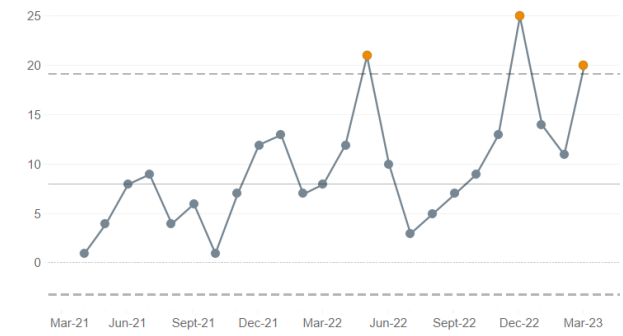
Data Observations

[1] SINGLE POINT

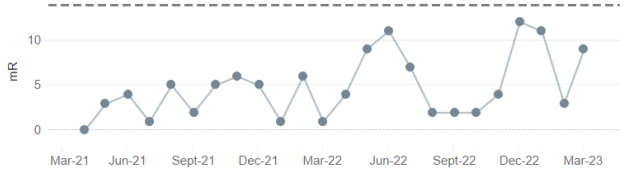
Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.

WARNING: chart may not show 0 (zero)

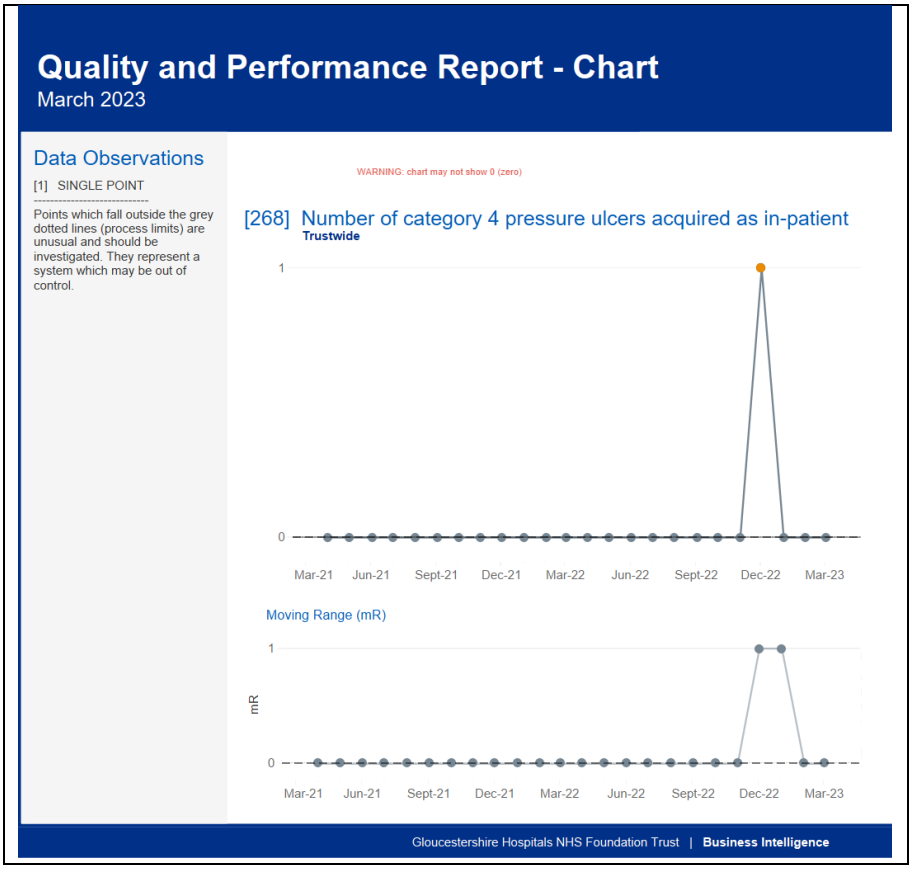
[462] Number of deep tissue injury pressure ulcers acquired as in..



Moving Range (mR)



Gloucestershire Hospitals NHS Foundation Trust | **Business Intelligence**



There are two main contributory factors to this reported increase in the number of Hospital Acquired Pressure Ulcers in 2022/23. 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 other factor is the number of patients delayed discharge or even admission to a hospital bed; higher levels of frailer and deconditioned patients awaiting social care has impacted nationally. Shortages in specialist nursing staff has also impacted on the ability to care for the patients' needs post-acute illness. As patients become frailer their mobility is often affected, this reduced mobility is the most significant factor in pressure ulcer development. Patients have experienced longer ambulance and emergency department waiting times and this has also impacted on the pressure ulcer risk assessment being delayed.
.
All reported cases of category 3, 4 and 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. Other areas that affect the prevention of pressure ulcers identified through

the review of cases at PHIH are Human factors such as patient's choices and reports of equipment access being delayed.

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

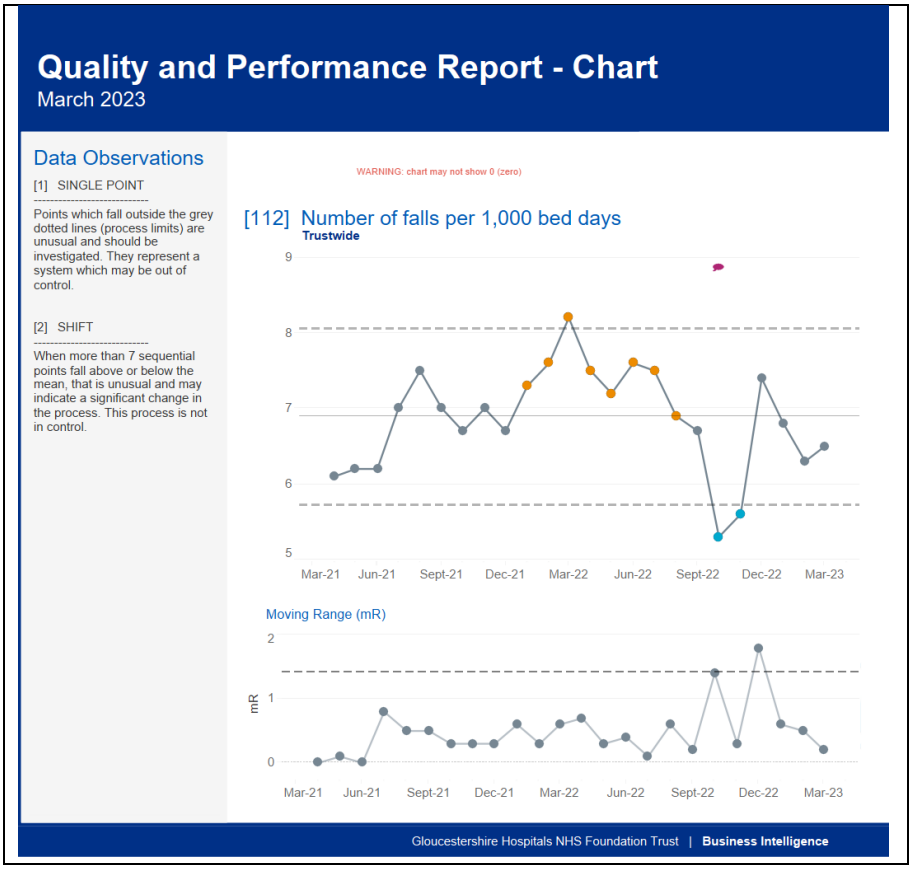
- Rapid dissemination of learning from Preventing Harm Improvement Hub and the shared decision making council.
- Pressure Ulcer Prevention training (PUP), formerly React to Red training.
- Increase in offerings of PUP training both face to face and virtual across all sites of the Trust.
- PUP videos "The Skin and Pressure Ulcers".
- Link nurses' Group for tissue viability identified across all divisions meetings held in 2022/23.
- #StopThePressure 18th November 2022 awareness event run on international pressure Ulcer awareness day.
- Daily offering of spoke placements for clinical staff including, Student Nurses, Doctors, Trainee Nurse Associates (TNAs), Dermatologists, Dieticians and Health Care Assistants (HCAs).
- Bespoke face to face and virtual PUP presentation at foundation level for Emergency Department (ED) commenced February 2022.
- Tissue Viability News Letter (4 x yearly) with emphasis always on Pressure Ulcer Prevention.
- Gloucestershire Hospitals Pressure Ulcer Prevention Guidance (clinical effectiveness).
- Clinical review of all patients with a hospital acquired pressure ulcers.
- A bespoke tissue viability conference for midwives and children's nurses with emphasis on pressure ulcer prevention.
- The development of the Pressure Ulcer Prevention Equipment (PUPE). A trolley with pressure ulcer prevention equipment on for use in the ambulance. This is in place following consultation with South West Ambulance Foundation Trust (SWAFT) for the prevention of pressure ulcers whilst patients are awaiting to be alighted from the ambulance. The trolley also has information leaflets for patients and education for staff in pressure ulcer prevention.
- There are also a number of improvements in progress, including:
    - Extra support for teams as required for pressure ulcer prevention when requested.
    - Audit of hospital mattresses to assure quality and ongoing procurement planned March 2023
    - Review of the Learning from and prevention of patient harm hub with more emphasis on the review of outcomes of the action plans.
    - CQUIN
    - Introduction of a new risk assessment tool PURPOSE-T

Falls

The falls prevention team consists of a Specialist Nurse and a Falls Practitioner (Physiotherapist) who was employed in November 2021. With the expansion of the team the work around education and patient reviews, following a second inpatient fall, has increased.

The charts below show the data for our falls per 1000 bed days and the number of falls resulting in harm.

Picture: Quality and Performance Reporting Falls



There remain challenges to the reduction of falls within the trust:

- The acuity of the patients remains higher and older people are more deconditioned as result of the pandemic
- Patients who are medically ‘optimised 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 continuing not to always being covered
- Staff fatigue.

Wards that have had an increasing number in falls and falls with harm have had ward based teaching sessions, namely the Respiratory unit. They have had some acutely unwell patients, who are End of Life but have evidence that falls assessments have been completed and appropriate interventions have been put in place.
All the wards have continued to engage with the falls prevention team and there have been occasions where the wards have made contact prior to any falls as a persuasion.

General falls prevention training has continued on a monthly basis and as of January 2023 the sessions have changed to a full days training. The training has been well attended with several wards ensuring that all their staff are booked on to attend. Therapy staff are also invited, but there has been little engagement to date.

The falls team continue to review patients who have had 2 inpatient falls during admission and the repeat fallers are beginning to reduce, however there are some patients who continue to fall due to their pre-existing medical conditions.

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 (to date (October 22 – February 23) 77staff (nursing and therapy) have attended training.
- In the Emergency Department (ED) – use of yellow blankets for identification of people identified as at risk of falls. This is also rolled out to the Care of the Elderly (COTE) and Stroke wards. This project has stalled due to ED capacity and the need for the project to be rolled out across the Medical Division. This is due to be reinstated within the ED department
- Falls prevention is now a regular session on the ED foundation training day
- Following audit of falls assessment documentation on the Electronic Patient Record (EPR) for the Emergency Department (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
- 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.
- Falls link roles have been opened up to include Therapy staff.
- The falls link training has been updated to a whole days training to include more education around certain aspects of falls prevention
- 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 Care of the Elderly (COTE) and Stroke wards to enable ongoing identification of patients who are at increased risk of falls
- People who fall more than once, “repeat fallers”, we have continued to review with a significant number of patients not falling again following review. Those who continued to fall, were going to fall despite interventions.
- Continuation with Prevention Harm Hub to ensure rapid dissemination of learning for the wards
- Falls newsletter is ow published quarterly with a theme for each quarter.
- 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.
- The falls steering group is due to be reinstated to ensure that there is governance and assurance around falls prevention – commencing April 2023

Plans for improvement 2023/24

Pressure ulcer prevention - In 2023/24, we will be taking part in the Commissioning for Quality and Innovation (CQUIN 12) the assessment and documentation of pressure ulcer

risk. NICE clinical guideline CG179 sets out best practice for assessing the risk of pressure ulcer development and acting upon any risks identified. It is fully aligned with the recently re-published National Pressure Injury Advisory Panel (NPIAP).

Falls prevention - In 2023/24, we will take forward the recommendations made by the NHSE Team when they visited the Trust and the National Audit of Inpatient Falls (NAIF) recommendations.

8. Quality priority

To improve our care of patients whose condition deteriorates

Background

Early Warning Scores (EWS)

Patient deterioration is linked to 90% of NHS bed days. Reducing the need for higher levels of care would free up capacity particularly in Intensive Care Units (ICU) by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts.

Early Warning Scores are clinical prediction models that use measured vital signs (temperature, heart rate, respiratory rate, systolic blood pressure, level of consciousness, oxygen saturation and temperature) to monitor patients' health during their hospital stay. The models identify the likelihood of patients deteriorating. When a patient shows signs of deterioration, the EWS triggers a warning so that care can be escalated. Historically EWSs were implemented on paper based systems, but across the Trust they are now becoming part of the electronic health record system with Adult EWS charts (NEWS2) being recorded on our digital system for the last 2 years.

Early Warning Scores assist healthcare professionals in recognising the deterioration of a patient by categorising the severity of illness, thus prompting staff to respond and request review at specific trigger points. Deterioration can be defined as when a person moves from their 'normal' clinical state to a 'worse' clinical state. The 4 tools we use in this organisation are: -

- Newborn Early Warning Track Trace (NEWTT) for our newborn infants,
- Paediatric Early Warning Scores (PEWS) for children and young people (age appropriate charts).
- Modified Obstetric Early Warning Scores (MOEWS) for our maternity population, and
- National Early Warning Scores (NEWS2) charts for our adult patients.

Commissioning for Quality and Innovation (CQUIN CCG03)

CQUINs were introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in in quality and innovation in specified areas of care. In March 2022, NHS England introduced a new Commissioning for Quality and Innovation (CQUIN) which involved recording of the NEWS2 score, escalation time and response time for unplanned critical care admissions. The ambition was that this measure would incentivise adherence to evidence-based steps in the identification and recording of deterioration, enabling a swifter response,

How we have performed 2022/23

Early Warning Scores (EWS) Audits

EWS was created to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients. The EWS 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. At a local service delivery level, clinical audit is one of a range of quality improvement methodologies that can deliver improved processes and outcomes for service users. Clinical audit is a way to find out if healthcare is being provided in line with standards and support us, and patients, to know where our services are doing well, and where there could be improvements. The next table summarises the audit findings and the planned actions to be taken to make improvements.

Table: Audit results

<table>
<tr><th>EWS</th><th>Number of patients audited</th><th>Audit findings</th><th>Planned actions for improvement</th></tr>
<tr><td>NEWTT</td><td>48</td><td>In this year 2 NEWTT audits have been completed.

<table>
<tr><th>Audit</th><th>Data</th></tr>
<tr><td>Number babies audited</td><td>48</td></tr>
<tr><td>NEWTT chart present</td><td>95%</td></tr>
<tr><td>Initial newborn observations (obs) recorded</td><td>95%</td></tr>
<tr><td>All parameters completed</td><td>95%</td></tr>
<tr><td>Risk factors identified</td><td>43.3%</td></tr>
<tr><td>Observations as expected (risk)</td><td>100%</td></tr>
<tr><td>1 Amber area alert</td><td>9/48</td></tr>
<tr><td>Observations repeated in 30 minutes</td><td>51%</td></tr>
<tr><td>2 Ambers or 1 red area</td><td>1/48</td></tr>
<tr><td>Escalated to medical team</td><td>100%</td></tr>
</table></td><td>– Staff advised that all babies should have their initial observations recorded on the NEWTT chart.
– Findings of the audit to be shared with staff and their ideas for improvement to be sought.
– Staff to be reminded to complete scoring section of the NEWTT chart.
– It is planned that there will be focused work in this area with the “Worries and Concerns” programme of work.
– NEWTT charts will be on the new maternity and neonatal digital system from June 2022.</td></tr>
<tr><td>PEWS</td><td>156</td><td>The paediatric team have been part of the National PEWs chart development auditing regularly and feeding back results to the centre. We have lots of data collected and have picked out a few highlights/issues that we need to improve in the below table.

<table>
<tr><th>Audit</th><th>Data</th></tr>
<tr><td>Total Number</td><td>156</td></tr>
<tr><td>PEWs chart present</td><td>100%</td></tr>
<tr><td>Initial observations (obs) taken</td><td>100%</td></tr>
<tr><td>Missing obs</td><td>63%</td></tr>
</table></td><td>– The PEWs audits have focused on providing the national team with data to finalise a standardised chart for the use across England.
– This work has just been completed and the new national charts will be available from end of March 2023.
– Focused work in this area with the “Worries and Concerns” programme will continue with a focus on recording parental concerns at the time of taking early warning score observations.</td></tr>
</table>

<table>
<tr><th>EWS</th><th>Number of patients audited</th><th>Audit findings</th><th>Planned actions for improvement</th></tr>
<tr><td></td><td></td><td><table><tr><td>Most common observation missing BP</td><td>60%</td></tr><tr><td>Parental concerns recorded</td><td>57%</td></tr></table></td><td></td></tr>
<tr><td>MEWS</td><td>92</td><td>There was a CQC section 29a warning notice for the Trust that our lack of auditing and a plan for audits was a concern.

<table><tr><th>Number of women (TOTAL)</th><th>92</th></tr><tr><td>MOEWS chart present</td><td>95%</td></tr><tr><td>5 parameters completed</td><td>100%</td></tr><tr><td>Scoring calculated correctly</td><td>89%</td></tr><tr><td>Amber score repeat observations</td><td>80%</td></tr><tr><td>Red score = escalation</td><td>95%</td></tr></table></td><td>– Monthly audits have been completed since July 2022.
– Focused work in this area with the “Worries and Concerns” programme of work will continue into next year.</td></tr>
<tr><td>NEWS2 Adult inpatient</td><td>146</td><td>NEWS2 “snap shot” audits have been undertaken in all Divisions with the results disseminated to the teams.

<table><tr><th>Audit</th><th>Data</th></tr><tr><td>Total Number</td><td>146</td></tr><tr><td>Chart present</td><td>100%</td></tr><tr><td>Initial observations (obs) taken</td><td>100% However varying time scales</td></tr><tr><td>Missing obs</td><td>0%</td></tr><tr><td>Triggered a score >5</td><td>23</td></tr><tr><td>No documented plan</td><td>8/23 (35%)</td></tr><tr><td>Missed observations</td><td>Frequent observation with no</td></tr></table></td><td>– Working with nursing colleagues we have set standards that observations should be recorded within 2 hours of arriving on a ward.
– The plan is to review the audit tool and complete regular audits throughout 2023/24.
– The Worries and Concerns audit team will review all Serious Incident Reports and look for themes and trends.
– We have joined the NHS England Worries and Concerns Pilot programme starting in April 2023.</td></tr>
</table>

EWS	Number of patients audited	Audit findings	Planned actions for improvement
		reason recorded	
NEWS2 Emergency Department	All attenders	**Timeliness** Observation taken within 30 minutes of arrival in the department over this last 20 days (February-March) the average is 63%.	– Focused improvement work in this area to improve standards working with the ED Teams.

Commissioning for Quality and Innovation (CQUIN)
Since April 2022 we have been participating with the CQUIN CCG3. The CQUIN CCG3 measure incentivises adherence to evidence-based steps in the identification and recording of adult deterioration, enabling swifter response, which will in turn reduce the rate of cardiac arrest and the rate of preventable deaths. The CQUIN guidance advise that deterioration is linked to 90% of NHS bed days. Reducing the need for higher levels of care will free up capacity particularly in Intensive Care (ICU) by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts.

Our CCG3 audit compliance results (goal 20-60%)

Table: CQUIN compliance Q1-3 ADD Q4

Title	CQUIN Requirement		Q1 result	Q2 result	Q3 result	Q4 result
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions Lead: Hayley McNeill	20-60% (Quarterly average)	Overall result	21/34 62%	30/43 70%	25/40 63%	Audit to be completed
		NEWS2 Recorded	33 97%	36 84%	36 90%	
		Escalation Time Recorded	22 65%	38 88%	32 80%	
		Response Time Recorded	34 100%	38 88%	31 78%	

Our plan is to continue making improvements by testing initiatives and learning more about our current system. Observations in practice are being undertaken to look at "work as done".

Plans for improvement 2023/24

CQUIN
We have chosen to participate with the CQUIN07: Recording of and response to NEWS2 score for unplanned critical care (with payments being made for 30% having timely response EWS 5-6 60 min and EWS 7+ 30 min).

NHS England "Worries and Concerns pilot/ learning collaborative
The Trust have been successful in a funding bid to pilot a Worries and Concerns direct referral mechanism to support identifying and treating deteriorating patients. Success will look like a system where medical and nursing staff have embraced the concept of inclusion and listening-all patients have information on admission about how to 'get help' if they are worried about clinical conditions

We recognise that patients, relatives and carers can tell when something is wrong before physiological changes happen and early warning scores (EWS) change. Our plan is that people, (patients, families and carers) will be enabled to escalate worries/concerns about acute illness or deterioration directly to our Acute Care Repose Team (ACRT).

Objective 1 - To develop, test, implement and evaluate reliable methods for patients (or their families/carers) to escalate worries and concerns about acute illness and deterioration when standard care is not meeting their needs.
Brief description - we will meet the aim by putting in a system where our patients, their families or carers, will be enabled to contact our Acute Care Response Team (24 hours a day, 7 days a week) if they want to escalate concerns about acute illness or deterioration.

Objective 2 - To develop, test, implement and evaluate reliable methods for patients (or their families/ carers) to routinely input their views regarding their wellness/ illness and trajectory, and any worries and concerns into the health record, with evidence that those views and worries and concerns are considered and acted on by the healthcare team.
Brief description - we will meet the aim by developing and testing means of recording the patient's view (and/or their family's or carers) of their illness/wellness as part of the early warning score assessment (NEWTT, PEWS, MEWS and NEWS2). Through the education of the healthcare teams when acute illness/deterioration is expressed and recorded, but there is no triggering score, the healthcare team will be empowered to escalate to the medical team/Acute Care Response Team.

9. Quality priority

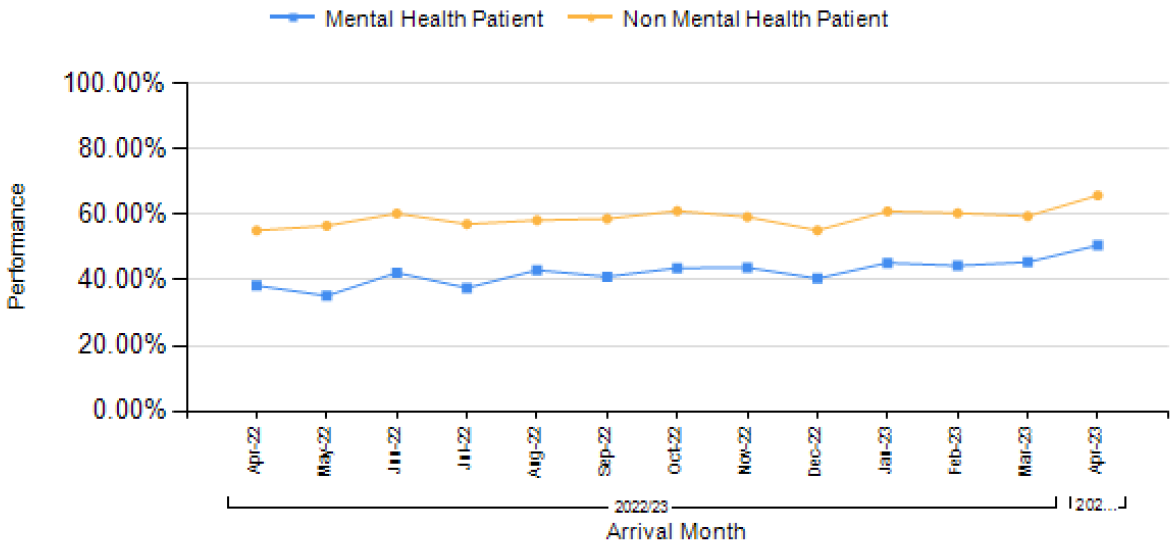
To improve mental health care for our patients coming to our acute hospital

Background

Our mental health care model is to ensure that people presenting at the emergency department (ED) 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.

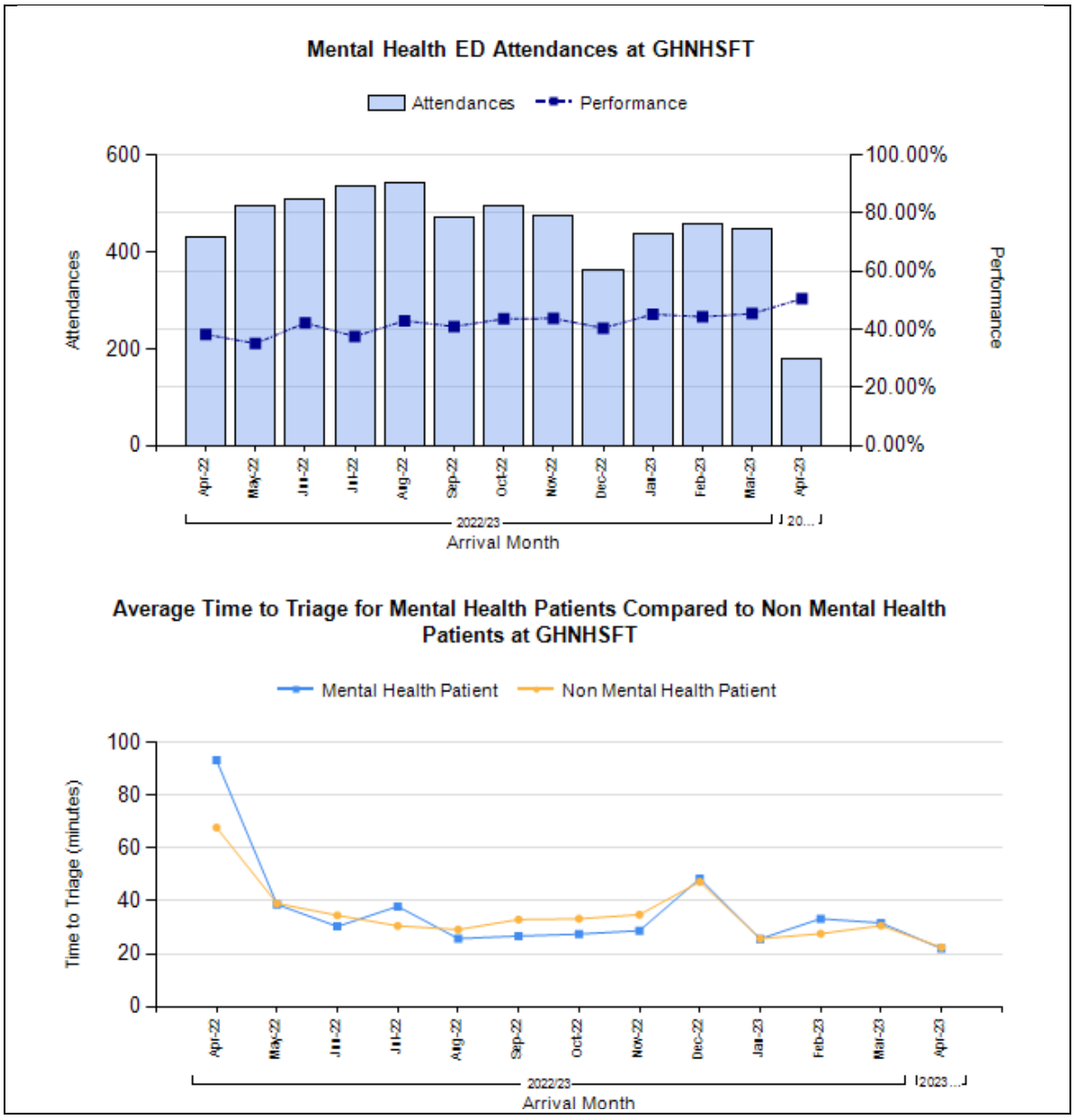
How we have performed 2022/23

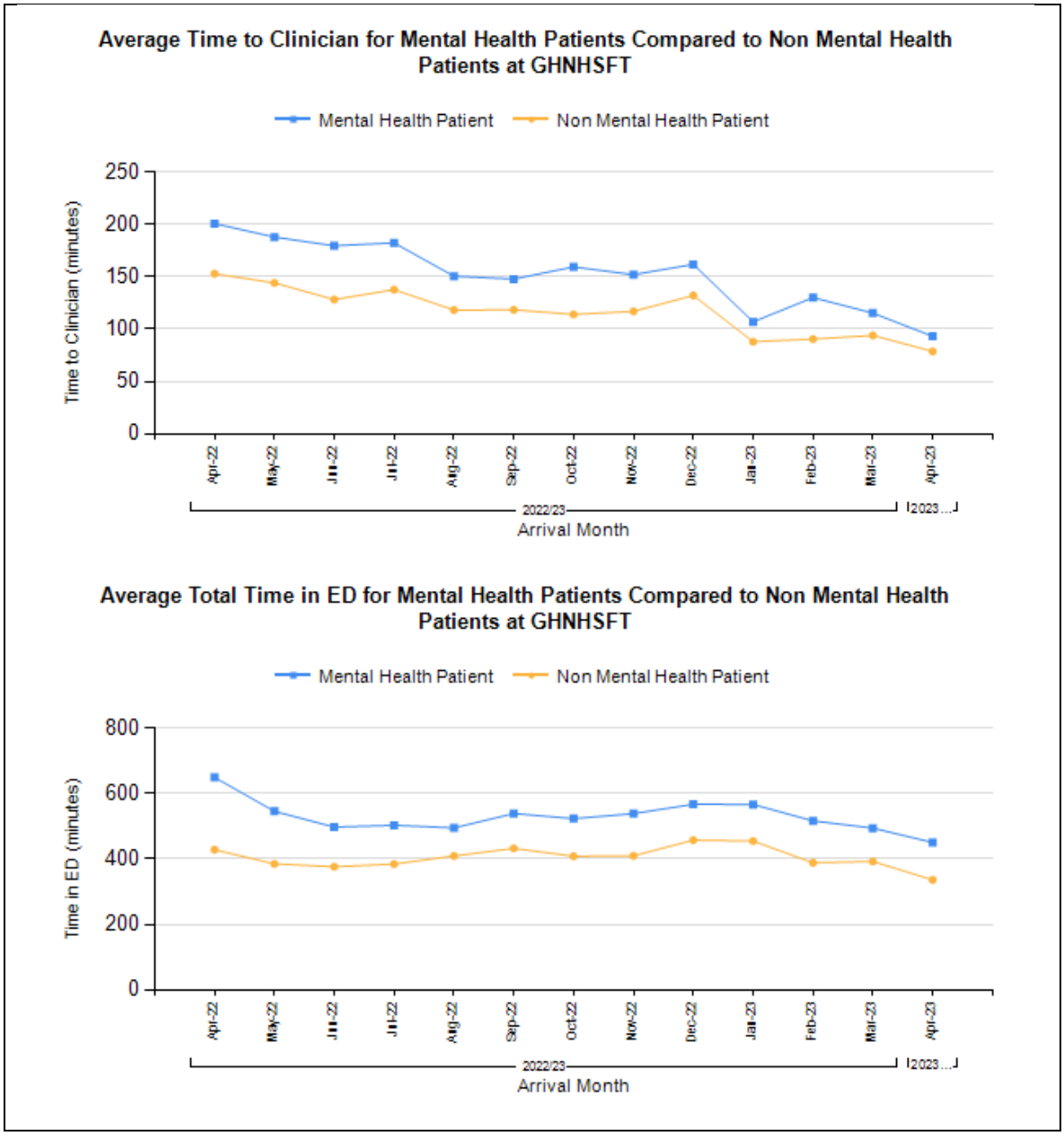
For our mental health patients in the emergency department our Length of Stay and 4-hour performance is unchanged likely representing the ongoing challenges and crowding of the Emergency Department. This year to date (April – March 2023), the Time to Triage metrics have improved overall and the time to see clinician has also improved; this represents the first time this trend has occurred in last 18 months.



Graph: 4-hour performance for mental health patients compared to non-mental health patients

Graphs: Mental Health ED metrics April 2022- April 2023 (please note April 2023 is not a complete month's data)





There has been progress on a number of areas to support our mental health patients in our emergency departments, including:

- New front door Mental Health (MH) Role - successful application for funding for two band 6 MH practitioners to have ring fenced roles at the 'front door' of ED (Pilot of Mental Health Liaison Team (MHLT) Rapid Streaming Service partially funded this request). The anticipated benefits included reduced Length of Stay (LOS), reduced Time to Clinician, improved safety and quality of care, improved patient experience and more comprehensive discharge package. **This approach is the first of its kind nationally.**

- Samaritans Project (ongoing) – face to face emotional support for patients in ED. Operational now for two months (every other week), extremely successful with positive feedback from patients and staff (I can supply feedback or quotes if required).

- High Intensity Users (HIU) Electronic Patient Record (EPR) modifications - patient alert on EPR live, all support plans also now live on EPR as linked external documents. Allows quick and easy access to support plans as required.

- High Intensity Users (HIU) and Social Prescribing (SP) Clinics (New) - Ongoing partnership between HIU team and ICS Social prescribing team – two clinics provided for co-production of support plans face to face with patients. (I have included a summary of this work too)

- Launch of Royal College of Emergency Medicine (RCEM) National Quality Improvement Project for Mental Health and Self Harm (New) - we will be taking part in this two year national strategy to drive up quality and consistency through benchmarking across nine organisational Standards and three clinical standards for mental and self-harm

- Eating Disorder Working Party (New) – wide stakeholder involvement (GHC, Community Eating Disorder team, Dietetics, Liaison Psychiatry, Medicine) to drive up the quality and safety of care for patients presenting to the acute trust with an eating disorder. Will feed into the ICS group

Plans for improvement 2023/24

Our priority for 2023/24 will be to continue to deliver the “Whole Person Care Strategy”.

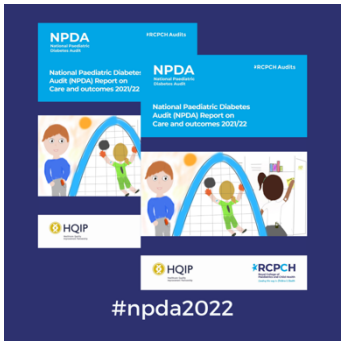
10. Quality priority

To improve our care for children and young people with diabetes

Background

Children and Young People

The National Paediatric Diabetes Audit Annual Report 2020-21 (online) was published April 2022. The NPDA is delivered by the Royal College of Paediatrics and Child Health (RCPCH) and has been reporting for 18 years. Data is submitted by healthcare professionals in Paediatric Diabetes Units (PDUs) in England and Wales about the care received by the children and young people with diabetes using their service.



How we have performed 2022/23

The National Paediatric Diabetes Audit Annual Report 2020-21 (online) was published April 2022. The effectiveness of diabetes care is measured against NICE guidelines (NG18, NICE 2015) and includes treatment targets, health checks, patient education, psychological wellbeing, and assessment of diabetes related complications including acute hospital admissions, all of which are vital to monitoring and improving the long-term health and wellbeing of children and young people with diabetes. The table below highlights the positive aspects as well as the aspects that we did not perform

Table: Gloucestershire Hospitals NHS Foundation Trust (GHT) compared to national benchmarking

Positive aspects	**GHT compared to national average (NA)**	**Aspects that we did not do as well when benchmarked to national average**	**GHT results and national average (NA)**
Level 3 carbohydrate counting	100% NA - 82%	HbA1C check	88.4% NA-90.6%
HbA1C <48% with excellent control	17% NA -11.8%	Blood pressure (BP)	43.7% NA-70.4%
HbA1C>80% with poor control	6% NA -12.9%	Foot exam	0.8% NA-57%
Mean HbA1c	59% NA - 63%	Urine albumin check	38.7% NA-64%
Psychology support	67.9% NA - 46.5%	Body Mass Index (BMI)	45.6% NA 78.6%
Recommendations on advice (Flu vaccine, sick day rules, blood ketone testing)	100% NA - 80-86%		

Thyroid Function Tests (TFT)	99.5% NA -7 7.9%		

Paediatrics improvement plan

- Improve data collection and trial a new data collection system
- Return clinics to face to face with the annual reviews
- Improve urine sample collection

Our Nursing Excellence programme

Nurses who publish are collectively widening the pool of nursing knowledge. They are encouraging their peers to think, reflect, get better at what they do. In this last year, one of our specialist paediatric diabetes nurse (supported by one of our GSQIA Gold Quality Improvement Coaches the Programme Director for Nursing and Midwifery Excellence) published their work in the Nursing Times about the improvement work the team did in the Covid-19 Pandemic setting up an innovative drive through clinic.

Maller K, Cro S (2022) A drive-through blood-testing clinic for young patients with diabetes. Nursing Times [online]; 118: 10.

Plans for improvement 2023/24

For 2023/24, we will continue to make improvements for children and young people with diabetes in response to the National Audit findings and this will be reported in the National Audits section of the next report.

11. Quality priority

To reduce health inequalities

Background

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

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

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

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

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

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

How we have performed 2022/23

Adult Programme Update

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

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

The plan is by end of 2023/24 that every patient admitted to Gloucestershire Hospitals NHS Foundation Trust (GHT) who smokes will be offered NHS funded tobacco treatment as all patients will be:

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

We have been collecting adult smoking status data since November 2022 and we have created an internal dashboard (Adults - % compliance on recorded smoking status (link)).

Table: % compliance on recorded smoking status (adults)

Adult pilot services	**% compliance on recorded smoking status average**
Trust compliance at end of year	36.7%

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

Nov	**Dec**	**Jan 2023**	**Feb**	**March**
35.3	34.3	35.7	36.8	41.4%

In the next table, we have summarised our key achievements over the last year and our plans for as for improving our service in 2023/24 will also start to take place.

Table: Key achievements over for the Adult Inpatient Programme over 2022/23

Programme Area	**Key Achievements from last reporting period**
Leadership and Co-Ordination	• We have recruited an 8B Head of Health Inequalities and Healthy Hospitals) who started in post in March 2022 and has been instrumental in setting up the programme. • We have recruited a Band 7 Health Improvement Manager (1st Nov 2022) • One Band 3 Tobacco Treatment advisor (1st Nov 2022) has started with a second post just recruited to. • The Trust Medical Clinical Lead was also identified.
Data Collection and Monitoring	• The Business Information (BI) team are very much engaged with this programme and are supporting the data collection. • The Electronic Patient Record (EPR) amended to support the relevant recording of smoking status • NHS England data submission requirements have just been updated. • Our daily smoking data dashboard has been created and the national metrics will be included.

Programme Area	Key Achievements from last reporting period
Governance and reporting	• An internal programme Board has been set up and are meeting monthly. • Leads attend the Integrated Care Board (ICB) Tackling Tobacco Dependency Steering group meeting. • There are NHS England assurance meetings monthly
Training and Development	• Advisors have attended specialised training programme. • Very Brief Advice (VBA) training sessions have been arranged for ward staff and practice development nurses. • We are developing bespoke training for tobacco-free champions.
Identification and Referral Pathways	• Healthy Lifestyle Service is in a pilot phase. • We have developed an enhanced community pharmacy offer- to be discussed with ICB/LPC once the programme is fully underway.
Stop Smoking Interventions	• Pharmacotherapy – Nicotine Replacement Therapy (NRT) is now available on all wards. • Patients will be supplied with 2 weeks' supply of NRT upon discharge • We have begun to look at our staff offer of support. • We have bespoke Quality Improvement (QI) support from British Thoracic Society for 6 months.
Communication and Engagement	• The pilot site on the 8th Floor (Respiratory Unit) are using a QI approach to their implementation. • There have been Trust wide communications about the programme. • So far, the programme has been rolled out to – Cardiology ward, Gallery Ward, Ward 7a and 7b. • The TTD Team are attending regular ward rounds and board rounds with our identified (early adopter) wards.

Maternity Programme Update

We have been continuing to support pregnant smokers to quit by implementing the NICE clinical effectiveness guidance (NICE guideline NG 209 Tobacco: preventing uptake, promoting quitting and treating dependence) and the NHS England Saving Babies' Lives (version 2 Care Bundle). The care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice and the first element is around reducing smoking in pregnancy as this element provides a practical approach to reducing smoking in pregnancy by following NICE guidance.

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

The interventions we have put in place are:

- CO testing should be offered to all pregnant women at the antenatal booking appointment, with the outcome recorded.

- Additional CO testing should be offered to pregnant women as appropriate throughout pregnancy, with the outcome recorded.
- CO testing should be offered to all pregnant women at the 36-week antenatal appointment, with the outcome recorded.
- Referral for those with elevated levels (4ppm or above) for support from a trained stop smoking specialist, based on an opt-out system. Referral pathway must include feedback and follow up processes. All relevant maternity staff should receive training on the use of the CO monitor and having a brief and have meaningful conversations with

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

Table: Maternity smoking data

Indicator	**Data**
Number of women smoking at booking	**594**
% women smoking at booking	**11.0**
Number of women smoking at delivery	**514**
% women smoking at delivery	***9.5***
Number of women smoking at booking	**654**
% women smoking at booking	***10.0%***
CO Monitoring at booking %	***93.2***
Number of women booking where CO reading >4ppm	**288**
% of women booking where CO reading >4ppm	***4.4%***
Number declining CO Monitoring at booking	**703**
Number of current smokers accepting referral to Smoking Cessation	**482**
% of current smokers who accepted referral to Smoking Cessation	***74.0***
% of current smokers who declined referral to Smoking Cessation	***23.5***
% of current smokers who were asked to be referred to Smoking Cessation	***97.5***
Healthy Lifestyles Smoking Referrals	**639**
HLS Referrals Declined, No response or blank	**314**

NHS Resolution Maternity Incentive Scheme **Safety Action 6** (Year 4) was to deliver SBLCBv2 and we **failed the data quality rating** on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. The implementation of the electronic patient record digital system Badgernet will improve this and we will continue to monitor this. The next table outlines our key achievements for the Maternity Programme.

Table: Key achievements for the Maternity Programme over for 2022/23

Programme Area	Key Achievements from last reporting period
Leadership and Co-Ordination	• We have recruited a Band 8a Lead Midwife Tackling Tobacco Dependency (TTD) who will commence in post in May 2023. • We have advertised for Maternity Support Workers (MSW) to be Smoke-free Advisors. • We met with the National Lead & Lead for Greater Manchester Smoke-free programme and discussed targeted support for our programme.
Planning and Commissioning	• TTD pathway in maternity services will be included in the Integrated Care Board (ICB) Maternity Services specification. • Areas with highest Smoking at Time of Delivery (SATOD) rates have been identified and linked to areas of highest deprivation in Gloucester and Forest of Dean (FoD). • Incentives and vaping are being explored with ICB TTD Steering group.
Data Collection and Monitoring	• Data was monitored by the service on a on monthly dashboard against a planned trajectory for improvement. • An audit was completed and action plan developed to review compliance for CO monitoring at 36 weeks.
Training and Development	• Training and development provided for Consultant Lead and for Lead Midwife. • Training has been identified for the MSW Smoke-free Advisors. • Very Brief Advice (VBA) training and e-learning training was put in place.
Identification and Referral Pathways	• The maternity service is working with Healthy Life Styles (HLSs) to review current pathway and HLS's Health Advisors now attending the Antenatal Clinic at Gloucester Royal Hospital (GRH).
Stop Smoking Interventions	• Research into the evidence for vaping, as an alternative to Nicotine Replacement Therapy (NRT), is being currently reviewed.
Communication and Engagement	• Midwives survey on knowledge of TTD pathway results presented to Local Maternity and Neonatal System (LMNS).

Plans for Improvement 2023/24

For adult inpatients in 2023/24, we are going to focus delivering the NHS Long Term Plan commitment of providing NHS funded tobacco dependency treatment to all inpatients who smoke, with everyone admitted overnight being able to access services by the end of 2023/24. Looking at our current data we have an ambition to increase collection of smoking status by 5% month on month as we roll out the programme.

For Maternity Services in 2023/24, we are rolling out a separate offer for all pregnant women who smoke, enabling them to access treatment while in direct contact with maternity services.

Part 2.2 Statements of assurance from the Board

Health services

We provide a range of health care services and outline these to our patients on our Trust website – click here.

Information on participation in clinical audit

From 1 April 2022 to 31 March 2023, 49 national clinical audits and 4 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides. During that period, Gloucestershire Hospitals NHS Foundation Trust participated in many national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in during 2022/23 are as follows:

	Eligible	**Participated**	**Status**
Case Mix Programme (CMP)	Y	Y	Ongoing
Elective Surgery (National PROMs Programme)	Y	Y	Ongoing
Emergency Medicine QIPS (RCEM) - Pain in Children (care in Emergency Departments)	Y	Y	Ongoing
Emergency Medicine QIPS (RCEM) - Assessing for cognitive impairment in older people	N	N	Cancelled
Emergency Medicine QIPS (RCEM) – Mental health self-harm	Y	N	PTP
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Y	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	Y	Y	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	Y	Y	Ongoing
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Y	Y	Ongoing

	Eligible	Participated	Status
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE)	Y	Y	Ongoing
Muscle Invasive Bladder Cancer Audit	Y	Y	Closed
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit	Y	Y	Ongoing
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	Y	Y	Ongoing
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Y	Y	Ongoing
National Asthma and COPD Audit Programme (NACAP) - Adult asthma secondary care	Y	Y	Ongoing
National Asthma and COPD Audit Programme (NACAP) - Paediatric asthma secondary care	Y	Y	Ongoing
National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Y	Y	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Y	Y	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	Complete
National Audit of Dementia (NAD)	Y	Y	Ongoing
National Bariatric Surgery Registry (NBSR)	Y	Y	Ongoing
National Cardiac Arrest Audit (NCAA)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	Ongoing

	Eligible	Participated	Status
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	Ongoing
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	Y	Y	Ongoing
National Child Mortality Database	Y	Y	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	Ongoing
National Joint Registry (NJR)	Y	Y	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	Ongoing
National Neonatal Audit Programme (NNAP)	Y	Y	Ongoing
National Ophthalmology Audit (NOD)	Y	Y	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	Ongoing
National Perinatal Mortality Review Tool	Y	Y	Ongoing
National Prostate Cancer Audit	Y	Y	Ongoing
National Vascular Registry	Y	Y	Ongoing
Perioperative Quality Improvement Programme	Y	Y	Ongoing
National Acute Kidney Injury Audit			
UK Renal Registry Chronic Kidney Disease registry	Y	Y	Ongoing
Adult Respiratory Support Audit	Y	Y	Ongoing

	Eligible	Participated	Status
Smoking Cessation Audit- Maternity and Mental Health Service	Y but data collection deferred	N/A	NYR
Sentinel Stroke National Audit programme (SSNAP)	Y	Y	Ongoing
Serious Hazards of Transfusion UK (SHOT) - National Haemovigilance Scheme	Y	Y	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)	Y	Y	Ongoing
The Trauma Audit and Research Network (TARN)	Y	Y	Ongoing
UK Cystic Fibrosis Registry	Y	Y	Ongoing
National Parkinson's Audit	Y	Y	Ongoing

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

The reports of the above national clinical audits were reviewed (or will be reviewed once available) by the provider in 2022/23.

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)	
Elective Surgery (National PROMs Programme)	The most recent data available for PROMs is April 2020-March 2021, reported in last year's Quality Account. Changes were made by NHS Digital to the linking of data fields from Hospital Episode Statistics (HES) and Patient Reported Outcome Measures. Due to this reporting has been paused, with no current timeframe for publication of results.
Emergency Medicine QIPS (RCEM) - Pain in Children (care in Emergency Departments)	The purpose of the QIP is to improve patient care by reducing pain and suffering, in a timely and effective manner through sufficient measurement to track change but with a rigorous focus on action to improve. The Royal College of Emergency Medicine (RCEM) will identify current performance in EDs against nationally agreed clinical standards and show the results in comparison with other departments The Trust has invested QIP time into other clinical topics which were identified via CG patterns and have taken forward as Silver Quality

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
	Improvements projects with GSQIA. This includes embedding a paediatric patient safety checklist learning from good practice with adults.
Emergency Medicine QIPS (RCEM) - Assessing for cognitive impairment in older people	N/A- Audit updated to 'Care of Older People' – data collection now due to commence May 2023 (to be confirmed)
Emergency Medicine QIPS (RCEM) – Mental health self-harm	In 2022 RCEM published a revised toolkit for Mental health in Emergency Departments which includes clinical standards for the care of mental health patients in the ED- • ED Mental Health Triage process • Observation of patients at risk of further self-harm or absconding • ED clinician assessment This QIP will track the current performance in EDs against clinical standards in individual departments and nationally on a real-time basis over a 2-year period. The Trust has registered for the Mental Health QIP, to identify scope for improvement work and monitor real time change.
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy 12 has the continued aim of helping epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. The Trust has ensured participation in Cohort 4 of data collection, comprised of clinical audit of the epilepsy care provided to children and young people with epilepsy and an organisational audit of paediatric epilepsy services. This information will be used to highlight areas where the service is doing well, and also identify areas with scope for improvement.
Falls and Fragility Fractures Audit programme (FFFAP) - National Audit of Inpatient Falls	The National Audit of Inpatient Falls (NAIF) reports on the care given to patients who fell while they were in hospital and sustained a hip fracture. The report presents information on post-fall management and tracks performance against NICE Quality Standard 86, which includes checking the patient for injury before moving, using safe lifting equipment and prompt medical assessment after the fall The Falls Prevention team for the Trust provide ongoing and regular training for all members of the multidisciplinary health care team with the aim of keeping staff competent and confident to carry out assessments, including the correct and appropriate management of post falls assessments, thereby identifying risk factors and ensure action is taken to address these risks. This includes high quality multi-factorial falls risk assessments (MFRA) for patients over 65 and other inpatients who may be at risk.
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.

Audit Title	Details of the audit and where the report was reviewed and what actions were taken as a result of audit/use of the database
	The Trust uploaded data from all hip fracture cases admitted to GRH. These data were analysed locally and discussed at monthly governance meetings. NHFD provided 3 monthly update reports allowing us to benchmark our Trust against other hospitals, these reports were also discussed at governance meeting. Improvement work continued around consolidation and embedding of previous years' actions, together with looking at additional theatre availability.
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Learning from Lives and Deaths (LeDeR) aims to improve care for people with a learning disability and autistic people, to reduce health inequalities and prevent people with a learning disability and autistic people dying prematurely. The Trust has continued to participate in data collection. The latest report has focused on the reviews of deaths of people with a learning disability that occurred predominantly in 2021 and uses comparisons with the deaths occurring in 2018, 2019 and 2020. This has allowed to identify trends over time and highlight the impact of the COVID19 pandemic. It will also be used to identify where the Trust has performed well and where there is scope for quality improvement.
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE)	The Maternal, Newborn and Infant Clinical Outcome Review Programme includes surveillance data on women who died during or up to one year after pregnancy between 2018 and 2020 in the UK. It also includes Confidential Enquiries into the care of women who died between 2018 and 2020 in the UK and Ireland from cardiovascular causes, hypertensive disorders, early pregnancy disorders and accidents and the care of women who died from mental-health related causes in 2020. The report also includes a Morbidity Confidential Enquiry into the care of 61 women with diabetic ketoacidosis in pregnancy. The Trust continues to participate in MBRRACE-UK data reporting and reviews the recommendations to identify any action plans including quality improvement work.
Muscle Invasive Bladder Cancer Audit	This BAUS snapshot audit was launched in January 2022. National and local results were published in August. Presentation of these results took place in September at a local audit meeting. Time from referral to trans urethral resection of bladder tumour (TURBT) was in keeping with the national average and time to cystectomy was better than the national average. A process mapping exercise with timings of the pathway was undertaken with review of where time could be saved and a new pathway proposed.
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit	The National Diabetes Inpatient Safety Audit (NDISA) reviews inpatient service provision in England and Wales. Service provision is assessed against recommendations in the 2020 Diabetes Getting It Right First Time (GIRFT) report. The rates and risk factors are reviewed for serious

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
	diabetes-specific inpatient harms that can occur to inpatients with diabetes in acute hospitals in England. The Trust continues to submit to NDSIA Harms on harms that are reported, errors are discussed by the Diabetes Team. It is recognised that staff shortages have impacted the ability to meet all GIRFT recommendations. Improvements include Mandatory e-learning that is now in place for staff who dispense, prescribe and/or administer insulin. Perioperative pathways are in place from pre-assessment through to discharge. In-hospital communication and e-referrals help to identify patients with diabetes. The team has worked on cost effective prescribing with further progress needed on new technologies.
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	The National Pregnancy in Diabetes Audit (NPID) is a work stream of the National Diabetes Audit (NDA) and measures the quality of pre-gestational diabetes care against NICE guideline based criteria and the outcomes of pre-gestational diabetic pregnancy. It focuses on key areas of preparing women with diabetes for pregnancy and taking appropriate steps to minimise adverse outcomes to the mother. The Trust continues to participate with ongoing data collection. Data is published nationally and usually reviewed at annual Diabetes in Pregnancy conference. Recent data indicates the Trust is slightly exceeding the national average. Appropriate steps are taken in line with recommendations to minimise adverse outcomes to the mother.
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. This supports Trusts to Identify and share best practice and identify gaps or shortfalls that are priorities for improvement. The Trust has continued to participate in the NDA. The annual report is reviewed at Diabetes Team Operational Meetings and the Gloucestershire Diabetes Clinical Program Group. Trust data is reviewed alongside recommendations from the report to identify any scope for local quality improvement work.
National Asthma and COPD Audit Programme (NACAP) - Adult asthma secondary care	Asthma and Chronic Obstructive Pulmonary Disease are two of the most common respiratory diseases in the UK. This report presents information on the structure and resourcing of 159 out of 198 (80.3%) of the hospital services that provide asthma and COPD care to adults in England and Wales. Data is measured against the key performance indicators recommended by NACAP to support good practice in the delivery of acute asthma and COPD secondary care. The Trust has participated in this audit and is now combining data for both sites to give a more accurate reflection of Trust data. The data will be used to identify improvement priorities which can drive improvements to 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
National Asthma and COPD Audit Programme (NACAP) - Paediatric asthma secondary care	Asthma affects one in 11 children and young people in the UK, which is contributing to a rise in hospital admissions. NACAP presents information on hospital-based services that provide acute asthma care to children and young people in England and Wales. Data is gathered and measured against key performance indicators recommended by NACAP to support good practice in the delivery of acute asthma care. The Trust is meeting recommendations on Spirometry and fractional exhaled nitric oxide (FeNO) service to aid diagnosis with suspected asthma. Staff working with CYP and families are appropriately trained to explain the risk of asthma exacerbations linked to smoking and indoor air quality and making referrals to smoking cessation specialist services. A formal transition service is in place for from child to adult asthma services. The Paediatric Respiratory service is reviewing options to meet recommendations on dedicated in-patient time for asthma.
National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Asthma and Chronic Obstructive Pulmonary Disease are two of the most common respiratory diseases in the UK. This report presents information on the structure and resourcing of 159 out of 198 (80.3%) of the hospital services that provide asthma and COPD care to adults in England and Wales. Data is measured against the key performance indicators recommended by NACAP to support good practice in the delivery of acute asthma and COPD secondary care. Collaborative work with IT and digital teams has helped to improve the identification patients with COPD that have been admitted, enabling more accurate Trust data. The Trust has also developed a COPD follow up clinic to deliver high quality care and rest of audit outcomes.
National Audit of Breast Cancer in Older People (NABCOP)	NABCOP is a national clinical audit run by the Association of Breast Surgery (ABS) and the Clinical Effectiveness Unit (CEU) of the Royal College of Surgeons of England (RCS). The aim of NABCOP is to support NHS providers to improve the quality of hospital care for older patients with breast cancer by publishing information about the care provided by all NHS hospitals that deliver breast cancer care in England and Wales, and looking at the care received by patients with breast cancer and their outcomes. The NABCOP audit pulls the anonymised data it requires automatically. The Trust reviews cases and reports at specialist departmental meetings. The NABCOP Patient information sheet for >70s is now used within clinics.
National Audit of Care at the End of Life (NACEL)	NACEL is designed to measure the experience of care at the end of life for dying people and those important to them, and to provide audit outputs which enable stakeholders to identify areas for service improvement. GHT took part in the 2022 round of the audit, the most recent publication was shared at Quality Delivery Group, Trust Mortality Group and End of life Delivery Group. An action plan has been developed and is overseen by the End of Life Delivery Group.

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 Dementia (NAD)	The National Audit of Dementia (NAD) audit relates to the quality of care received by people with dementia in general hospitals. The audit is reviewed at the monthly COTE Business Governance Meeting. An MDT is held weekly to look at people with dementia with an extended length of stay and what the barriers are, and to revisit TOCB referrals. The Trust has identified the need to improve assessment and treatment of delirium, QI initiatives have included: - Updating dementia and delirium eLearning to include recognition and assessment tools - Addition of the delirium clinical pathway to the intranet - Contribution to the ICS Ageing Well Programme delirium project group - Working with BI to improve the capture of delirium on EPR to support the NAD audit - Development of dementia dashboard that shows the outcomes for inpatients with dementia - Testing of a Do Not Transfer process aiming to minimise the risk of delirium, falls, violence and aggression and delayed discharge as a result of multiple bed moves for this cohort. - Undertaking the NICE required benchmark for delirium
National Bowel Cancer Audit	The annual report was published in January 2023 and discussed at the Upper GI clinical governance meeting in Feb 2023. Discussion of results has highlighted areas for work over the coming 12 months, looking at: Ileostomy closure, adjuvant chemo and laparoscopy rates.
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)	We subscribe to the National Cardiac Arrest Audit (NCAA) which is a national data collection and presentation network auditing in-hospital cardiac arrests in the UK and Ireland. The aims of the audit are to: improve patient outcomes; decrease incidence of avoidable cardiac arrests; decrease incidence of inappropriate resuscitation as well as to promote adoption and compliance with evidence-based practice. All NCAA reports are reviewed as a department as well as quarterly at the Deteriorating Patient & Resuscitation Committee. The reports are also available on the Deteriorating Patient & Resuscitation Committee shared drive so that they can be accessed and be reviewed by appropriate clinicians with access.

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
	We also publish the Audit data within the department newsletter issued across the Trust as well as being accessible on the Intranet, staff notice boards, and shared with department heads for dissemination. The Trust continues to share the results at Induction sessions and Mandatory updates. Any inappropriate CPR attempts are highlighted and reviewed, and if appropriate, simulated to help focus teaching and lessons learned.
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	The NACRM report details activity in cardiac rhythm management device and ablation procedures for England & Wales. Implants of pacemakers, defibrillators, and cardiac resynchronisation devices fell by 20-30% across England and Wales in 2020/21. Ablation was down by 35% over the whole year. The latest report was shared at the arrhythmia group meeting and with the clinical lead and pacing operators. The Trust's yearly pacing audit was compared to NICOR data for the relevant year. The NICOR data has a focus on numbers and the completeness of the data. The Trust numbers for the data collection period were not an accurate reflection of the number of implants actually done. If they had been, then the Trust would have been higher than the national trends as there was no reduction in patients implanted during COVID. The Trust's complication and redo rates were below national average.
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	This year, data from NAPCI is being combined with data in the Myocardial Ischaemia National Audit Project (MINAP) to create a report that focuses on the care given to individuals admitted to hospital with a heart attack. For many patients suffering a heart attack, optimal care includes a PCI procedure. Consequently, the time delays to treatment for patients presenting with ST segment elevation myocardial infarction or non-ST-segment elevation (STEMI and NSTEMI) appear within that report. Data for 2020-21 and 2021-22 shows the Trust exceeds national average metrics for delivering day case elective procedures and use of radial artery access (and has done for many years). The data also shows that the Trust meets standards for use of drug-eluting stents. The average age of patients undergoing PCI in this unit is higher than national average, but despite this higher risk patient group, outcome data on death and major adverse events remains less than the national average. There is a higher than national average PCI/CABG ratio reported in this Trust as well as a slightly higher than national rate of PCI per million population. Operator procedure volumes are significantly higher than national averages and have been for several years, raising questions over sustainability and workload for the future. Overall, the data supports the conclusion that the local service is safe and efficient, despite a challenged physical environment

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
	(temporary/aged catheter labs, split acute sites, poor patient flows) and staff shortages.
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	MINAP summarises the care given to over 80,000 cases of heart attack patients admitted to hospitals in England, Wales and Northern Ireland during 2020/21. The quality of care is assessed against a set of quality improvement metrics derived from national and/or international standards and guidelines. For many patients suffering a heart attack, optimal care includes a percutaneous coronary intervention (PCI). This is provided as soon as possible for patients with higher risk ST-segment elevation myocardial infarction (STEMI) heart attacks and following a period of initial medical treatment for patients with lower risk non-ST-segment elevation myocardial infarction (NSTEMI) heart attacks. Quality improvements are in progress within the Trust on data completeness and accurate representation of data from both sites. This includes quarterly PPCI timings, regular reporting on this and improving data completeness on ambulance timings on STEMI and NSTEMI.
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	National Heart Failure Audit (NHFA) deals with a specific and crucial phase in the disease trajectory of patients admitted to hospital with heart failure. There is a particular focus on a set of quality improvement metrics, based on standards and guidelines, which aim to drive up standards of care during the acute admission phase to achieve better patient outcomes. The Trust is implementing measures to maintain data input levels. Ongoing quality improvements are being implemented to support inpatient access to NT-proBNP testing as a means to stratify echo provision. A nurse-led referral pathway is in development for community HF service referrals, in an effort to increase the rate of referrals prior to discharge and enable early follow-up appointments.
National Child Mortality Database	The National Child Mortality Database (NCMD) aims to understand patterns and trends in child deaths where an event before, or around, the time of birth had a significant impact on life, and the risk of dying in childhood. Over the past 12 months this has included thematic reports on the contribution of newborn health to child mortality across England and unexpected deaths of infants and children. The Trust continues to participate in the NCDM and reviews local data along with recommendations to identify any action plans including quality improvement work. The Trust is compliant with the national initiatives, care bundles and interventions mentioned and work is ongoing to explore and improve our preterm birth rate through detailed audit.
National Early Inflammatory Arthritis Audit (NEIAA)	The NEIAA assesses the provision of care and the impact of that care on outcomes for people with Early Inflammatory Arthritis in England and Wales. NEIAA determines whether the care provided is consistent with current recommended best practice defined by NICE QS 33. The audit

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
	assesses seven key metrics of care for people with new symptoms of suspected inflammatory arthritis attending rheumatology services. The Trust has continued to participate in the audit. The report and local data have been reviewed at the departmental governance meeting. Recommendations have been reviewed and an action plan is in progress for areas where quality improvement is required.
National Emergency Laparotomy Audit (NELA)	Report published February 2023, summary and action plan to be advised Data continues to be uploaded to the NELA website, with quarterly joint surgical and anaesthetic NELA meetings to review results. The publication of the most recent quarters Individual Hospital Audit data has seen a delay. Awaiting these results to inform any additional actions
National Joint Registry (NJR)	
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 most recent publication was included in last year's quality account, and the next report is due. Outcomes will be reviewed at the Lung AGM and appropriate specialty and governance meetings. Quality improvement projects to improve our service and pathways are ongoing.
National Maternity and Perinatal Audit (NMPA)	The National Maternity and Perinatal Audit (NMPA) is a large-scale project established to provide data and information to those working in and using maternity services. It helps us understand the maternity journey by bringing together information about maternity care and information about hospital admissions. The NMPA clinical audit provides information on a number of measures, based on births in England and Wales from April 2018 to March 2019. The Trust continues to participate in the NMPA and reviews the annual report alongside local data to highlight areas of potential service improvement.
National Neonatal Audit Programme (NNAP)	The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. This includes key outcomes of neonatal care, measures of optimal perinatal care, maternal breastmilk feeding, parental partnership, neonatal nurse staffing levels, and other important care processes. Trust data is reviewed quarterly, alongside recommendations from the report to identify any scope for local quality improvement work.
National Ophthalmology Audit (NOD)	The two primary outcome indicators of the National Cataract audit are complication rates and visual acuity loss due to surgery. The data set for this national audit is uploaded via the Medisoft system. The overall consultant surgeon Posterior Capsular Rupture rate nationally was 1.1%,

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
	with GHT at 0.92%. Nationally the audit findings indicate high quality surgery is being delivered to NHS patients. Specifically, among the contributors, no outlying centres or surgeons were found for PCR or postoperative VA Loss.
National Paediatric Diabetes Audit (NPDA)	The NPDA measures effectiveness of diabetes care against NICE guidelines and includes treatment targets, health checks, patient education, psychological wellbeing, and assessment of diabetes related complications including acute hospital admissions. GHNHSFT's Paediatric Diabetes team have ongoing action plans in progress to support children and young adults including; updates to protocols, a new telephone advice sheet and inpatient guidelines for management of patients admitted to the ward. Regarding key health checks, there are ongoing actions in place such as improving foot checks during annual review clinics, encourage patients to send an early morning urine sample to the lab and visits if patients do not attend or cancel annual review appointments. A GSQIA Silver project is underway looking at preparing 14-16 year olds with diabetes to transition to adult services with a view to increase confidence in self-management.
National Parkinson's Audit	The National Parkinson's Audit provides data about the state of Parkinson's services across the UK, which inform priorities and help drive service improvement and measure change. The audit uses evidence-based clinical guidelines as the basis for measuring the quality of care in the outpatient setting. Local Trust data reports on Neurology, COTE and Physiotherapy will be reviewed as part of a planned collaborative approach to identify quality improvement initiatives. This will take into account a series of national priority programmes facilitated by the Excellence Network.
National Perinatal Mortality Review Tool	The PMRT is designed to support the review of baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths and neonatal deaths. For about 90% of parents the PMRT review process is likely to be the only hospital review of their baby's death that will take place. The main focus of this year's report is 'quality' in terms of parent engagement, the review process and subsequent actions plans. The Trust continues to participate in PMRT data reporting and inputs all stillbirths and early neonatal deaths. Each case is reviewed at the monthly M&M meeting. The PMRT is then finalised and individual reports are generated and any individual actions.
National Prostate Cancer Audit	
National Oesophago-gastric Cancer Audit	Specific recommendations received from publication around the nutritional status and dietetic support for patients. A second specialist cancer support dietician was employed in August 22 and all patients undergoing curative surgery for OG cancer now have access to specialist dietetic support before, during and after surgery in our trust. Plans are in place to develop a nutritional database to allow submission of these results increasing completeness of the NOGCA data set
National Vascular Registry	The NVR data entry system is a secure online database where vascular

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
	specialists working in NHS hospitals in the UK can enter their data for vascular procedures they carry out. 100% of data is extracted from the NVR database. The reports are reviewed at the specialty meetings and there are no reported actions (Patent outcomes (mortality and revision rate) within expected boundaries).
Perioperative Quality Improvement Programme	The Perioperative Quality Improvement Programme (PQIP) aims to review the perioperative care of patients undergoing major non-cardiac surgery and measure complication rates, failure to rescue (failure to prevent a death resulting from a complication of medical care) and patient reported outcomes. This work links to the DrEaMing CQUIN (**Dr**inking, **Ea**ting, **M**obilis**ing**) the Trust participated in during 22/23 (and continues into 23/24) where the provision of fluids, food and mobilisation within 24 hours of surgery are assessed. Excellent results were found from this CQUIN. The scope will extend to a wider range of surgery during 23/24.
National Acute Kidney Injury Audit	The primary aim of the acute kidney programme, is to reduce the risk and burden of acute kidney injury. To do so, it will lead work on the development of sustainable clinical tools, information and levers and prioritise patient empowerment. It will engage commissioning pathways and other clinical networks whilst establishing local and national data collection and audit leading to further safety improvement. It will identify areas of research need and provide the framework to improve care quality.
UK Renal Registry Chronic Kidney Disease registry	**The UK Renal Registry) collates data from renal centres and hospital laboratories to improve the care of patients with kidney disease in the UK.** Data collection has recently been expanded to include cases of acute kidney injury (AKI) in primary and secondary care in England and cases of advanced chronic kidney disease (CKD) in secondary care, not on RRT, in England and Wales. The Trust continues to submit data, with a quarterly annual validation and query resolution. Registry data is used for quality assurance and feeds in to other audit and quality improvement activity and is discussed in other meetings, such as GIRFT, regional Kidney Quality Improvement Partnership and the renal regional network.
Adult Respiratory Support Audit	The Respiratory Support Pilot Audit was the first stage of a project to capture data on adult patients requiring enhanced ward-level monitoring and treatment. Data was collected to calculate the Non-Invasive Ventilation Outcomes (NIVO) score. The pilot was by invitation to selected Trusts, which did not include GHNHSFT however the Trust is currently embarking on data collection for the full RSU audit. The Trust is participating in the 'Improving NIV care' project and will be implementing the NIV care bundle in line with the BTS guidelines

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
	following 2 previous BTS audits. The aim of this project is to: 1) Implement the use of a standardized NIV care Bundle 2) Reduce the mortality rates of patients receiving NIV in the Hospital 3) Improve staff knowledge and confidence 4) Improve patient experience Data will be collected on Trust performance and guidelines adherence through the year.
Smoking Cessation Audit- Maternity and Mental Health Service	Previously National smoking cessation audit – data collection timeframe deferred to 2023
Sentinel Stroke National Audit programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) measures how well stroke care is being delivered in the NHS in England, Wales and Northern Ireland. The clinical audit measures the processes of care provided to stroke patients in inpatient and community settings. The organisational audits measure the structure of stroke services in acute hospital settings and the structure of stroke services in community settings All audits measure stroke care against evidence based standards. The report is reviewed in Stroke Monthly business meetings. The Trust accesses the SSNAP data directly and it is used to provide regular data for a number of purposes and is reviewed on a regular basis by ED, radiology, stroke nurses, consultants and the wider stroke team. It helps inform potential quality improvements within the stroke service
Serious Hazards of Transfusion UK (SHOT) - National Haemovigilance Scheme	The SHOT report was published in July 2022 and circulated to members of the Hospital Transfusion Committee. GAP analysis resulted in review of the following areas to ensure compliance: • storage processes, • SOP • planning and delivery of staff training/retraining • removal/restocking of expired components from storage locations

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) provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 23rd June 2022. At the time of SAMBA22, urgent and emergency care services were under increasing pressure. The insights gained through SAMBA can be used to improve the care provided for acute medical patients. The Trust has made improvements in order to reduce pressures- • Front door specialists' involvement to shorten waiting time for post take rounds • Front door team in the Emergency Department to improve early discharges • New PCR electronic system and electronic prescribing system • Employed more Acute Consultants. • New Acute Medicine department in majors to decrease ambulance waiting time and speed up triage.
The Trauma Audit and Research Network (TARN)	TARN was developed by the Trauma Audit & Research Network to help patients who have been injured, with reports being reviewed every two months within the Major Trauma meeting. We excel in obtaining timely scans of our trauma patients on their arrival in the Emergency Department, but have faced a number of challenges over the past couple of years with our mortality rates and senior decision-makers seeing patients within target time. To tackle this there has been an integrated approach with close co-operation with our colleagues in the trauma network. Having moved into the new ED at GRH, we have already implemented a number of initiatives and are embarking on a deep dive of our data.
UK Cystic Fibrosis Registry	The UK Cystic Fibrosis report is aimed at anyone who is interested in the health, care, and outcomes of people with cystic fibrosis (CF) in the UK. The CF Registry is a powerful tool that will be especially important over the coming years to look for trends of improvement in the outcomes for our children, young people and adults who are on a CF Modulator Therapy (e.g. Kaftrio). It can currently be used for tracking growth and lung function and pharmaco-surveillance of liver function and side effects. The registry is also a data platform for the CF START research trial. The cystic fibrosis (CF) anti-staphylococcal antibiotic prophylaxis trial (CF START) is a randomised registry trial to assess the safety and efficacy of flucloxacillin as a long-term prophylaxis agent for infants with CF. The Trust currently has 4 patients enrolled on the study, 2 of whom are just about to complete their 4 years of monitoring/participation.

Local clinical audits

The reports of 135 local clinical audits and Quality Improvement projects were registered in 2022/23 and these are reviewed and actioned locally. In addition, 22 'Silver' quality improvement projects which graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2022/23. Some examples of actions associated with audits and completed QI projects are as follows:

Examples of local audits and Quality Improvement (QI) projects
Optimising the Use of Micro-enemas for Patients undergoing Prostate Radiotherapy - Micro-enemas are used to provide a consistently empty rectum to optimise prostate radiotherapy. Used routinely immediately prior to planning CT scan and for all 20 fractions of radiotherapy. Some patients' rectums remain too full at their CT scan and require a second appointment, and some men experience proctitis towards the end of their radiotherapy. The aim was to reduce the number of patients requiring repeat CT appointments due to overfull rectums, as well as reduce acute rectal toxicity in prostate cancer patients at week 4 of radiotherapy. In order to do this the timing of enemas was changed for patients receiving prostate planning and radiotherapy, this did not reduce the number of repeat CT appointments needed for rectal issues, and patients preferred to try enemas at home before their CT. However, reducing enema use from 20 to 10 fractions resulted in fewer patients experiencing anal / rectal bleeding at week 4 of radiotherapy. Next steps will include checking that reducing enemas do not affect the daily plan verification of radiotherapy, and continue to reduce repeat planning CT appointments whilst improving patient education.
Improving Compliance with Renal Cell Carcinoma Follow up Protocol Post Nephrectomy - Surveillance is recommended for 5 years after kidney cancer surgery to detect early recurrent/residual disease. There is no consensus regarding the best schedule for surveillance scans with a number of different protocols offered; a protocol was designed based on low, intermediate or high risk for recurrence, which was validated in 2021. The data showed that only 34% were compliant with protocol, whilst 66% of the high-risk group missed at least one scan and 48% missed 2 or more scans over the 5-year period. In order to improve protocol compliance, an updated protocol based on new literature/practice was agreed, and laminated copies were distributed. Patient involvement was encouraged through the use of risk group patient information leaflets and risk allocation was added to the histology report and documented in the MDT. This resulted in protocol compliance for the high-risk group increasing from 34% pre-intervention to 100%; 66% compliance for the intermediate-risk and 63% for the low-risk group. In order to further improve compliance. A wide range of MDT engagement allowed the project to achieve its aim in a relatively short timeframe, further steps to improve compliance further include encouraging patient involvement and the use of an excel tracker file, there are also discussions with radiology to allow bulk requesting of all surveillance scans required.
To improve documentation of patients with Return of Spontaneous Circulation (ROSC) by following a care bundle formulated from using the RCUK (2021) guidelines for post-resuscitation care. The Safety concern: When reviewing patient notes for NCAA (National Cardiac Arrest Audit), the documentation of the care/actions/plan after the cardiac arrest is not always completed. The Improvement Aim: To improve documentation of patients with Return of Spontaneous Circulation (ROSC) by following a care bundle formulated from using the RCUK (2021) guidelines for post-resuscitation care. *To Improve documentation of Post ROSC Care by 30%* Measures: **OUTCOME** – How many patients have ROSC? How many have ROSC care documented? **PROCESS** – Number of patients who have their ROSC care documented & what do other Trusts do? **BALANCING** – Time taken to do actions, pressure on DCC beds, staff awareness of bundle, is more equipment needed? • Key Results: Initially a good response with completion. • ED staff were engaging and had good understanding of post ROSC care

- When the ROSC care bundle was used, it provided a cohesive template for documentation

ROSC Care Bundle V3:

- **R** – Remain still (keep the patient still for at least 10mins post ROSC if possible to help with reperfusion syndrome)
- **O** – Observations (Inc. A-E assessment & 12 lead ECG)
- **S** – Saturations. (Maintain Normocapnia)
- **C** – Continuation of care

Next Steps:

- ACRT the one consistent so use them as a champion
- Roll out onto wards/clinical areas for all CA
- Have a digital version on EPR with post ROSC care listed to aid documentation compliance increase

Paediatric Audit Results: NICE (2019) Fever in under 5s: assessment and initial management (NICE Guideline 143).

- Management of infants up to and including 3 months of age with fever and presumed bacterial infection
- Audit was conducted between 1st Jan-30th Aug 2019, cohort of 50
- Up to and including 3 months of age
- Admitted for > 24hours to Children's In-patients (CIP)
- Coded for fever, sepsis and unwell

Aim: To reduce Viral PCR Turnaround time from 4.2 days to 36 hours within 6 months.
Outcome Measures: Turnaround time for viral PCR samples.
Process Measures:

- Number of CSF samples received from paediatrics for viral PCR.
- How many Viral PCR results available after 36 hours from sample being taken.
- How many Viral PCR samples were received in the laboratory within 12 hours of admission.

Balancing Measures:
Increased costs associated with bringing testing within house, staffing, reagents, maintenance contracts.

Results ongoing and next steps to implement new assay and create a long-term financial plan.

Participation in clinical research

The number of patients receiving relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust in 2022/2023 that were recruited during that period to participate in research approved by a research ethics committee was 2567.

Commissioning for Quality and Innovation (CQUINs)

CQUINs summary 2022/23

The Commissioning for Quality and Innovation (CQUIN) scheme provides a framework to support improvement in the quality of services. A total of 15 indicators were published for 2022-23, 9 of which were relevant to acute Trusts. This is the first year that CQUINs have been undertaken since Covid. In previous years Gloucestershire Hospitals Trust (GHT) has been able to choose CQUINs based on Trust priorities. For 2022/23 and continuing into 2023/24 there is an expectation that all CQUINs will be undertaken and reported on, with the 'top 5' being linked to the scheme's financial incentive.

- CCG1: Flu vaccinations for frontline healthcare workers
    - Aim – Vaccination rate for frontline workers to be 70-90% (1st September 2022 - 28th February 2023) Result = 47.1%. Difficulties at the start of the vaccination scheme with documentation of staff group means that this result is not reflective of 'true' vaccination rates for frontline staff.

- CCG2: Appropriate antibiotic prescribing for urinary tract infections (UTI) in adults aged 16+
    - Due to high workload that this CQUIN required, while not reflecting the priorities of the department, it was agreed with ICB colleagues that his CQUIN would not be undertaken.

- CCG3: Recording of National Early Warning Score version 2 (NEWS2), escalation time and response time for unplanned critical care admissions
    - Aim - 20-60% as a quarterly average of all the following requirements being documented a) NEWS2 Recorded b) Escalation Time Recorded c) Response Time Recorded. Q3 result 63% (with each individual requirement at 78% compliance or higher.

- CCG4: Compliance with timed diagnostic pathways for cancer services
    - Due to differences in CQUIN data requirements compared to the national upload and the resource it would take to manually transfer data across, it was agreed with ICB colleagues that this CQUIN would not be undertaken.

- CCG5: Treatment of community acquired pneumonia in line with British Thoracic Society (BTS) care bundle
    - Aim - 45-70% quarterly average of all the following requirements being present a) X-ray within 4 hours b) CURB65 score documented c) Antibiotics within 4 hours d) Antibiotics appropriately prescribed based on severity/ judgement/ NG138). QI project undertaken to develop documentation in Same Day Emergency Care (SDEC) to include CURB65 score and input to EPR.

- CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery 45-60%
    - Aim – 45-60% quarterly average for compliance with each of the following requirements: a) Haemoglobin (Hb) measured at pre-op assessment, or reviewed and recorded if test results were already available, b) If anaemia present, have serum ferritin level tested, c) If diagnosed with iron-deficiency anaemia offered appropriate iron treatment (oral and/or IV iron); or refer to back to primary care for treatment where an existing local pathway is in place. Q3 results show 92% compliance overall.

- CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service

- Aim – 0.5-1.5% over whole period. For this CQUIN GHT were reliant on community pharmacies accepting and claiming the referral. Current results stand at 0.5% with working being undertaken to allow a working interface between the Trust pharmacy system and PharmOutcomes.

- CCG8: Supporting patients to drink, eat and mobilise after surgery
    - Aim – 60-70% quarterly average where all the following requirements are compliant: a) ordering and provision of free fluids b) ordering and provision of food c) ordering and provision of patient mobilisation. Excellent results found for compliance with fluid, food and mobilisation being provided. Reflecting the national picture, the ordering of these elements showed lower compliance. This CQUIN continues into 23/24 and only the provision of fluid, food and mobilisation has been carried forwards.

- CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients
    - Aim 25-35% quarterly average. Requirement for additional test to be made available within ED and acute medicine. Fib4 bloods available vis GP practices through the fibro scan pathway launched in February 2021.

Plans for 2023/24

We will be participating in all the CQUINs and will have a focus on 5 priorities as agreed with the ICB about which CQUINs we will be participating in is being agreed with our ICB colleagues.

Table CQUIN

Title		Q1 result	Q2 result	Q3 result	Q4
CCG1: Flu vaccinations for frontline healthcare workers		---- Vaccination figures Sept 2022 to February 2023 Drs 684/1765 38.8% Nurses, MW, Health visitors 1159/273 57% Other professionally qualifies clinical staff 805/3405 23.6% Support to clinical staff 1569/1887 83.1% Support to GP staff 1/6 16.7% **Total** 4618/9798 47.1%			
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+		Nil return			
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Overall	21/34 62%	30/43 70%	25/40 63%	20/31 65%
	NEWS2 Recorded	33 97%	36 84%	36 90%	26 84%
	Escalation Time Recorded	22 65%	38 88%	32 80%	24 77%
	Response Time Recorded	34 100%	38 88%	31 78%	27 87%
CCG4: Compliance with timed diagnostic pathways for cancer services		Nil return			
CG5: Treatment of community acquired pneumonia in line with BTS care bundle	Overall	1/29 3%	1/14 7%	0/9 0%	2/15 13%
	X-ray within 4 hours	18 62%	6	3/9 33%	9/15 60%
	CURB65 score	4 14%	1/6	3/9 33%	5/15 33%
	Antibiotics within 4 hours	16 55%	2/6	1/9 11%	9/15 60%
	Antibiotics appropriately prescribed based on severity/ judgement/ NG138)	15 52%	5/6	7/9 78%	10/15 67%
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery	Overall	89/100 89%	90/100 90%	92/100 92%	94/100 94%
	Haemoglobin (Hb) measured at pre-op assessment, or reviewed and recorded if test results were already available	100 100%	100 100%	100 100%	100 100%
	If anaemia present, have serum ferritin level tested - (*Applicable in n cases)	*41 100%	*43 100%	40/41* 98%	35/35 100%

Title		Q1 result	Q2 result	Q3 result	Q4
	If diagnosed with iron-deficiency anaemia offered appropriate iron treatment (oral and/or IV iron); or refer to back to primary care for treatment where an existing local pathway is in place - (*Applicable in n cases)	*17 61%	*40 75%	10/18* 55%	12/18 67%
CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service		Q1 0.5%	Q2 0.5%	Q3 0.52%	Q4 A/W
CCG8: Supporting patients to drink, eat and mobilise after surgery	Overall	6/30 20%	28/97 29%	28/100 28%	18/100 18%
	Free fluids ordered by clinical team	7 23%	38 39%	38 38%	33 33%
	Free fluids given to the patient	29 97%	97 100%	99 99%	99 99%
	Food ordered by clinical team	6 20%	32 33%	31 31%	24 24%
	Food given to the patient	28 93%	95 98%	97 97%	97 97%
	Order for support to be given to the patient to mobilise	23 77%	84 87%	87 87%	80 80%
	Patient provided with support to mobilise	29 97%	95 98%	97 97%	97 97%
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients		6/84 7%	0/43 0%	0/31 0%	3/39 8%

Care Quality Commission

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

The year started In April 2022 with unannounced inspections in our core services of Maternity and Surgery. This was followed by a planned Well Led Inspection shortly after. In September, the CQC published its report. The inspections resulted in a downgrading of our current ratings, Maternity and Surgical Services from "Good" to "Inadequate" and the Trust's Well-Led rating from "Good" to "Requires Improvement". In regard of the Well-led review, the report has raised some very important issues in respect of the culture within the Trust. There are no circumstances when it is ever acceptable for staff to feel bullied, to be subjected to discrimination or to fear reprisals when they have had the courage to speak out. These are issues that have been raised through our own staff survey and as such have received, and continue to receive, the leadership's full attention. We are determined that our CQC inspection reports will provide further momentum and impetus to address these issues and we are working harder than ever to engage and involve our frontline colleagues in finding solutions to our challenges.

Inspections

CQC have carried out Inspections of Maternity Services, (April 2022), Surgical Services (April 2022), a Trust Well Led inspection (July 2022) and an Ionising Radiation (Medical Exposure) Regulation (I(R)MER) inspection (end October 2022). The table below summarises the inspection activity, ratings and contains links to the full reports on the CQC website.

Table: Inspection activity and reports received 2022/23

Inspection	Dates of inspection	Reports received	Links to reports	Rating
Core Service – Maternity (Unannounced focused Inspection) **Section 29a Warning Notice**	6-7 April 2022	22 July 2022	Report	**Overall inadequate**
Core Service - Surgery (Unannounced comprehensive inspection) **Section 29a Warning Notice**	12 & 13 April 2022	7 October 2022	Report	**Overall inadequate**
Trust Well led	13 & 14 July 2022	7 October 2022	Report	**Requires improvement**
Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection	26 & 27 October 2022		Improvement notice issued now closed.	**Not a rated inspection - inspection file closed**

Warning and improvement notices

Section 29a

In 2022, the Trust was issued with two section 29a Warning Notices for Maternity and Surgery as they found that significant improvement was required in areas of safety, leadership, risk management and governance for both services.

BBraun (subcontracted renal dialysis service) received a Section 29A Warning notice which relates primarily to the high levels of damage and deterioration which the inspectors witnessed around the buildings. The main criticism of BBraun is that they did not escalate when the Trust failed to undertake the repairs and maintenance which were urgently required and as a result there were potential health and safety issues in the Unit. BBraun have written to the Trust on 14 December 2022 and have asked the CEO to take action. A lead for the programme is confirmed, improvement works have taken place.

Summary of action plan progress

Core Service	**Initial action plan shared with CQC**	**Warning and improvement notices**	**Next review by CQC**	**Progress on all actions**
Maternity	August 2022	S29A reviewed with CQC, ICB and LMNS 21 Feb 2023	No further reviews until CQC inspection	S29A - 3 areas flagging Delivery at risk for delays in induction, timeliness of review of low/no risk clinical incidents and 1:1 care in labour.
Surgery	November 2022	S29A reviewed with CQC and ICB on 13 Feb 2023	No further reviews until CQC inspection	S29A – areas flagging Escalation Policy review, Surgical Assessment Unit (SAU) and theatres delays in flow and electronic patient record (EPR) keeping standards below 90% completion standard. Mixed Sex Accommodation Breaches (MSA) breaches.
Well Led	November 2022		Via updates to Q&P	To be monitored by Board, People and OD Committee and Q&P Committee.

The implications for the organisation are that we must continue to improve our services significantly to meet our registration requirements. We await re-inspection from the CQC in 2023/24 and are preparing for this.

Information governance Incidents 2022/ 2023

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

Fifteen incidents have been reported to the ICO during the 2022/23 reporting period. This compares to six reported in the previous period.

Table: Summary of incidents reported to the Information Commissioner

Summary of incidents reported to the ICO under Article 33 GDPR			
Month Incident Reported	**Nature of Incident**	**Number Affected**	**How Patients informed**
April 2022	A member of staff appears to have accessed patient health records for non-work related purposes and accordingly without authority. **Lessons learnt –** managed through human resources process. Staff reminded of their responsibilities and code of confidentiality	2	Patient aware through reporting
May 2022	Member of staff appears to have accessed records of a patient for non-work related purposes **Lessons learnt –** managed through human resources process. Staff reminded of their responsibilities and code of confidentiality	2	Patient aware through reporting
June 2022	A patient was given a hospital bag which should have contained his property. It was later ascertained that it contained information relating to other patients. **Lessons learnt –** importance of checking patient ID when processing and packing discharge letters and belongings	2	Patient contacted and apologised to.
June 2022	Care plans were created for and sent to two dermatology patients. The plans were placed in the wrong envelopes with the accompanying letters so each patient received the other patient's plan.	2	Both patients have been spoken to with apologies

	Lessons learnt – importance of checking patient ID and when processing letters		
June 2022	Patient was discharged from hospital. We were later contacted by his son who advised that the bag of belongings he was given on discharge contained documents relating to several other patients including personal details. These included DNR forms **Lessons learnt –** importance of checking patient ID when processing and packing discharge letters and belongings	2	It has not been possible to identify the patients affected – documents not returned.
July 2022	A patient was discharged from a ward to home. He later returned to inform us that he had found another patient's discharge summary with his belongings. This included full identifiers and demographics and detailed clinical information **Lessons learnt -** importance of checking patient ID when processing and packing discharge letters and belongings	2	Patient not able to be informed
Aug 2022	Patient's referral letter to another service accidently posted to another patient **Lessons learnt -** importance of checking patient ID and that no additional documents are included when preparing documents for posting	1	Patient contacted and apologised to.
Sept 2022	A patient's hospital discharge summary containing special category healthcare data was sent by post to another patient's address. **Lessons learnt -** importance of checking patient ID and that no additional documents are included when preparing documents for posting	1	Patient contacted and apologised to.
Sept 2022	A laptop and bag were stolen whilst packing up after a clinic held at external premises the laptop was system level encrypted and incident initially assessed as not reportable due to encryption control. Investigation subsequently discovered that in addition to the laptop the bag had also contained printed patient special category healthcare data.	5	Papers recovered intact – no evidence that seen by third party. Reporting not required.

	Lessons learnt - Investigation ongoing		
Oct 2022	A copy of a patient's hospital discharge summary containing special category health data was given in error to the wrong patient **Lessons learnt -** importance of checking patient ID when processing and packing discharge letters and belongings	1	Patient contacted and apologised to.
Oct 2022	A PC that has been stolen from the trust has been identified as having a report saved on the hard drive containing detailed pathology results for patients attending outpatients. **Lessons learnt -** Review required of security measures in the outpatient department resulting in Installation of security screen Review required of BCP PC set up process and controls as process not fully followed for this PC Review required of reporting and management process where incidents reported involve a loss and theft of IT equipment to ensure security, IT, IG and police processes are aligned, ensuring no unnecessary delay and information sharing between teams	1093	Patients not informed
Nov 2022	Member of staff accessed patient records for purposes not related to care and may have orally relayed information seen to third parties **Lessons learnt** - Investigation ongoing	9	Patient aware through reporting
Nov 2022	Patient A received by post a confidential report relating to another patient (B) **Lessons learnt** - Investigation ongoing	1	Duty of Candour (DoC) letter sent and uploaded to Datix
February 2023	On discharging of a patient (A) a set of health records relating to another patient (B) was sent home with him **Lessons learnt - Investigation ongoing**	1	No but is planned
March 2023	A paediatric handover sheet containing sensitive patient data was left unattended on a table next to	21	Under review

	a water dispenser where it was seen and (at least in part) read by parent filling a water bottle		
	Lessons learnt - Service will review guidelines for the handling of handover sheets		

All of the above incidents have been now been closed by the ICO with the ICO expressing satisfaction with the steps taken by the Trust to mitigate the effects and minimise the risk of recurrence, and requiring no further action, unless new matters came to light. In the case of breaches by staff we are also requested to report the outcome of disciplinary action when concluded so that ICO can further consider the issue of criminal liability under s170 Data Protection Act 2018 for unauthorised access or disclosure.

A large number of the 298 no breach/near miss reported incidents (222) relate to lost SmartCards which are disabled when reported as missing.

Summary of confidentiality incidents internally reported 2022/23	
Reportable breaches	(detailed above) 15
Number of confirmed Non-reportable breaches	165
Number of no breach / Near miss incidents.	298
Total number of confidentiality incidents internally reported	474

The effectiveness and capacity of these systems has been routinely monitored by our Trust's Digital Care Delivery Group A performance summary is presented to our and Finance and Digital Committee and/or Trust Board annually.

Learning from deaths

During 2022/ 2023 there were 2355 of Gloucestershire Hospitals NHS Foundation Trust patients who died. This comprised the following number of adult in hospital deaths which occurred in each quarter of that reporting period:

- 599 in the first quarter
- 561 in the second quarter
- 605 in the third quarter
- 590 in the fourth quarter (quarter not fully reported due to still collating data)

NB the following figures are not be complete due to quarter 4 not being fully reported:

The total number of deaths across all Divisions for the reporting year 2022/2023 is 2347 of which 100% are reviewed by the Medical Examiner as per Trust policy.

Of these 2355 deaths 466 have been triggered for an investigation by structured judgement review (SJR).

Of these 2355 deaths, 356 have so far been subjected to a detailed investigation by way of satisfying the criteria to trigger a Structured Judgement Review (SJR) (not all Q4 deaths have been completed due to 3-month time lag for review).

Of these 2355 deaths 15 have been reviewed by other means (harm review/ investigation, PIR, complaint)

Of these 356 SJRs carried out, 3 have identified that the cause of death is judged to be more likely than no to have been due to problems in the care provided to the patient. (i.e. that means went on to be a harm investigation or serious complaint)

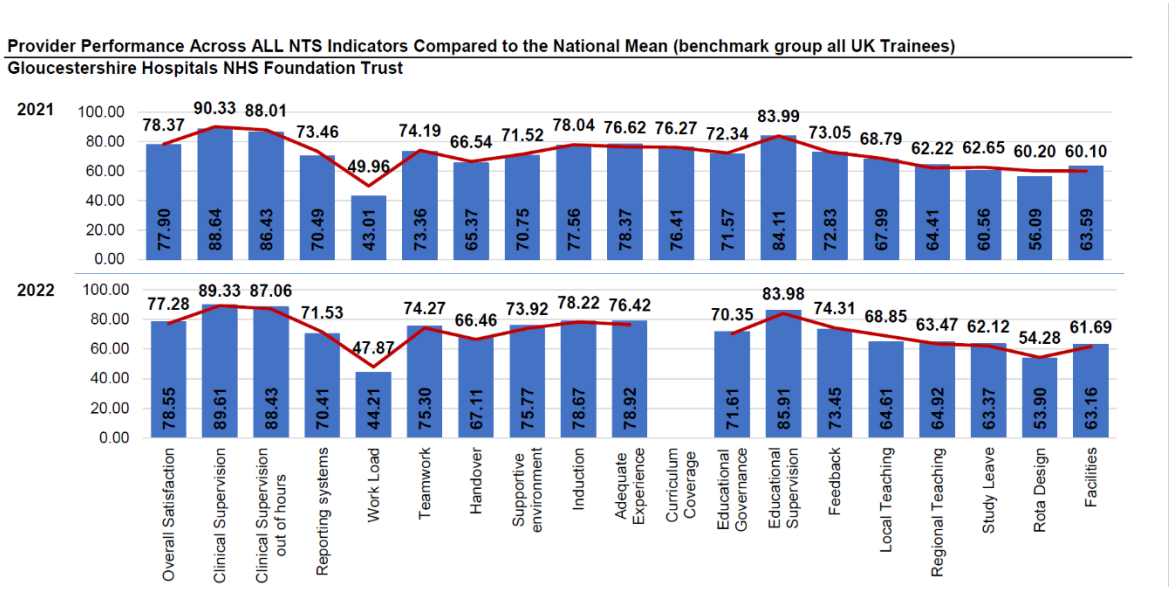
- The percentage of deaths which were selected for SJR=20%
- The percentage of deaths which have been reviewed as an SJR=15% (Q4 deaths may not have been completed due to 4-month time lag for review)
- The percentage of deaths reviewed by other means =1%
- Out of all 356 SJRs conducted (up until 11/05/2023), the percentage of deaths identified as having sub-optimal care as a contributing factor to the death = 0.8%

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 11/05/2021) = 0.8%

Statement from NHS doctors in training rota gaps

Context and Background:
The impact of rota gaps can be significant, not only for the doctors in training who may have to work longer hours and take on additional responsibilities, but also for patient safety and the quality of care provided. Therefore, it is important for our organisation to address this issue and ensure that doctors in training have a safe and sustainable workload. In the last National Training Survey (NTS) (Fig .1) we are well below national average on both work load and rota design.

Figure 1: National Training Survey (NTS) compared to the National mean



The incidence of training rota gaps within our organisation can vary depending on the specialty (medicine and paediatrics are some of the specialties with significant gaps in their rotas when compared to other specialties in our trust).

Monitoring, delivery and assurance:
Guardian of Safe Working: Dr Jessica Gunn, has provided the quarterly reports to Trust Board on rota gaps amongst specialties and the exception reports. She has now stepped down from role and the post has been advertised.

Quality Panel (QP) Reports:
Annual QP reports from South West Health Education England (HEE) provide us with HEE appointed trainee feedback on rota gaps and work load.

National Training Survey:
Nationally this report covers the workload and rota design both from HEE appointed trainees and also from locally employed doctors.

Rota gaps mitigation 2022/2023:
Discussion with rota gap leads in all specialties and working on solutions to reduce the rota gaps via:

- International medical graduates (IMG's) via a company called Remedium.
- Physician Associate (PA) number expansion across all specialties
- Locally employed doctors (LED'S) and hybrid posts (Teaching fellows etc.).

Challenges for 2023/24

- Maternity leave in some specialties significantly affecting rota gaps (paediatrics/ Obstetrics and Gynaecology (OBG)).
- Trainees coming off on-calls or doing amended duties (GP trainees in general medicine as IMGs with no previous NHS placement or experience) after review due occupational health reasons (stress related, maternity leave).
- Increase in Less Than Full Time Training (LTFT) (80%) across all specialties and some specialties have predominantly no trainees working full time (OBG and paediatrics).
- Many doctors under wrong cost code (especially in medicine).
- PGDiT extensions proving a huge challenge with not only placements but supervision/ curriculum completion & sign-off;
- Breakdown in communication between rota /department leads, medical staffing and finance.
- Community Placements/GP Supervision, with part-time GP's/Practices merging/GP's retiring.

Next Steps (2023/24)

- Health Education England (HEE) over the last 12 months has been working on re-balancing the number of HEE trainees factoring in the heavy workload from busy ED department compared to neighbouring NHS trusts across South West.
- Following a further increase of HEE funded specialty training posts from August 2023, our trust has secured additional training posts in speciality training (9 posts across all specialties) and also foundation programme doctors due to oversubscription from Aug 2023 (22 additional posts as Foundation Year (FY)1 and 9 as FY2).
- Coordinated effort to tackle rota gaps with involvement of medical staffing, finance, rota leads and Postgraduate Medical Education (PGME).
- Collaboration with HEE to pick up the rota gaps well in advance to mitigate rota gaps and recruit right number of NHS doctors to cover training gaps.
- For IMG's we need to build in shadowing time to allow stability, growth in confidence, understand the British Medical System, whilst not rostering them on nights for the first month. This will definitely aid retention, job satisfaction, patient safety.
- Increase in Programmed Activities (PAs), Advanced Nurse Practitioners (ANPs) and working towards self-sustaining workforce especially in departments such as medicine, paediatrics, OBG and emergency medicine.

Overall, we are taking a range of measures to address training rota gaps and ensure that doctors in training are able to provide high-quality patient care. However, gaps are widening (increase in LTFT numbers) and coordinated workforce planning will need to be actioned soon.

Veteran aware

Veteran Awareness Performance for 2022/23

From 29 February 2022 - 1 March 2023 there were 1479 Veterans identified on admission to Gloucester Hospitals NHS Foundation Trust across both Cheltenham and Gloucester sites. This is an increase of 109 identified in the year 2021/22, and the Veteran population making up 3.6% of the total patient population of hospital admissions. Veteran identification has risen from 75.7% in 2021/22 to 79.5% in 2022/23. The length of stay ranged from 2-110 days with an average daily total of 30 Veterans across the medical, surgical and specialty divisions. Wards and departments have sustained an improvement in identifying Veterans with Oncology having a 100% return on their Veteran status; there are areas such as neurology with low returns on Veteran status of 18%, exacerbated by the patient condition and some day-case areas which should not be included in the monitoring which may be skewing the percentage calculations.

Objectives Achieved for 2022/23

- Educate Trust workforce in relation to the Armed Forces Covenant and Electronic Patient Record (EPR) compliance-achieved on every Trust induction since May 2022 and ward-based training. Trust induction training has been sustained but the uptake of training has been challenged by operational pressures.
- Both Armed Forces Advocates to represent Gloucestershire Hospitals at Gloucester Armed Forces Day on 25 June 2022-photo (twitter) Gloucester Quays
- Represented Trust and Armed Forces Covenant at Gloucester Tall Ships Festival at Gloucester Docks and Cotswold Country Faye at Cirencester.
- Attended Armed Forces Covenant Annual Conference in May 22 at Cotswold Country Show.
- Attended the Gloucester Armed Forces Hub, a monthly engagement with service charities, education and social club.
- Develop partner working across the ICS – drug & alcohol team; homeless team; safeguarding
- Trust representation at the SW NHS Challenge hosted by 243 Field Hospital-this was cancelled by the Field Hospital due to Ukraine
- Achieved GHT Information Governance requirements and clearance for inputting Veterans' data onto the Defence Medical Welfare Services Armed Forces Portal.
- Jan 23 Commenced data input to the Defence Medical Welfare Services Armed Forces Advocates portal as part of the Veterans in an Acute Setting Research Programme.
- Ward Leaflets have been completed and handed to wards at the Trust Open Day in March and are available on the Veteran Intranet site Armed Forces Advocates and supporting our Veterans (gloshospitals.nhs.uk)
- Armed Forces Covenant; Gold Employer Recognition Scheme table on Trust Nursing and AHP Open Day 4 March 2023 with Reserves collaborating with Armed Forces Advocates.

- Reaccredited with Veteran Healthcare Alliance in June 2022, information on the internet site Veteran Aware Hospitals (gloshospitals.nhs.uk), the accreditation lasts 3 years.
- Instigated regular meetings with GHT Drug and Alcohol Services liaising across primary and secondary care to focus on veterans and admission avoidance, engagement with Drug & Alcohol services and ensuring High Impact Users care plans are updated and shared in clinical notes. Encourages early referral to Op Courage which is a specialist mental health and drug and alcohol service.
- Activities included a multi-faith Remembrance Service in the Atrium on 11 Nov 2022.
- Presented to the Trust Board – A Board Story – about who the Armed Forces Advocates were, what they did and how they assisted the patient journey and staff experience.

Good News Stories:

- Urology – A Veteran who had been exposed to chemical experiments at the Armed Forces Scientific Laboratory at Porton Down and had Service attributable symptoms had his wait to be seem reduced from 6 months to 1 month.
- A Veteran patient from Snowshill ward had his 6 months wait for a prostate operation reduced to 2 months due to the prostate symptoms exacerbating his post-traumatic stress disorder, a mental health condition he experienced after his Service in the Falklands war of 1982.
- Staff support offered to a highly valued Veteran member of staff who was struggling with mental and social issues, exacerbated by the time they spent in the Armed Forces.
- One of the Armed Forces Advocates facilitated a training placement change for a member of the Armed Forces community due to a serving partner being deployed overseas which meant they could not train too far from the family home.
- A staff member had a manageable shift pattern implemented while their partner was deployed for 6 months in order to manage their dependents.
- The Departments of Critical Care support a number of Armed Forces personnel from the Royal Air Force on honorary contracts to undertake clinical placements when they are not undertaking casualty evacuation flights from Brize Norton.
- The Surgical Directorate supports a number of Armed Forces personnel from the local Army Units on honorary contracts to undertake surgical experience.
- The Emergency Department is developing support to Armed Forces personnel from the local Army units to undertake emergency care placements.
- The Armed Forces Lead has been contacted by a number of Armed Forces personnel leaving the Armed Forces and looking for NHS roles in the Gloucestershire area, they are put in touch with Divisional leads from the area of interest.
- Recruited a new Armed Forces Lead with 37 years Armed Forces experience and strong links to 243 Field Hospital activity, including a recent engagement visit.

Objectives for 2023/24

- Continue data collection and submit Veteran data daily to the Defence Medical Welfare Service portal until 31 Dec 2023.
- Ward Education – target wards with a lower Veteran status compliance.
- Continue with monthly ward audits of Veteran status compliance and target those needing support to reach over 90%.
- Request to Divisional Deputy Divisional Directors of Quality and Nursing (DDDQNs) that Veteran status measurement is one of the metrics supported by the Quality & Performance Metrics, to reinforce its importance.
- Revise and re-publish the Trust Armed Forces Reserves Policy due to expire in May 2023.
- Work with the Business Intelligence Team to ensure daily and monthly measurements are focussed on the areas required and remove day case areas which may skew the compliance data.

- Represent the South West NHS by supporting teams at the South West NHS Challenge hosted by 243 Field Hospital 16-18 June 2023 in Exeter
- Restart Armed Forces Council to raise Armed Forces Awareness – invite advocates, support Reserve Services and Armed Forces community staff members.
- Link leaflets & poster to intranet and internet pages.
- Update intranet and internet page with Op Courage (the Veterans mental health and addictions service) referral form hyper-linked and other service charity contact details.
- Foster Armed Forces Lead links with HMS Flying Fox, the Royal Navy Reserve Unit in Bristol and RAF Brize Norton, the Royal Air Force Reserve Unit in Carterton, Oxfordshire.

Freedom to Speak Up

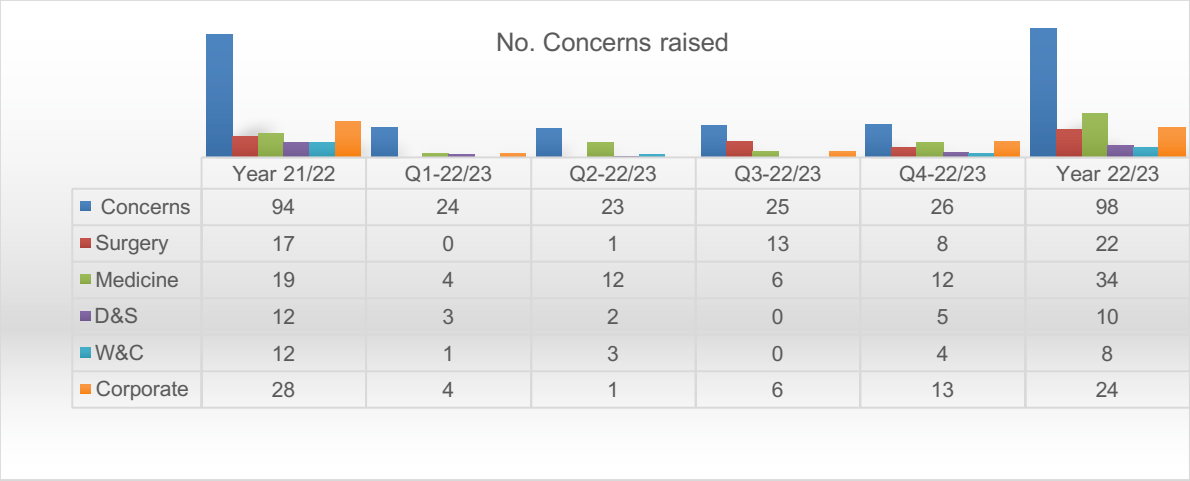
Our Trust is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life and in all of its practices. The Trust recognises that those who work for our organisation are in the best position to recognise when something is going seriously wrong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

The Trust actively encourages its employees to raise concerns in a safe environment as often this is the most direct way to prevent harm to patients, users and other Trust staff. Raising concerns provides an opportunity for issues to be addressed in a timely fashion and for both individuals and the Trust to improve practices and procedures in a sustainable way. This is a Trust priority in response to the CQC Well-Led inspection in 2022, and staff survey results.

Trust Data

At our Trust, In the year 2022/23, 98 people spoke to Guardians, with a total of 140 concerns including 3 teams who spoke up to the Freedom to Speak Up Guardian between 1 April 2022 through to 31 March 2023.

Table: Number of concerns raised by year and by quarter



	Year 21/22	Q1-22/23	Q2-22/23	Q3-22/23	Q4-22/23	Year 22/23
Concerns	94	24	23	25	26	98
Surgery	17	0	1	13	8	22
Medicine	19	4	12	6	12	34
D&S	12	3	2	0	5	10
W&C	12	1	3	0	4	8
Corporate	28	4	1	6	13	24

Of the 98 people:

- 77 spoke up about issues about staff experience (bullying and harassment behaviours)
- 6 had reported detriment in result of speaking up
- 23 had quality and safety elements within their concerns.
- 34 people raised their concerns anonymously

Key themes were:

- Bullying harassment, from manager in both situations, resulting in stress and anxiety;
- Pressures at work, lack of valid response from senior team;
- Team culture and individuals not feeling valued and supported
- Concerns about safety of services - due to short staffing and operational pressures, as well as changes to services;
- Concerns about discrimination; Issues about leadership style, lack of process being followed and favouritism within teams

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 are routinely monitored, reviewed and revised
- Routine Data Quality (DQ) reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence 'BI Hub' (previously '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.

Secondary users' services (SUS) 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 2022 to March 2023, the percentage of records which included a valid data was:
    - 97.9% for admitted patient care (regional average: 97.8%)
    - 98.6% for outpatient care (regional average: 95.0%)
    - 93.1% for maternity care (regional average: 94.7%)
    - 81.1% for accident and emergency care (national average: 83.4%)

Quality and Performance Reporting

A comprehensive suite of data quality reports covering the Trust's main operational system (TrakCare) is available and acted upon. These are run on a daily, weekly and monthly are available through the Trust's Business Intelligence 'BI Hub'. These include areas such as:

- Outpatients (looking at missing attendances, outcomes, invalid procedures)
- Inpatients (missing theatre episodes, invalid timings, errors with discharges)
- Critical care (Missing activity data, invalid care levels)
- A&E (incomplete discharges, incomplete clinical documentation)
- Patient Demographics (Invalid GP practice codes, missing NHS numbers, activity after deceased date)
- Waiting list including duplicate entries

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.

Part 2.3 Reporting against core indications

Domain	Indicator	Years	Trust	Comments
Domain 1 Preventing people from dying prematurely	The value and banding of the **Summary Hospital Level Indicator SHMI** for trust for the reporting period	2021/22		Reported at Board
		2022/23		
Domain 2 - Enhancing quality of life for people with long-term conditions	Not applicable			N/A
Domain 3 - Helping people to recover from episodes of ill health or following injury	Patient Reported Outcome Measures (PROMs)	2021/22		See next table
		2022/23		
	Percentage of patients aged 0–15 readmitted to hospital within 30 days of being discharged	2021/22	13.19%	
		2022/23	13.40%	The Women and Children's Divisi continue to monitor readmission rates.
Domain 4 - Ensuring people have a positive experience of care	Responsiveness to the personal needs of patients	2021/22	N/A	This data has not been published nationally since 2020 the pandem disrupted the national survey programme. Publication of this da has not been resumed therefore r data available for this report.
		2022/23	N/A	
	Staff who would recommend the trust to their family or friends	2021/22	58.4%	We have a cultural improvement work stream to improve our result in this area.
		2022/23	44.1%	
	Patients who rate the quality of their care as positive or extremely positive	2021/22	**89.6%**	
		2022/23	**89.7%**	
Domain 5 - Treating and caring for people in a safe environment and	patients admitted to hospital who were risk assessed for venous thromboembolism	2021/22	89.53%	
		2022/23	82.87%	
	rate of C.difficile infection	2021/22	30.48	

Domain	Indicator	Years	Trust	Comments
protecting them from avoidable harm		2022/23	28.48	
	patient safety incidents and the percentage that resulted in severe harm or death	2021/22	97	
		2022/23	112	

Patient Reported Outcomes

The data below is from the national website, for the period April 20 – March 21 (that's the most up to date data, published as at February 22).

	EQ-5D		EQ VAS		Oxford Score	
	Trust (%)	*England (%)*	*Trust (%)*	*England (%)*	*Trust (%)*	*England (%)*
Total Hip	90.70%	89.85%	83.33%	69.73%	97.83%	97.33%
Total Knee	83.33%	82.14%	64.41%	59.34%	92.54%	94.57%

Quality and Performance Report

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

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Friends & Family Test	ED % positive	No Target	Mar-23	79.3%	
	Inpatients % positive	No Target	Mar-23	91.7%	
	Maternity % positive	No Target	Mar-23	86.1%	
	Outpatients % positive	No Target	Mar-23	94.7%	
	Total % positive	No Target	Mar-23	92.3%	
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target	Mar-23	387	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target	Mar-23	748	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target	Mar-23	572	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target	Mar-23	557	
	Clostridium difficile - infection rate per 100,000 bed days	↓ Lower	Mar-23	14.7	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower	Mar-23	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7	Mar-23	14.7	
	Number of MSSA bacteraemia cases	≤ 8	Mar-23	4	
	Number of bed days lost due to infection control outbreaks	↓ Lower	Mar-23	125	
	Number of community-onset healthcare-associated Clostridioides difficile cases per month	≤ 5	Mar-23	2	
	Number of ecoli cases	No Target	Mar-23	2	
	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	≤ 5	Mar-23	2	
	Number of klebsiella cases	No Target	Mar-23	0	
	Number of pseudomona cases	No Target	Mar-23	1	
	Number of trust apportioned Clostridium difficile cases per month	< 10	Mar-23	4	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Infection Control	Number of trust apportioned MRSA bacteraemia	= 0	Mar-23	0	
Maternity	% PPH >1.5 litres	↓ Lower	Mar-23	2.9%	
	% breastfeeding (discharge to CMW)	= 0.0%	Mar-23	61.7%	
	% breastfeeding (initiation)	No Target	Mar-23	79.4%	
	% of women smoking at delivery	≤ 14.50%	Mar-23	9.41%	
	% of women that have an induced labour	≤ 30.00%	Mar-23	30.86%	
	% stillbirths as percentage of all pregnancies	< 0.52%	Mar-23	0.00%	
	Number of births less than 27 weeks	No Target	Feb-23	4	
	Number of births less than 34 weeks	No Target	Mar-23	7	
	Number of births less than 37 weeks	No Target	Mar-23	46	
	Number of maternal deaths	No Target	Mar-23	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target	Mar-23	1.9%	
	Total births	No Target	Mar-23	424	
Mortality	Number of deaths of patients with a learning disability	No Target	Mar-23	2	
	Number of inpatient deaths	No Target	Mar-23	172	
	Summary hospital mortality indicator (SHMI) - national data	No Target	Sept-22	1.124	
MSA	Number of breaches of mixed sex accommodation	≤ 10	Mar-23	40	
Patient Advice and Liaison Service (PA..	% of PALS concerns closed in 5 days	No Target	Mar-23	82%	
	Number of PALS concerns logged	↓ Lower	Mar-23	337	
Patient Safety Incid..	Medication error resulting in low harm	↓ Lower	Mar-23	12	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Patient Safety Incidents	Medication error resulting in moderate harm	↓ Lower	Mar-23	0	
	Medication error resulting in severe harm	↓ Lower	Mar-23	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Mar-23	38	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Mar-23	3	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Mar-23	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Mar-23	20	
	Number of falls per 1,000 bed days	↓ Lower	Mar-23	6.50	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Mar-23	3	
	Number of patient safety incidents - severe harm (major/death)	No Target	Mar-23	6	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Mar-23	19	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target	Nov-22	70.74%	
	Number of DoLs applied for	No Target	Mar-23	87	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Mar-23	85	
	Total admissions aged 0-17 with DSH	↓ Lower	Mar-23	39	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Mar-23	2	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Mar-23	0	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower	Mar-23	0	
	Total number of maternity social concerns forms completed	No Target	Mar-23	86	
Serious Incidents	Number of never events reported	= 0	Mar-23	0	
	Number of serious incidents reported	↓ Lower	Mar-23	4	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	> 80%	Mar-23	10,000%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%	Mar-23	10,000.0%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Mar-23	53.5%	

Part 3: Other information

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

Placeholder –

Gloucestershire County Council Health and Overview Scrutiny Committee - statement to follow

9.06.2023

Statement from Healthwatch Gloucestershire

Thank you for sharing the Quality Accounts for Gloucestershire Hospitals NHS Foundation Trust for 22/23, highlighting a very challenging 12 months. It was good to read a thanks from the CEO for the commitment and determination shown by her colleagues in the face of this.

We note the priorities for improvement around patient safety and patient experience, the work that has been done so far, and the work being planned to implement these improvements. Particularly in response to the focussed CQC inspections. We are pleased to see that there is an emphasis on collaborative working with patients and their families, partner organisations and the voluntary and community sector in driving this forward, as well as the investment and recruitment of key leadership roles, 'front door' and patient experience roles.

We acknowledge the recognition of the staff experience survey results, and appreciate that this will be an ongoing and long term challenge.

Healthwatch Gloucestershire are also particularly pleased to have one of our Board members included as part of the Quality Committee which has provided opportunities for openness and challenge in striving to improve.

Healthwatch Gloucestershire is happy to have a positive working relationship with the Trust and particularly welcome it's level of engagement activity and focus this year on discharge safety, Mental health strategy, End of life care and health inequalities.

We congratulate the Gloucestershire Hospitals NHS Foundation Trust on their achievements during the period and look forward to continuing to work together.

May 2023

NHS One Gloucestershire Integrated Care Board (ICB) response to Gloucestershire Hospitals NHS Foundation Trust's Quality Accounts 2022/23

NHS Gloucestershire Integrated Care Board (ICB) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2022-23. The past year has continued to present major challenges across both Health and Social care in Gloucestershire as we work to recover from the COVID-19 pandemic alongside the ongoing success of the Vaccination Programme and impact on the health of our residents. In the past year we have continued to see GHNHSFT working closely with partner organisations including the ICB 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. The ICB would like to thank the Trust for all the continuing efforts, dedication and hard work over the past year in dealing with the challenges.

Over the past year the Trust has continued to work with the independent regulators and has undergone a number of CQC re-inspections and reviews based on the findings of the previous surgical and maternity services reports which presented many concerns and highlighted a number of areas for improvement. The Trust have worked very hard alongside the ICB and CQC teams to progress the detailed action plans and to address concerns. Some significant improvements have now been made in patient care and the experience for patients and families, though we recognise there is still work to be done to achieve a consistent level of service to all. The impressive work of the Never Event programme has resulted in a notable reduction in Never Events and the Trusts improvement approach and shared learning has been commended by regional colleagues. Likewise, the theatre teams work supporting the avoidance of elective patient overnight stays in recovery, has resulting in an end to this practice and a much better experience for patients.

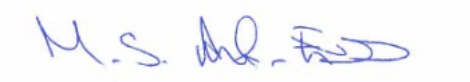
The ICB is also pleased to note and support the quality priorities listed in this year's Quality Account. The ICB is keen to continue to support the Trust with the maternity experience improvement plan and continues to work in partnership with the Gloucestershire Maternity Voices. The ICB were very pleased to see Gloucestershire voted as one of the best places in England to give birth by the CQC National Maternity Patient Survey. The ICB also recognises the importance of improving quality and experience for inpatients and are pleased to see work on reducing the risk of harm including pressure ulcers and falls which are listed as ongoing priorities, as well as the focus on improving the care of the deteriorating patient. 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 Framework (PSIRF) to enhance and improve safety culture is a further priority. This will better support Trust staff, helping them to raise concerns and as an ICB we would welcome staff involvement at all levels, recognising the feedback from the recent Staff Survey responses.

The ICB have continued to work alongside Trust colleagues to monitor and review Serious Incidents and Never Events that GHNHSFT have reported in the last year. A system approach helps to ensure that all the learning and improvement actions are monitored and embedded within the clinical environments, which includes feedback to system partners, community teams and Primary Care. The Trust's Safety and Experience Review Group, with representation and challenge from the ICB, continues to function successfully to retain detailed oversight of all Serious Incidents and Never Events and complaints. The Safety team alongside ICB colleagues and members of the Learning Academy, maintain a clear and robust system for ongoing monitoring of all action plans and recommendations.

The ICB endorses the Quality priorities that the Trust have selected for 2023/24 and are particularly pleased to see work to include the focus on children and young people's experience of transition to adult services and improving care for children and young people with diabetes. The ICB are also pleased to note the focus on improving mental health care for patients coming into hospital with several work schemes focusing on this area of care. In particular, the ICB note the successful application for the pilot involving two new front door Mental Health practitioner posts, with help from Rapid Streaming Service funds. The ICB looks forward to reviewing the impact of these new roles in line with the "Whole Person Care Strategy". This dovetails with the Trust's commitment and priority to improve the experience for people in the Emergency Department, including the ICS Urgent and Emergency Care Transformation Programme.

The ICB 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 and experience 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 ICB confirms that to the best of our knowledge we consider that the 2022/23 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT.



Dr Marion Andrews-Evans
Executive Chief Nurse
NHS Gloucestershire ICB

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

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

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23 and supporting guidance
- detailed requirements for quality reports 2022/23
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023 (Link)
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from Gloucestershire Integrated Care System May 2023
    - feedback from local Healthwatch organisation dated June 2023
    - feedback from the Health Overview and Scrutiny Committee - to follow
    - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2021/22 (Link to latest published report)
    - the 2021 National Patient Survey published by CQC September 2022 (Link)
    - the 2022 national staff survey published 9 March 2023 (Benchmark report Link)
    - CQC inspection reports (RTE inspection Reports Link)

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

The quality performance information reported in the quality report is reliable and accurate.

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

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

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

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

By order of the board

 Deborah Evans Chair	 Deborah Lee Chief Executive