



Gloucestershire Hospitals
NHS Foundation Trust

Quality Account

2018/19

What is a quality account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS.

Our Quality Account looks back on how well we have done in the past year at achieving our 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

I am delighted to introduce you this year's Quality Account. Every NHS Trust is required to publish a Quality Account which sets out how the Trust is performing against the quality standards and priorities set both nationally by Government and locally by the Trust Board and its commissioners. However, in Gloucestershire Hospitals, we have aimed to make it so much more.

Our aim has been to develop an Account that connects our community and our staff with the huge achievements of the last year alongside our ambitions for the future.

And, whilst the Quality Account is our opportunity to reflect on and celebrate the many, many things that we have achieved in the last year, equally importantly, it is our chance to look back on the challenges that we did not conquer and to ensure that we learn from these and remain focused on improvement, wherever it is called for.

The Year That's Gone

The year was characterised by numerous highlights which are described throughout this report, however, for many staff and myself included, it will be the year in which we secured a 'good' rating following the Care Quality Commission's (CQC) inspection of our services in the autumn of last year. The 'good' rating in itself was a huge achievement with more than 90% of our services now rated 'good' or 'outstanding'. However, ratings aside, what was most pleasing was the accompanying narrative which described the huge progress we have made since the CQC's last inspection two years ago, in respect of culture, leadership and

quality improvement. These things take time to develop, they are not easily achieved (or always maintained) but they stand us in such good stead as we continue our Journey to Outstanding.

One particular approach that was highlighted as outstanding practice is something we have chosen to focus on in our Quality Account; namely the work of our Improvement Academy. The CQC acknowledged and recognised that we now have a "fully embedded and systematic approach to quality improvement throughout our organisation" and that this is due to the work of all our staff and, importantly, through the leadership and enabling culture of our Gloucestershire Safety and Quality Improvement Academy (GSQIA).

The CQC weren't the only visitors to heap praise on the Academy this year. International safety guru and expert, Dr Don Berwick visited Gloucestershire in October last year and spent time immersed in some of the things we are doing throughout Gloucestershire to drive quality improvement. His comments about the Trust soon became the talk of the County and beyond, as social media platforms tweeted and posted his now infamous comments.

“”

What's in the water here? I've not had an experience in these visits as exciting as what is happening in Gloucestershire. I don't think I've seen anything like this; it's really special.

Dr Don Berwick

Under the leadership of our Director of Quality Improvement & Safety, Andrew Seaton, quality improvement has now become a frontline activity with more than 25% of our workforce – clinical and non-clinical - trained to listen to patients and implement small and larger-scale changes that make a real difference to patient care. As a result of this, each Monday, my weekly staff messages typically contain mention of a member of staff or team who has received acclaim for the things they are doing here in Gloucestershire, or the words of a patient or family member who has written to me thanking the Trust for the excellent care they, or their loved one, has received.

It is no coincidence that the NHS Constitutional standards are all about patients' experience of waiting; waiting for NHS care, whether it be waiting more than four hours to be seen in our Emergency Department or 18 weeks for an outpatient appointment or operation, is one of the things that patients and the wider public tell us matters the most when they are judging the quality of NHS healthcare. In 2018/19 we made considerable progress in this area; more than 90% of our patients in ED were seen in line with the national 4 hour standard positioning us in the top 25% of Trusts nationally, the previously elusive two week cancer waiting time standard was achieved in December 2018 - for the first time in more than two years – and was delivered for the rest of the year whilst more than 99% of patients received their diagnostic test within six weeks of referral, leaving the Trust the best performing hospital in the South West Region for this standard.

However, there is much more to be done in this area; cancer patients continue to wait too long to be treated following diagnosis and patients waiting for elective operations such as a cataract surgery or hip replacement are not routinely treated within the national standard of 18 weeks from referral. Improving the waiting experience

of our patients will therefore remain a huge priority for 2019/20 and we have set ourselves the ambitious goal of achieving the 62 day cancer waiting time standard from September this year.

In the year that has gone, we have made some important decisions about our 'digital future' and under the leadership of our Chief Digital and Information Officer, Mark Hutchinson, this year is the year that we can say that we have finally recovered from the challenging introduction of our replacement Patient Administration System some two years ago. This milestone enabled us to look out and ahead and we have now embarked upon realising the original vision for our patients and our staff of a fully electronic patient record driving increasingly safe and reliable care whilst releasing our doctors, nurses and other staff from administrative tasks which will free them up to spend more time with our patients and families.

One of the things that characterises the very best organisations is their willingness to look out and learn from others as well as to look inwards and examine themselves.

In our attempt to embrace this philosophy, our regular 100 Leaders' Forum has become characterised by a 'keynote speaker' whose brief is to expose us to the world outside Gloucestershire Hospitals and challenge our thinking. This year we have been fortunate in having a wide variety of speakers and three in particular stand out for me; Chris Hopson, Chief Executive of NHS Providers who gave us the most thrilling insights into the 'politics' of life at the top of the NHS, Duncan Selbie, Chief Executive of Public Health England challenged us to truly examine whether our actions as a healthcare organisation (or individuals) are enough given the limited evidence that we are closing the longstanding health inequalities gap between the best and worst off and Aidan Fowler, National Director of Safety who reminded us that organisations cannot "blame their way to safety" but must embrace every near miss and incident as a gift through which we can learn and in so doing, become safer.

The Year Ahead

Our community's health and care needs are changing. People are living longer; new medicines and technologies are being discovered and more of us are living with long-term conditions such as diabetes, asthma or enduring mental illness. We need our services to be designed around the patient and their increasingly complex needs, so that care is not only patient centred but personalised. Our quality priorities for the next year have been developed knowing that they will be important and meaningful

for our whole community and reflect the priorities of our developing Integrated Care System (ICS). This ambition is perhaps best reflected in one of our recently developed Strategic Objectives for the coming years ahead, which states that Health and social care across Gloucestershire is experienced to be 'without boundaries'. Patients, carers and staff designing, receiving and delivering integrated care across organisations, with the patient, their carers and their family at the heart of all we do.

2019/20 will be a year when we achieve a 'step change' in our approach to co-designing services through involving and engaging the public, our patients and their advocates and our staff by making sure that we all 'walk in their shoes'. The Sweeney Projects we have embarked upon capture this essence through the words of their founder and GP, Dr Kieran Sweeney who said "despite being a caring and compassionate healthcare professional, it was only when I became a patient himself did I truly understand the value of stepping into the patients shoes and seeing care through their eyes".

Thank you

The NHS is nothing without its dedicated and skilled staff and my colleagues throughout Gloucestershire Hospitals exemplify this sentiment. The backdrop to this contribution from staff is an NHS which is busier than ever, with patients who (rightly) expect more and more from us all and stakeholders who are (rightly) impatient for us to address the residual challenges we face. However, challenges there may be, but not a day goes by when the endeavours of a staff member aren't brought to my attention for the outstanding expertise, care and compassion they have shown a patient, a family member or colleague; or a week when I am not asked to shine a spotlight on a team or individual who has 'gone the extra mile' for a patient or colleague or a month when I am not proud to announce another 'first' in respect of our improving performance.

Finally, quality improvement doesn't just happen; it needs passion, direction, scrutiny, challenge and most importantly unrelenting support from the very top of the organisation and therefore, I'd like to take this opportunity to formally thank Dr Claire Feehily, non-executive board director and chair of the Trust's Quality and Performance (Q&P) Committee, who as Chair of the Q&P Committee has steered the organisation through the last two years of unprecedented improvement and has been a champion for every patient, every carer and every staff member that needed their voice to be heard at the 'top of the shop'. In keeping with our philosophy, Claire is handing over the baton for Q&P to Board colleague Alison Moon (and in turn

picking up the baton for Audit Committee) and therefore I'd like to formally thank Claire for her huge contribution to quality improvement in our Trust.

Formal bit

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



Deborah Lee
Chief Executive Officer

PART 2

Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following two sections are divided into four parts:

- ◀ **Part 2**
- ◀ **Part 2.1**
 - ◀ **What our priorities for 2019/20 are:** explains why these priorities have been identified and how we intend to meet our targets in the year ahead.
 - ◀ **How well have we done in 2018/19:** looks at what our priorities were during 2017/18 and whether we achieved the goals we set ourselves. Where performance was below what was expected, we explain what went wrong and what we are doing to improve
- ◀ **Part 2.2:** Statements of assurance from the Board
- ◀ **Part 2.3:** Reporting against core indicators.
- ◀ **Part 3:** The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

PART 2.1

Our priorities

Our priorities for improving quality 2019/20

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

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

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

Our consultation process

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

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

- ◀ Analysis of themes arising from internal and external quality reports and indicators
- ◀ **Patient experience insights:** National Survey Programme data, Complaints, PALS concerns, Compliments, feedback from the Friends and Family Test (FFT), and local survey data, focus groups, experience stories to Board.
- ◀ **Patient safety data:** safer staffing data, national reviews, incidents, claims, duty of candour, mortality reviews and Freedom to Speak up data.
- ◀ **Effectiveness and outcomes:** Getting It Right First Time reports, clinical audits, outcomes data.
- ◀ Staff, key stakeholders and public engagement – seeking the views of people at engagement events.
- ◀ Engaging directly with our Governors on our quality priorities as they are required by law to represent the interests of both members of our Trust and of the public in Gloucestershire.

Many of our Governors sit on steering groups and committees and so are able to influence and challenge quality of care.

- ◀ Review of progress against last year's priorities, carrying forward any work streams which have scope for on-going improvement.
- ◀ Ensuring alignment with national priorities and those defined by the Academic Health Science Network patient safety collaborative.

Reviewing key reports such as

- ◀ The NHS Long Term Plan so that we consider how we will deliver the national aspirations locally.
- ◀ "Learning from Gosport" which was the Government's response to the report of the independent panel.

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

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

The Quality Delivery Group is responsible for monitoring the progress of the organisation against our quality improvement priorities.

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

Priority quality indicator goals 2019/2020	Why we have chosen this indicator
WELL LED: Continuous improvement	<p>Continuous quality improvement with the GSQIA. To further enhance our quality improvement systems with support from the Quality Improvement by our Gloucestershire Safety and Quality Improvement Academy (GSQIA)</p>
To continue to develop our speaking up systems and processes through Freedom to Speak Up	<ul style="list-style-type: none"> ◀ To further embed our QI approach to enable us to be rated as an outstanding organisation by the CQC. ◀ CQC were impressed with our overall QI approach. <ul style="list-style-type: none"> ◀ This is an area that staff have indicated that they would like us to improve ◀ National driver to improve after the Gosport Independent Enquiry. ◀ Staff Survey results
To improve patient experience of our discharge processes	<ul style="list-style-type: none"> ◀ Continuation of the safe and proactive discharge programme which was a Commissioning for Quality Improvement (CQUIN 19/20). ◀ Our Adult Inpatient Survey data indicates this as an area of improvement. ◀ Endorsed by our Governors.
To improve cancer patient experience	<ul style="list-style-type: none"> ◀ In order to achieve an Outstanding rating for Cancer Services, we want to co-ordinate our improvement work to where it is most needed. ◀ Local data from our Cancer Survey.
To improve outpatient experience	<ul style="list-style-type: none"> ◀ Our local data supports that this is an area for improvement. ◀ Endorsed by our Governors
To improve mental health care for our patients coming to our acute hospital	<ul style="list-style-type: none"> ◀ Our CQC feedback from our most recent inspection advises us that we can make improvements in this area. Our local data and The Long Term Plan supports that this is an area for improvement.

Priority quality indicator goals 2019/2020	Why we have chosen this indicator
To develop a real time patient experience survey programme	<ul style="list-style-type: none"> ↳ Our staff would like access to more real time patient experience data (Staff Survey) ↳ Our patients would like to provide us with feedback on how we could improve.
SAFETY: Lessons are learnt and improvements are made	
To enhance and improve our safety culture	<ul style="list-style-type: none"> ↳ National driver with the consultation for the national patient safety strategy and also the CQC Never Events report. ↳ Our Staff Survey results
To improve our patients beginning their first treatment for cancer within 62 days following an urgent GP referral for suspected cancer.	<ul style="list-style-type: none"> ↳ National NHS Constitution target
To improve the issue of patients being lost to follow up	<ul style="list-style-type: none"> ↳ Local data supports this as an area of focus ↳ Endorsed by our Governors
To improve our prevention of pressure ulcers	<ul style="list-style-type: none"> ↳ The national Stop the Pressure programme led by NHS Improvement.
To prevent hospital falls	<ul style="list-style-type: none"> ↳ Implementing the three high impact actions ↳ CQUIN 2019/20 ↳ Endorsed by our Governors
To improve the learning from our investigations into our serious medication errors	<ul style="list-style-type: none"> ↳ Our local data supports this as an area of focus.
To improve our care of patients whose condition deteriorates and to deliver time critical care – (to include Stroke care, VTE and sepsis).	<ul style="list-style-type: none"> ↳ National drivers – The Long Term Plan. ↳ Local data supports that we need to fully embed our NEWS2 system and that we appropriately respond to our patients.

Priority quality indicator goals 2019/2020	Why we have chosen this indicator
CLINICAL EFFECTIVENESS / RESPONSIVENESS	
To improve our learning into action systems – including learning from national investigation reports as well as learning from our own local investigations (learning from deaths, complaints, Duty of Candour, serious incidents and legal claims).	<ul style="list-style-type: none"> ↳ National driver after Gosport Independent Panel findings. ↳ Our staff tells us that this is an area where they would like to see an improvement. ↳ Endorsed by our Governors
To improve our care for patients with diabetes	<ul style="list-style-type: none"> ↳ National Driver – Long Term Plan. ↳ Our local data supports that this is an area that we should focus on improvements.
To improve our care of patients with dementia (including diagnosis and post diagnostic support)	<ul style="list-style-type: none"> ↳ National drivers – Long Term Plan. ↳ Our local data supports that this is an area that we should focus on.
To improve our nursing care standards the continuation of Nursing Assessment and Accreditation Scheme (NAAS)	<ul style="list-style-type: none"> ↳ Local data supports this as an area for improvement.
To improve our infection prevention and control standards (reducing our Gram-negative blood stream infections by 50% by 2021)	<ul style="list-style-type: none"> ↳ National driver ↳ Endorsed by our Governors
Rolling out of Getting it Right First Time standards in targeted standards	<ul style="list-style-type: none"> ↳ National driver ↳ Endorsed by our Governors
Delivering the 10 standards for seven day services (especially 2, 8, 5, 6)	<ul style="list-style-type: none"> ↳ National driver
To deliver the programme of Better Births (maternity care)	<ul style="list-style-type: none"> ↳ National driver
To improve our care of children transitioning to adult care	<ul style="list-style-type: none"> ↳ National driver ↳ Local data supports this as an improvement area ↳ Endorsed by our Governors

PART 2.1

How well have we done in 2018/19?

Well led

Learning to Improve: our quality improvement academy

Quality priority

- ↳ To continue to build the capacity and capability of our staff to improve services through the Gloucestershire Safety and Quality Improvement Academy (GSQIA)

Background

The GSQIA was built in June 2015 with the aim of developing a centralised source of safety and quality improvement education programmes to provide staff with the skills, tools and the support to contribute to the Trust vision of embedding continuous quality improvement into normal everyday working. Quality Improvement (QI) is about making a real difference, directly or indirectly, to patient care. It's not about finding new clinical approaches (research) but about improving our own systems and processes to make them more patient focused, safe, efficient, timely or relevant to the latest clinical guidelines. We offer 3 levels of QI training 'Bronze', 'Silver' and 'Gold'.

See Figure 1.

How have we performed 2017/18

Progress continued to be made in terms of embedding the Trust approach to Quality Improvement and increasing the capability and capacity of staff to undertake QI projects. The GSQIA was also recognised externally for its approach and was shortlisted for two Health Service Journal (HSJ) awards, under the following titles:

- ↳ A communication strategy to create an Improvement Movement in an Acute Hospital Trust
- ↳ Learning to Improve: An Academy Approach

How have we performed 2018/19

The GSQIA has exceeded its targets for numbers trained in the Bronze and Silver levels of the QI programme. Only eight Gold QI coaches completed the next level of the programme, partially due to delays in the roll-out of the revised Quality Model, to which it is linked.

A visit by Don Berwick, former President and Chief Executive Officer of the Institute for Healthcare Improvement, provided positive feedback on the work of the GSQIA and the consistency of the scientific approach to Quality Improvement. Similarly the CQC visit highlighted the work of the Academy as an area of outstanding practice.

See Figure 2.

Data

Following an initial target to train approximately 10% of staff (800) in Quality Improvement methods by the end of 2018, revised targets were proposed and included in the Trust objectives for 2017–2019.

	March 2019 Target Increase (Totals)	Q3 2018/19 Increase (Totals)	Q4 Final numbers (at 18/03/19)
Bronze	+900 (1537)	+1131 (1768)	+1318 (1955)
Silver	+70 (97)	+86 (113)	+99 (126)
Gold	+45 (45)	+8 (8)	+8 (8)

Figure 1: Overview of Gloucestershire Quality Improvement Academy Training

Bronze Level: Introduction to Quality Improvement

The Bronze level course provides an overview of quality improvement tools and methods. It is a four hour classroom-based session and is suitable for anyone sponsoring or taking part in a Quality Improvement initiative or who has an interest in learning about Quality Improvement.

Silver level: Quality Improvement in Action

On the Silver Level course, Improvers come with an area for improvement identified and the QI team works with them to create and support their Quality Improvement project. The programme is a combination of taught theory and supported application of QI tools, to create improvement aims, diagnose problems, identify and test change ideas and measure the impact. The six month programme includes monthly follow-on sessions with continued support and culminates in the participants creating a poster and presenting the results of their improvement work to qualify as an Improvement Practitioner at their Graduation and Awards Ceremony.

Gold level: Coaching Quality Improvement

The Gold programme covers a combination of leadership, coaching and QI skills, designed to develop an improvement 'habit' within individuals. Gold QI coaches will support Improvers to undertake QI projects at a local level and work within their department to identify and coordinate a programme of improvements.

Figure 2: Overview of Gloucestershire Quality Improvement Academy Training

"You're clearly building on a sense of community. It's really special"

– Don Berwick

"Across the trust there was a fully embedded and systematic approach to improvement called the Gloucestershire Safety and Quality Improvement Academy (GSQIA). This framework empowered frontline staff with the tools to support a change and implement a quality improvement project. Staff said that this had created a recognisable brand, and some described it as a 'social movement'. Throughout all the focus groups there was a narrative on quality improvement and innovation. Staff at all levels were engaged in the process and could give examples where quality of care for patients had improved because of quality improvement projects."

– CQC Inspection report



Numbers of staff completing courses (excluding non-GHT staff):

Bronze: 1804 staff, including NHS Gloucestershire Managed Services (GMS) Staff (GMS is a wholly owned subsidiary company set up by the Trust on 1st April 2018).

Silver: 126 staff, with a further 129 projects in progress

Gold: Eight staff, with an additional 16 starting in the new cohorts 3 and 4, taking the total to 32 Gold QI coaches currently in training.

Plans for improvement 2019/20

The work of the GSQIA will continue and information can be reviewed on our Trust website, with regular communications about our work on Facebook, Instagram, LinkedIn and Twitter.

Two new cohorts of Gold Quality Improvement coaches began their training programmes in March 2019, as we continue to work towards the ambition of having 90 Gold QI coaches across the Trust.

This year will also see the introduction of the first Human Factors programme to the GSQIA portfolio of training. This will mark the beginning of the expansion of the GSQIA into the field of Safety. In addition, training on experience based co-design will mark further expansion into patient experience.

Figure 3: Bronze Quality Improvement training

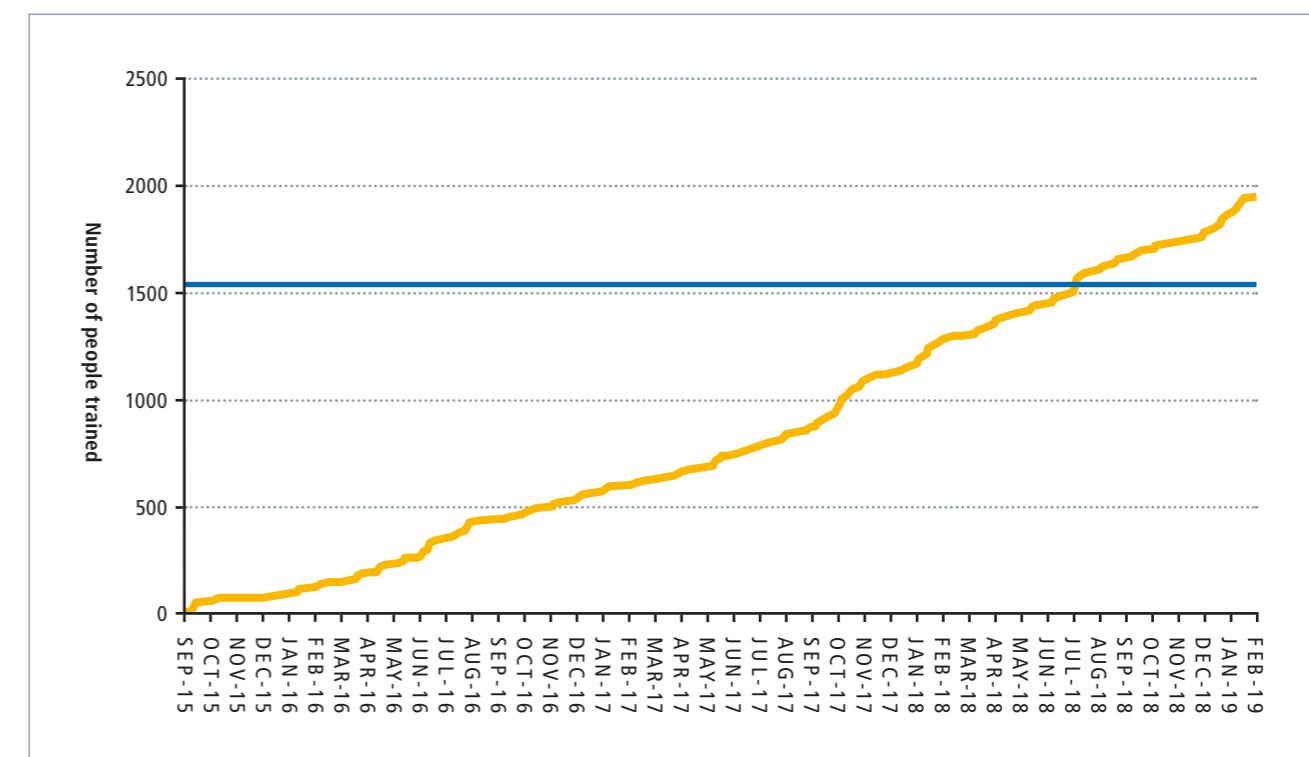
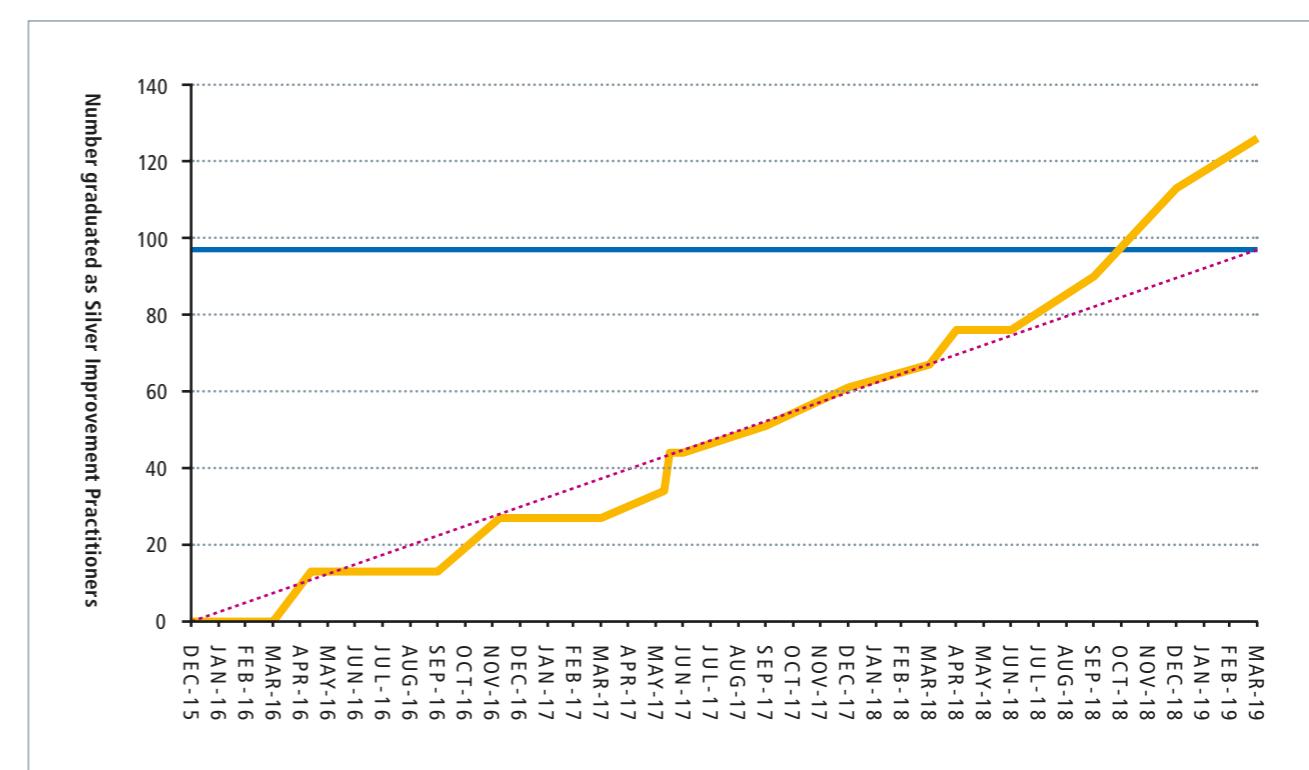


Figure 4: Silver Quality Improvement training



Learning to Improve: national audits

Quality priority

To participate in and learn from the results of national audits

Background

Clinical audit is a way to find out if healthcare is being provided in line with standards and enables care providers and patients know where their service is doing well and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits).

An example of improvement work that has taken place in response to a specific clinical audit would be our response to The National Paediatric Diabetes Audit 2016-17 Report (published in 2018).

The National Paediatric Diabetes Audit

The Gloucestershire Paediatric Diabetes Team has recently implemented a number of changes to develop their service in response to the audit findings. The improvements include:

- ◀ Starting carbohydrate counting from diagnosis,
- ◀ Holding high HbA1c meetings (HbA1c, is a form of haemoglobin (a blood pigment that carries oxygen that is bound to glucose). The blood test for HbA1c level is routinely performed in people with type 1 and type 2 diabetes mellitus),
- ◀ Starting annual review clinics,
- ◀ Holding more regular team meetings,
- ◀ Producing a quarterly patient newsletter,
- ◀ Holding parents' evenings,
- ◀ Organising a PGL adventure holiday camp, and
- ◀ Family events.

These service improvements and interventions have helped to improve patient experience and outcomes and are reflective of the recommendations from the report.

The 2018 report highlighted that one of the outcomes that teams should be working towards is to "Ensure that all children and young people with diabetes are provided with an ongoing programme of structured education from diagnosis, tailored to their individual needs".

As part of the RCPCH Quality Improvement programme, the Gloucestershire Paediatric Diabetes

Team wanted to focus on making their service more patient-centred and improve patient engagement. Their aim was to improve the clinic experience for patients and their families, as well as staff, based on their own input, thereby encouraging greater engagement and patient attendance.

Identifying areas for improvement

After the audit the improvement team surveyed patients, families and staff to identify areas for improvements. They formed working groups for four main interventions and trialled a series of changes, adapting as they went through.

Improvements implemented included:

- ◀ Amending clinic letters and allowing extra time to prepare for clinics and reduce waiting times.
- ◀ Introducing a "Getting Ready for Clinic Sheet" in order to provide clear written action plans that could be taken away from the clinic.
- ◀ Rearranging the clinic furniture so the sessions felt less "interview-like".
- ◀ Supporting patients to have greater ownership of their diabetes management by providing information and guidance on downloading during clinics, enabling them to download HbA1c records from home.

How we have performed 2018/19

The improvement team surveyed patients/families' opinions of their interventions using a 'smiley face' scale. The improvements have been very well received. Responses to the changes in clinic furniture layout were 88% positive and 12% neutral. Similarly, their 'Getting Ready for Clinic' sheet yielded 94% positive responses and 6% neutral, with comments such as, "It let us have a voice in the clinic". Verbal and written feedback indicates that patients and their families feel "highly motivated" by the HbA1c log charts in clinic.

Requesting that patients arrive 15 minutes early for appointments has yielded no improvement on clinic duration. The greatest impact on this is the length of time spent in with the consultant, reflecting the complexity of our patients' needs. Their next step is to consider effective use of waiting time, perhaps with micro-teaching.

Results show offering downloading instructions to the portal Diasend in clinic was valuable and 72% of those surveyed indicated that they would now be happy to download at home, with some

indicating that knowing they would need to download in clinic would encourage them to do it at home prior to clinic. The number of patients now using the portal Diasend to download at home has increased since their intervention, from 55% of the caseload, to 63%. They have also begun recording monthly clinic HbA1c averages, with a view to monitoring the impact of future interventions on this key aspect of diabetes management.

Plans for improvement 2019/20

The Gloucestershire Paediatric Diabetes Team want to continue to improve their services and have a number of further quality improvement projects in development, such as tracking HbA1c levels, using new technology and improving diabetes education.

Learning to Improve: Getting it Right First Time

Quality priority

- To participate in and learn from reviews of our services: Getting it Right First Time (GIRFT)

Background

Getting It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and sometimes resultant cost savings.

Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

How we have performed 2018/19

We are dedicated to implementing and embedding the 'Getting it Right First Time' standards within the Trust and have now recruited a Clinical Lead and a Service Improvement Lead to undertake this work. There are now regular meetings with the clinical and service improvement leads to review progress and facilitate progress and an annual review will take place with the executive team. Many of the actions required are not only within the gift of each service but have implications to service redesign and sometimes countywide input.

Reconfiguration of Trauma & Orthopaedics (T&O) service to support compliance was implemented from October 2017. The rationale was to split the Trauma (non-planned patients) and Elective (planned) patients. All trauma and paediatric surgery is now carried out in Gloucestershire Royal, although fracture clinics remain at Cheltenham General Hospital, Gloucestershire Royal Hospital and Stroud Hospital. All arthroplasty (joint replacement surgery) is carried out at Cheltenham where the wards are ring-fenced however it was not possible to take all elective surgery to Cheltenham due to theatre availability and kit requirements; spinal surgery and some foot and ankle surgery currently remain at Gloucester.

Elective outpatient clinics remain at both main sites and all community hospitals. Benefits for Trauma patients include a review seven days a week, the availability of a senior decision maker in the Emergency Department and dedicated Trauma theatres with timely specialist surgery available. Benefits for Elective patients have been an increased number of patients and fewer cancellations. There has been a slight drop in the number of elective cases in January and February 2018; this is partly due to the refurbishment of one of the Orthopaedic Theatres at CGH and partly due to the winter pressures which have affected the elective work on the GRH site.

Data

See opposite page for data.

Plans for improvement 2019/20

Further work will be undertaken to raise the profile of this work in the coming year and to link with the excellent New Quality Framework.

There are a number of challenges that are very challenging and will require multiple agency working. Reconfiguration of estate for the Urology service is almost complete enabling completion of a number of actions including timely assessment for patients with suspected cancer.

GIRFT is also championing the veteran's aware process; this is to ensure that ex-forces personnel are able to access expert care within the NHS and are not disadvantaged by moves to different areas. Gloucestershire Hospitals is working towards the Veteran's Covenant Hospital Alliance accreditation which we hope will be achieved in the coming year.

Figure 6: Services that have had GIRFT reviews, and are working on the recommendations

Service	GIRFT Visit	No. of GIRFT recommendations	Number of Actions:			
			Completed	Green	Amber	Red
Dermatology	19.12.2018	20	0	20	0	0
Diabetes	22.01.2019	14	0	14	0	0
Endocrinology	02.11.2018	6	0	6	0	0
Ear, Nose and Throat (ENT)	21.04.2017	10	2	8	0	0
General Surgery	13.03.2018	7	2	5	0	0
Obstetrics & Gynaecology	29.11.2017	14	3	6	5	0
Oral, Maxillo Facial (OMF)	21.04.2017	6	3	3	0	0
Ophthalmology	30.08.2017	7	2	4	1	0
Paediatric Surgery	11.08.2017	8	5	1	1	1
Spinal	23.11.2016	8	3	1	2	2
T&O	04.07.2014 & 10.01.2017	24	20	1	3	0
Vascular	10.02.2017	16	2	12	2	0
Urology	21.06.2017	26	12	10	3	1

Figure 7: Services that have had a GIRFT review but await the recommendations:
Anaesthetics & Perioperative Medicine,
Emergency Medicine, Renal

Specialty	Date of Meeting
Anaesthetics and Perioperative Medicine	23.11.2018
Emergency Medicine	11.10.2018
Renal	11.01.2019

Figure 8: Services that have completed their questionnaire and expect a visit in 2019/20

Specialty
Acute and General Medicine
Breast Surgery
Cardiology
Radiology
Respiratory
Rheumatology

Learning to Improve: Proactive and safe discharge

Quality priority

To improve care for a proactive and safe discharge from hospital (CQUIN)

Background

Our goal is that we enable patients to get back to their usual place of residence in a timely and safe way. For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. Hospital stays for older adults are longer and more disruptive than for younger people and their care does not always fit within usual ambulatory care pathways (NHS England, 2013). In addition, older people are more likely to stay a long time in hospital, to be moved while there, to experience delayed discharge, and to be readmitted within a month as an emergency (McMurdo and Witham 2013; British Geriatrics Society 2012a; Cornwell 2012).

In 2018/19, the local CQUIN for proactive and safe discharge focused on the quality of discharges. The local CQUIN element was based on the safer discharge bundle as a measure of the quality of discharges.

Monitoring was focused on five areas:

- ◀ Number of discharges before 12pm
- ◀ Number of TTOs arranged the day before discharge
- ◀ Number of patients with TTOs on discharge
- ◀ Number and quality of discharge summaries
- ◀ Number of patient transports aborted on the day because the patient was not ready for discharge
- ◀ Number of discharge related complaints

How have we performed

The Trust continued to build upon the work undertaken last year to implement and embed the SAFER Programme.

The SAFER programme focused on improved patient flow is enabling us to improve our discharge rates to return patients to their place of safety within seven days of admission.

The introduction of this initiative reduced length of stay and now this has been further improved by the introduction of the Red2Green toolkit as part of SAFER which identifies a set of tasks for the day which need to be completed for each patient in order to progress their discharge and improve the

quality of their inpatient stay. We have mapped existing discharge pathways and collected baseline information on effectiveness of discharge processes from every ward creating a real time dashboard.

Improvements that we made:

- ◀ Workstations on Wheels (WoWs) were resurrected and then linked to printers.
- ◀ Staff education sessions were held to enable speedier processes for Tablets to Take Home and Discharge Summaries.
- ◀ A change of process for discharging overnight patients in Bibury Ward. Now to be discharged from Endoscopy thereby being discharged from Bibury from Midday.
- ◀ Twilight Ward clerk team now operating on the Gloucester site between 17:00-21:00.
- ◀ Silver QI project with the implementation of the 'Golden' patient identified the day before as the patient that staff must proactively support to get home by midday.
- ◀ Introduced 'Breakfast Club' in Discharge Waiting Area so that suitable patients could arrive early for their breakfast
- ◀ Transport to be booked following Board round
- ◀ One-Stop dispensing training for all staff
- ◀ Discharge Dashboard
- ◀ Involve Volunteers in collection from pharmacy

Data

See opposite page for data.

Plans for improvement 2018/19

There is a considerable evidence for the harm caused by poor patient flow through our hospitals. Delays can lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people's needs, and increasing costs to local health economies and so we will continue our improvement work in 2019/20. The desired outcomes will be improvement in patient outcomes, improvement in patient flow, and reduction in delayed discharges (and thus reduction in associated costs).

Figure 9: Number of discharges before 12 midday

Ward	Baseline data	Quarter 3	End of February 2019
Avening Ward	6.5%	8.7%	11.1%
Bibury Ward	9.4%	10.8%	8.7%
Ward 3A	14.2%	27.4%	33.3%
Ward 8B	10.2%	8.2%	6.7%

Figure 10: Number of discharges before 12 midday

Ward	Baseline <=24hr	Quarter 3	Baseline >24hr	Quarter 3
Avening Ward	63.6%	66.2%	29.1%	23.5%
Bibury Ward	53.2%	48.9%	36.5%	31.8%
Ward 3A	45.9%	39.0%	46.6%	58.5%
Ward 8B	65.4%	68.7%	24.9%	20.1%

Figure 11: Number of discharge summaries ready on day of discharge

Ward	Baseline data	Quarter 3
Avening Ward	94.3%	98.7%
Bibury Ward	91.4%	83.9%
Ward 3A	82.4%	97.6%
Ward 8B	90.4%	96.4%

Harnessing the benefits of technology: Ordering of test results

Quality priority

- ↳ To develop the use of our clinical information system to support the ordering of tests and the communication of results and preparing to use the system for prescribing.

Background

Currently we operate a paper based process for the ordering of tests. This reliance on paper has a number of risks and inefficiencies as well as a limited ability to provide an audit trail or assurance of requests.

How have we performed 2018/19

Following a NHS Digital Deep Dive exercise in September 2017 it was recommended to the Trust that the development of TrakCare (the procured patient administration system) be stopped until a time that the Trust had returned to reporting national required Referral to Treatment Times (RTT) and regained stability with its ability to function as a trusted Patient Administration System.

This prevented the Trust from planning, designing or allocating any resource in to the roll out of the functionality that has been clearly identified as a necessary development.

The Trust then entered a period of recovery which had an unknown timescale at that stage. This recovery period is now nearing completion with the trust planning to go back to RTT reporting March 2019 data.

Plans for improvement 2019/20

The development of our clinical systems to enable clinicians to order and communicate results remains a priority. Now that the Patient Administration System has achieved a level of stability and optimisation, the Information Management Technology team remain committed to delivering an ambitious agenda that will see the improvement of the Trust's digital maturity and the role out of advanced clinical functionality including order communications over the next two years.

The 2019/20 work plan sees the initiation of a project that includes the design, configuration and roll-out of advanced clinical functionality including clinical documentation, order communications and electronic prescribing. It is worth noting that this will not all be rolled out within the 2019/20 year but the necessary and significant design and build work will take place.

Harnessing the benefits of technology: Offering advice and guidance

Quality priority

- ↳ To set up and operate Advice & Guidance (A&G) services through the Electronic Record System platform for non-urgent General Practitioners (GP) referrals, allowing GPs to access consultant advice prior to referring patients into secondary care.

Background

The GP Forward View set out the need to improve GP access to consultant advice on potential referrals into secondary care.

In 2016 Winpenny et al. reviewed a large number of studies on interventions in primary care aimed at improving the effectiveness and efficiency of outpatient services, including studies on email and phone requests for specialist advice and concluded that, "there is substantial opportunity to reduce the number of patients who are seen in outpatients clinics"; reducing inappropriate referrals with a proportion not requiring referrals after advice was given.

The design of this CQUIN draws on learning from local areas around the country where A&G services have already been set up. Early outcomes do not yet constitute a robust evidence base on referrals and activity avoided, so have not been generalised as expectations for the wider system, but they do show encouraging early signs.

How have we performed

2017/18: The requirement for A&G services to be in place for specialties covering 35% of referrals was met for 4 required services.

Quality standards: A&G within 2 days met throughout Q4 but A&G within 5 days not achieved throughout Q4, (related to 4 specialties). Achieved 50% of total value for achievement of Q1 and Q2; Q3 and Q4 Quality standards were not achieved.

2018/19: The requirement for A&G services to be in place for specialties covering 75% of referrals were met for 17 services by start Q4 – appears achieved but not confirmed as yet.

Quality Standard of A&G within 2 days and 5 days – both standards met in Q1 and Q3; not achieved in Q2; Q4 data not yet available.

Data

Final indicator requires A&G services in place for 17 specialities responsible for receiving 75% coverage of total GP referrals by start Q4 and quarterly delivering A&G on 2 local quality standards – i) 80% A&G given within 2 days and ii) 95% A&G given within 5 days as an aggregate of the 17 services.

Plans for improvement 2019/20

This CQUIN ends as of 31st March 2019.

It is anticipated that the standards may appear in the quality schedule of the main contract, but this is as yet unconfirmed.

On a divisional level it has been reported that the specialties will struggle to maintain this service without further resource.

It is not certain how effective this service has been in reducing the referrals into secondary care.

Patient safety

Investigations and learning from deaths:

Our annual summary on reviewing and learning from deaths

Quality priority

- ↳ Our aim is to prevent missed opportunities to have learnt from patient deaths and for us to improve our ability to include and listen to families when an investigation happens.

Background

In March 2017, the National Quality Board published the first National Learning from Deaths Guidance 'A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. In response to this guidance, our Hospital Mortality Review Group has developed a 'Learning from Deaths' policy which is published on our Trust website.

In this section of our report, we aim to help you understand what we do when people within our community experience loss of a loved one whilst in the care of our Trust. We are very sorry for anyone who experiences a loss and we know that this can be a very difficult and distressing time. As a family member, partner, friend or carer of someone who has died, we know that they may have had comments, questions or concerns about the care and treatment that their loved one received and they may also want to find out more information about the reasons for their death.

We know that the death of a loved one is traumatic for families and so we provide people with information about bereavement support services and practical advice about the things you may need to do following bereavement. This includes:

- ↳ collecting any personal items belonging to the person who has died,
- ↳ making arrangements to see the person who has died,
- ↳ collecting the death certificate,
- ↳ how to register the death.

We know that this can be even more concerning when concerns have been raised, or when a family is involved in an investigation process. Case note reviews (or case record reviews) are carried out in certain circumstances.

Firstly, case note reviews are routinely carried out in our Trust on a proportion of deaths to learn, develop and improve healthcare, as well as when a problem in care may be suspected. A clinician (usually a doctor), who was not directly involved in the care, will look carefully at their case notes. They will look at each aspect of their care and how well it was provided. When a routine review finds any issues with a patient's care, we contact their family to discuss this further.

Secondly, we also carry out case note reviews when a significant concern is raised with us about the care we provided to a patient. We consider a 'significant concern' to mean:

- ↳ any concerns raised by the family that cannot be answered at the time; or
- ↳ anything that is not answered to the family's satisfaction or which does not reassure them.

This may happen when a death is sudden, unexpected, untoward or accidental. When a significant concern has been raised, we will undertake a case note review for your loved one and share our findings with you.

Aside from case note reviews, there are specific processes and procedures that we need to follow where the deceased had a learning disability, a child died, or a mother died in a maternity setting, or as a result of a mental health related homicide. If this is the case, we will provide you with the relevant details on these processes.

How have we performed 2018/19

- ↳ All deaths (100%) in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.
- ↳ All families meet with the Bereavement Team and have the opportunity to give us any comments on care.
- ↳ Patients are logged on a dedicated section of the Trust Datix System designed to also accommodate the recording of Structured Judgement Reviews (SJRs) and has been structured to include the comments from families

to the Bereavement Team when they meet the family to pass on the Death Certificate.

- ↳ The feedback is overwhelmingly positive and is routinely shared with the relevant ward area. Areas for improvement reflect the general pressure on staff.
- ↳ Themes are now emerging of areas for improvement including our response to the deteriorating patient, communication between teams, the importance of early senior review and the importance of ensuring the completion of robust documentation.
- ↳ Areas of excellent care are also being identified although the approach to using this information to drive change requires further work.
- ↳ Further work is ongoing to draw out learning themes from death reviews across all Divisions, with the Divisional Representatives on the Hospital Mortality Group now bringing to the group the top three themes to emerge from deaths reviews to each monthly meeting.
- ↳ It is intended to separate the Hospital Mortality group into two sections in preparation for the attendance of two family representatives at the meeting. It is also under discussion to set up a separate family represented reference group.
- ↳ Family attendance at a surgical multidisciplinary group is being planned with the intention of rolling this approach out to other Divisions.

Data

The HSMR is a method of comparing mortality levels in different years or for different sub-populations in the same year, while taking account of differences in case mix.

The ratio is of observed to expected deaths (multiplied conventionally by 100). Thus, if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100.

The HSMR is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of diagnoses which give rise to around 80% of in-hospital deaths.

HSMRs are based on the routinely collected administrative data often known as Hospital Episode Statistics (HES), Secondary Uses Service Data (SUS) or Commissioning Datasets (CDS).

For all of the 56 diagnosis groups, the observed deaths are the numbers that have occurred following admission in each NHS Trust during the specified time period.

The expected number of deaths in each analysis is the sum of the estimated risks of death for every patient.

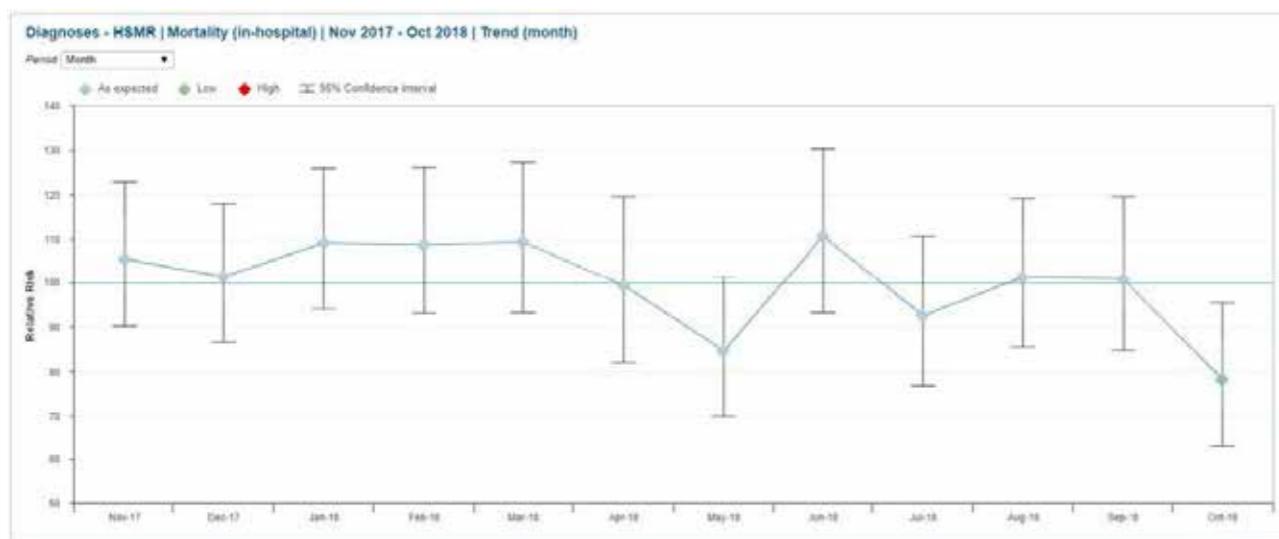
See page over for graphs.

Plans for improvement 2019/20

The requirement for us is clear. It is not simply enough to have a robust process for reviewing deaths in care, important though this is. We need to continue to engage with and support bereaved families, to provide mechanisms for staff support and debriefing and to ensure active and robust oversight.

Most importantly we need to continue to translate learning into sustainable action to improve the way we look after the people in our care.

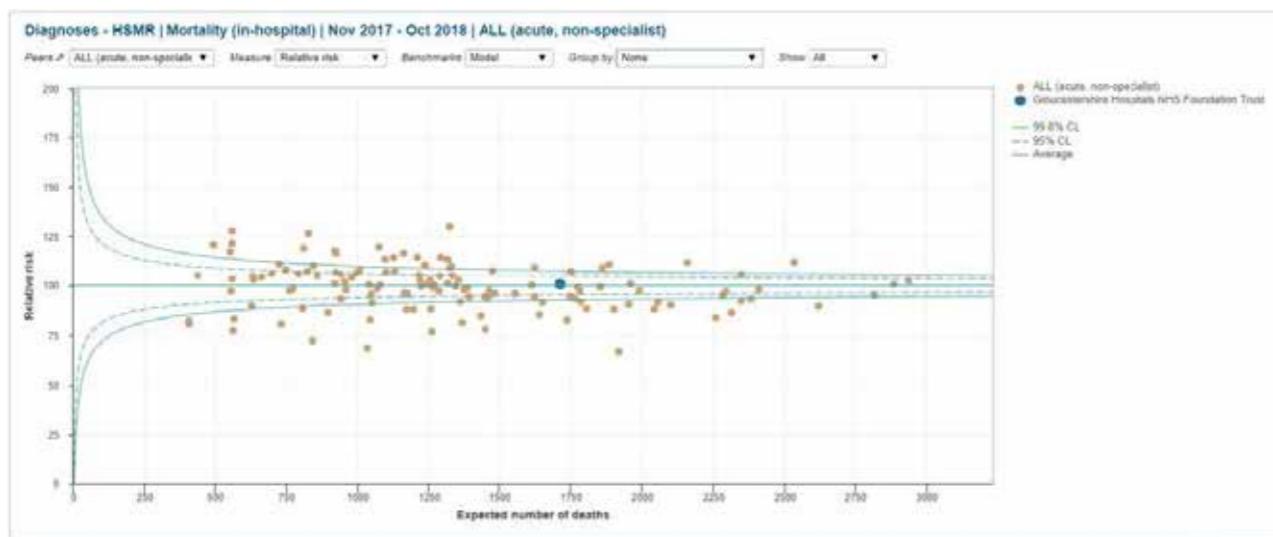
Figure 12: HMSR



HMSR Data

Quarter	Deaths	Bereavement	Medical Examiner Review
Quarter 4 17/18	651	651	651
Quarter 1 18/19	460	460	460
Quarter 2 18/19	463	463	463
Quarter 3 18/19	475	475	475

Figure 13: HMSR, funnel plot



Reducing the impact of serious infections

Quality priority

- ◀ **There should be timely (90%) identification of patients with sepsis in emergency departments and acute inpatient settings.**
- ◀ **There should be timely (90%) treatment for sepsis in the emergency departments and acute inpatient settings.**
- ◀ **Assessment of clinical antibiotic review should happen between 24 and 72 hours of patients with sepsis.**
- ◀ **There should be a reduction in total antibiotic consumption per 1000 admissions, carbapenem (restricted antibiotics not used as first line) antibiotic consumption per 1,000 admissions and an increase in the proportion of antibiotics used in the Access group of the AWaRe category (as defined by the World health Organisation). Antibiotics within the Access group are defined by NHS Improvement as "key antibiotics which are narrow spectrum and used as first-line treatment options".**

Background

Every year in the UK there are 150,000 cases of sepsis, resulting in 44,000 deaths, more than bowel, breast and colon cancer combined.

Sepsis is a life-threatening condition that arises when the body's own response to an infection injures its own tissues and organs.

Sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated quickly.

How have we performed

In 2018/19, as in the previous year, reducing the impact of serious infections CQUIN has four main objectives:

- ◀ Part A: patients who meet the clinical criteria for sepsis should be screened for sepsis using locally agreed protocol
- ◀ Part B: those who present with red flag sepsis, severe sepsis or septic shock must receive antibiotics within an hour. These patients should also receive a review after three days of antibiotics.
- ◀ Part C: patients presenting with sepsis and initiated on antibiotics must have the antibiotics

reviewed within 24-72 hours by a competent clinician. The plan following the review must be documented within the medical records and must include a documented rationale if intravenous antibiotics are continued beyond the review.

◀ Part D: reduction in total antibiotic consumption per 1000 admissions, reduction in carbapenem consumption per 1000 admissions and an increase in the proportion of antibiotics used in the Access group of the AWaRe category. Note: This part applies to all patients, not only patients presenting with sepsis.

For the past four years, the screening of sepsis patients in the emergency department has been, on average, above 90%.

The delivery of antibiotics within an hour of diagnosis has improved and continues to be delivered to high levels. This improved performance supported by the Gloucestershire Safety and Quality Improvement Academy (GSQIA) and the Trust has been recognised as one of the most improved hospitals in England.

In 2017/18 part 2c was only achieved in 84% of patients against a target of 90% at the end of quarter 4. For part 2d the total antibiotic target was not met. However the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) Report 2018 by Public Health England noted that, "In 2017, the increased level of antibiotic prescribing in hospital inpatients also reflects a shortage in the supply of a key broad-spectrum antibiotic, piperacillin/tazobactam. The need to use two or more alternative antibiotics to give the same degree of antibacterial coverage resulted in an additional 2.2 million Defined Daily Dose (DDDs) being dispensed."

Data

See following page.

Plans for improvement 2018/19

For 2019–20, sepsis management will undergo a review alongside a review of the management of the deteriorating patient, from this review an improvement programme will be established which will be monitored by the Resuscitation & Deteriorating patient Committee. Any national or local reporting requirements will be maintained.

2c: Further work is being undertaken to improve documentation in the medical records with regards to the course length following the

antibiotic review, this is the main reason for not achieving the target for 2c to date in 2018/19.

2d: Further Antimicrobial Stewardship work will continue to be undertaken to ensure that antibiotics are prescribed and reviewed appropriately and that antibiotics are not continued unnecessarily.

Relevant CQUINS for 2019/2020 include:

Prevention of ill health:

Antimicrobial Resistance

- ◀ Lower Urinary Tract Infections in Older People
- ◀ Antibiotic Prophylaxis in Colorectal Surgery

Medicines optimisation and stewardship:

- ◀ Improved Antifungal Stewardship across the NHS in England

Figure 14: Emergency Department: Proportion of patients who required screening for Sepsis who received screening

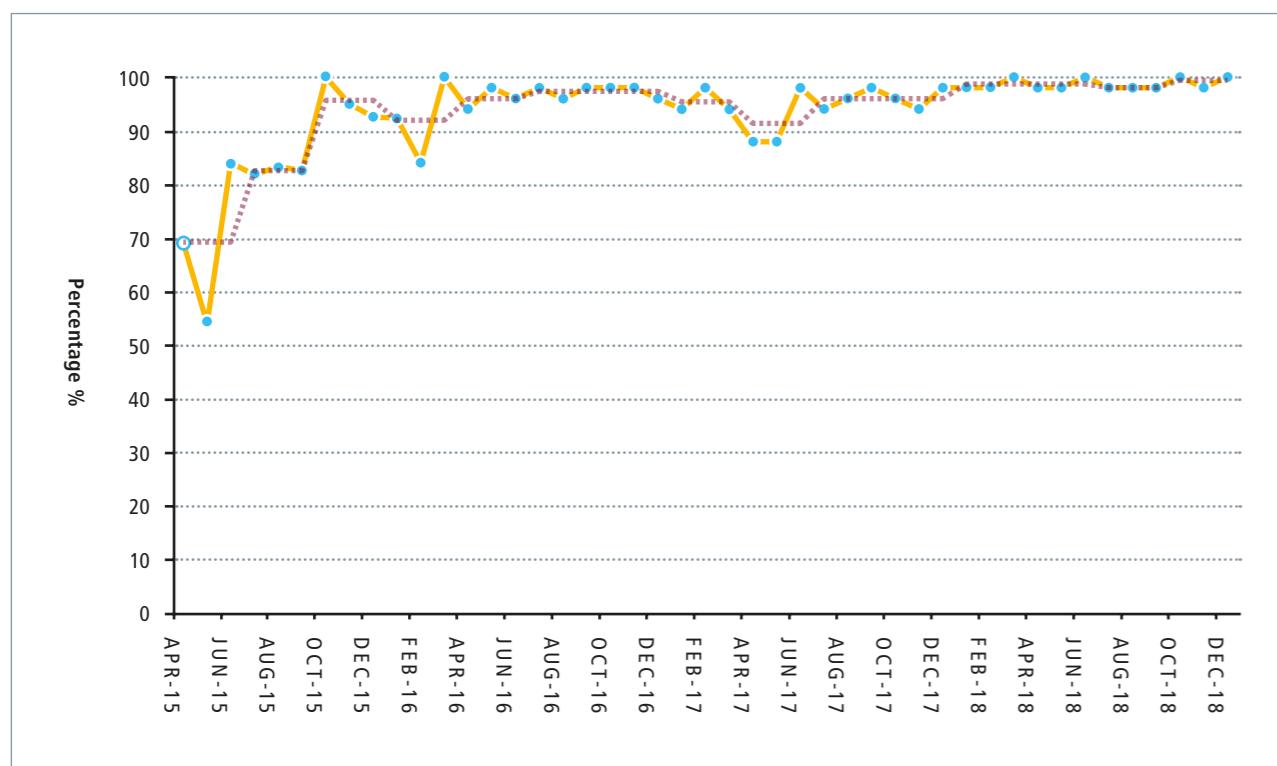


Figure 15: Emergency Department: Proportion of patients who received Antibiotics within 1 hour of diagnosis of Sepsis

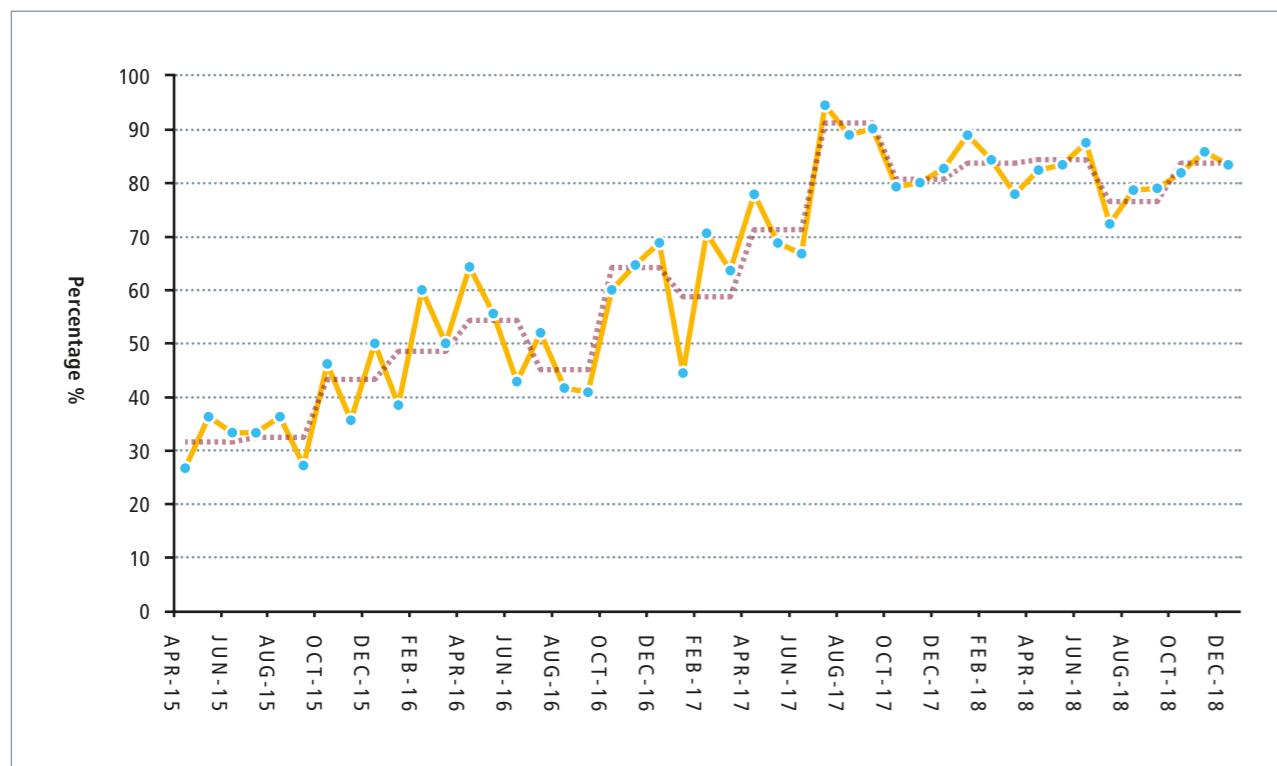


Figure 16: Part 2c

2017/2018	Q1: Apr-Jun-17	Q2: Jul-Sep17	Q3: Oct-Dec17	Q4: Jan-Mar18
Percentage of antibiotic prescriptions reviewed within 72 hours	79%	83%	74%	*84%
Target	>25%	>50%	>75%	>90%
2018/2019	Q1: Apr-Jun-18	Q2: Jul-Sep18	Q3: Oct-Dec18	Q4: Jan-Mar19
Percentage of antibiotic prescriptions reviewed between 24-72 hours as per criteria	72%	60%	51%	Results pending
Target	≥25%	≥50%	≥75%	≥90%

The target has not been achieved in Quarter 3 2018/2019.

Figure 17: Part D, Total antibiotic and carbapenems

	2017-18 antibiotic consumption (DDD/1000adm) (figures below from fingertips)	18/19 target antibiotic consumption (DDD/1000adm) (Total 3% ↓ on 17/18 consumption: CPM 3% ↓ on 17/18 consumption)	2018-19			
			Q1 DDD/1000 adm (rolling 12 month ave)	Q2 DDD/1000 adm (rolling 12 month ave)	Q3 DDD/1000 adm (rolling 12 month ave)	Q4 DDD/1000 adm (rolling 12 month ave)
Total	4058	3936	4151	3990	4459 provisional	Results pending
CPM	88	85	77.5	71.3	59 provisional	Results pending

Figure 18: Proportion of antibiotics used in the Access group of the AWaRe category

Target for 18/19 (increase by 3% from baseline 2016 calendar year)	Q1	Q2	Q3	Q4
49.09%	44.4%	51.5%	49%	Results pending

On target to achieve this but await confirmed figures for Q3 and Q4. This was a new target for 2018/19 and was not monitored in 2017/18.

Serious incidents

Quality priority

[◀ To learn from serious incidents](#)

Background

Quality management is the act of overseeing all activities and tasks needed to maintain a desired level of excellence. Establishing a quality approach involves quality control and assurance mechanisms (checking), and quality improvement. Quality improvement is the technique that moves learning into practice. The management of incidents is one of the components of a safety system. It requires an open fair blame culture, the ability to carry out high quality investigations, the technical ability to assess the incident (root cause analysis) through a human factors lens and to take recommendations through to quality improvement to test changes and behaviours embedding them into everyday practice.

Following the introduction of the Statutory Duty of Candour, the Trust reviewed its incident investigation model to ensure that all incidents considered to have caused moderate (or above) harm to patients were investigated through detailed Root Cause Analysis (RCAs) and investigation reports shared with patients, next of kin and/or families and centralised investigation in the Safety Department, thereby providing an evident increase in both quality, efficiency and learning. By way of further improvement, as of 2019, the Complaints team joined to form the Patient Investigation and Learning Team.

How have we performed

Incident reporting rates in the Trust are very healthy, on average the Trust reports 16,000 incidents a year which places the Trust positively in the top half of reporting rates in the NHS and reflects a good open culture.

There have been two Never Events in the past year, the first involving the wrong route of medication and the second involving the wrong site operation. Overall there have been 31 serious incidents (including Never Events), the main theme being delays to care.

All investigations were completed on time or had formal extensions granted and generated an improvement plan which is monitored until completion. The serious incident process follows Duty of Candour principles involving the patient and/or the next of kin, this includes an extra step to ask the patient or family if they require any questions answered as part of the investigation response.

Plans for improvement 2018/19

To improve the learning and therefore improvement we aim to develop a human factors faculty as part of the GSQIA. Our aim is to improve our analysis of the root cause analysis and future design or solutions to the problem through this approach.

Human Factors, often referred to as ergonomics, is an established scientific discipline used in many other safety critical industries. Human Factors approaches underpin current patient safety and quality improvement science, offering an integrated, evidenced and coherent approach to patient safety, quality improvement and clinical excellence.

Human Factors principles can be applied in the identification, assessment and management of patient safety risks, and in the analysis of incidents to identify learning and corrective actions. More broadly, Human Factors understanding and techniques can be used to inform quality improvement in teams and services, support change management, and help to emphasise the importance of the design of equipment, processes and procedures.

In the coming year we will train 16 members of staff who will develop the approach and mechanisms to support our goal, this will be in parallel to the introduction of the Quality Framework which enables the infrastructure to enhance this improved approach.

Effective

Delivering high quality urgent and emergency care

Quality priority

To ensure our local response to the National Urgent and Emergency Care Review includes the development of models of care that ensure patients are treated with the very best expertise and facilities in order to maximise their chances of survival and a good recovery

Background

Urgent and Emergency Care is provided by a number of different practitioners. The vast majority is provided in primary care by General Practitioners, nurses, pharmacists and in other community settings such as Minor Injury Units. The Emergency Departments at Gloucestershire Royal and Cheltenham General Hospitals see the sickest and most urgent patients and those referred from primary care. Ensuring that the patient is seen by the most appropriate practitioner first time is one of the ways to improve the quality of care and the speed with which it can be delivered.

The national benchmark for Emergency Departments is the 95% 4-hour standard: 95% of patients should be seen, treated and either discharged or admitted within four hours of arriving at the department. In the last few years we have failed to meet this target. In 2017, we have worked hard to improve our systems, to reduce unnecessary steps in the patient pathway and to improve the quality of care we give.

How have we performed

Our Urgent and Emergency Care Performance (as per validated monthly return) has improved over the last two years, although has shown periods of considerable variation from one month to the next.

We have not delivered the 95% standard since November 2017 (and prior to this the trust had not delivered the standard since August 2014). Since November 2017, however, the Trust has consistently performed slightly higher than the national average, and generally above the regional average (only dipping slightly below the regional average in August 18, December 18 and January 19 in the last year and reporting in excess of 85% in every month of 2018).

See Graphs 1 & 2 and Tables 1–3 below for monthly published 4-hour performance, 17/18 and 18/19 in relation to STP and Regional performance, as well as Trust performance over the last three years.

Data

As illustrated in table 1, over the course of the year performance over Financial Year (FY) 2018/19 has exceeded that in FY 2017/18.

After achieving the 95% 4-hour standard across both hospitals in the November of 2017/18, the new financial year (2018/19) saw continued delivery of >90%. This has been above of the agreed NHSI performance trajectory.

However, the Trust and wider health economy has experienced a challenging winter period, with unprecedented levels of patients attending GHNHSFT's Emergency Departments. Despite this the number of patients seen, treated or discharged within four hours is greater month on month when compared to 2017/18 (Table 2).

Table 2: Total Emergency department attendances seen, treated and admitted or discharged within four hours of arrival 2017/18 vs 2018/19

Same Day Emergency Care (SDEC) has seen a significant improvement in the number of patients attending Acute Medical Initial Assessment and the Surgical Assessment Unit. Approximately 35% of the medical take is now processed through an ambulatory pathway with 85% discharged on the same day.

This is what we said we would do

i) We will increase the number of hours that the Ambulatory Emergency Care unit is open, extending it until late in to the evening.

As demonstrated in figure 1, there has been a significant increase in ambulatory care presentations due to four main factors:

- ◀ Extended opening hours
- ◀ Weekend working
- ◀ Process over pathway
- ◀ Relocation to of AMIA to dedicated outpatient facility

ii) We will open a dedicated Surgical Admissions Unit for emergency admissions.

In October 2018, the Surgical Assessment Unit opened at GRH. This was achieved by ring-fencing eight beds on surgical ward and changing the staffing model to

enable rapid assessment and treatment of ambulatory patients. This is a 24/7 model.

It is anticipated that throughput will increase from September 2019 when there will be a dedicated Consultant (not based in theatre) who will support the on call admission of patients.

Surgery is also involved in the roll out plan for Cinapsis which will enable them to manage their referrals in a semi-bookable environment and accept patients directly from GP practices.

Plans for improvement 2018/19

- ◀ Ambulatory Medical Initial Assessment to run 24 hours a day 7days a week
- ◀ Surgical Assessment Unit to have dedicated Consultant
- ◀ Explore further ambulatory care facilities including gynaecology and trauma
- ◀ Roll out of Cinapsis programme across the whole hospital
- ◀ Pilot Urgent Treatment Centre model at both GRH and CGH (including bookable appointments for 111)
- ◀ Improved performance against the 60 minute time to assessment ED quality metric

Figure 16: Attendances, admissions, discharges and sent home

Month	No. of attendances	No. admitted to a bed	No. discharged	No. sent home to return (admissions saved)
November 2018	413	186 (45%)	161 (39%)	66 (16%)
December 2018	413	173 (42%)	185 (45%)	55 (13%)
January 2019	468	190 (40.5%)	219 (47%)	59 (12.5%)
February 2019	461	184 (40%)	201 (44%)	74 (16%)
March 2019	511	173 (34%)	235 (46%)	103 (20%)

Figure 17: All Type A&E Performance, Gloucestershire Hospitals NHS Foundation Trust vs. South West and England

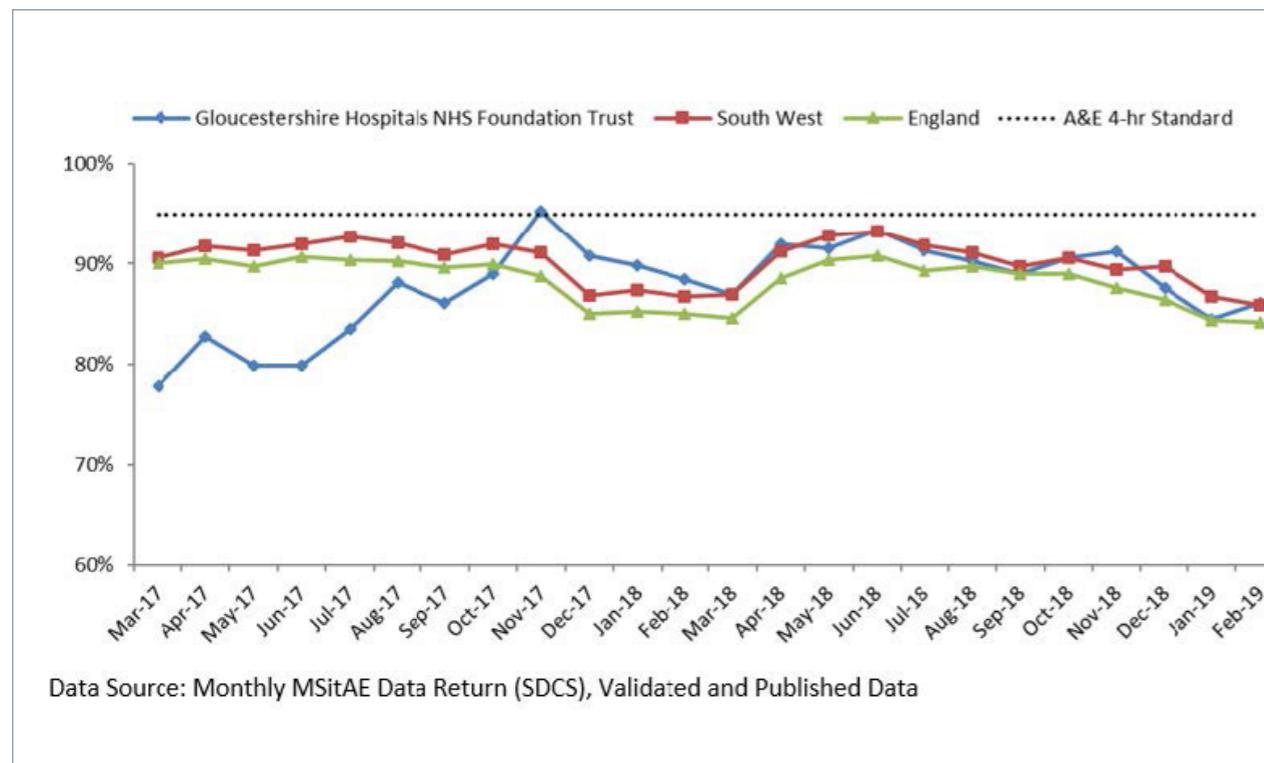


Figure 19: Total Emergency department attendances seen, treated and admitted or discharged within 4 hours 2017/18 vs 2018/19

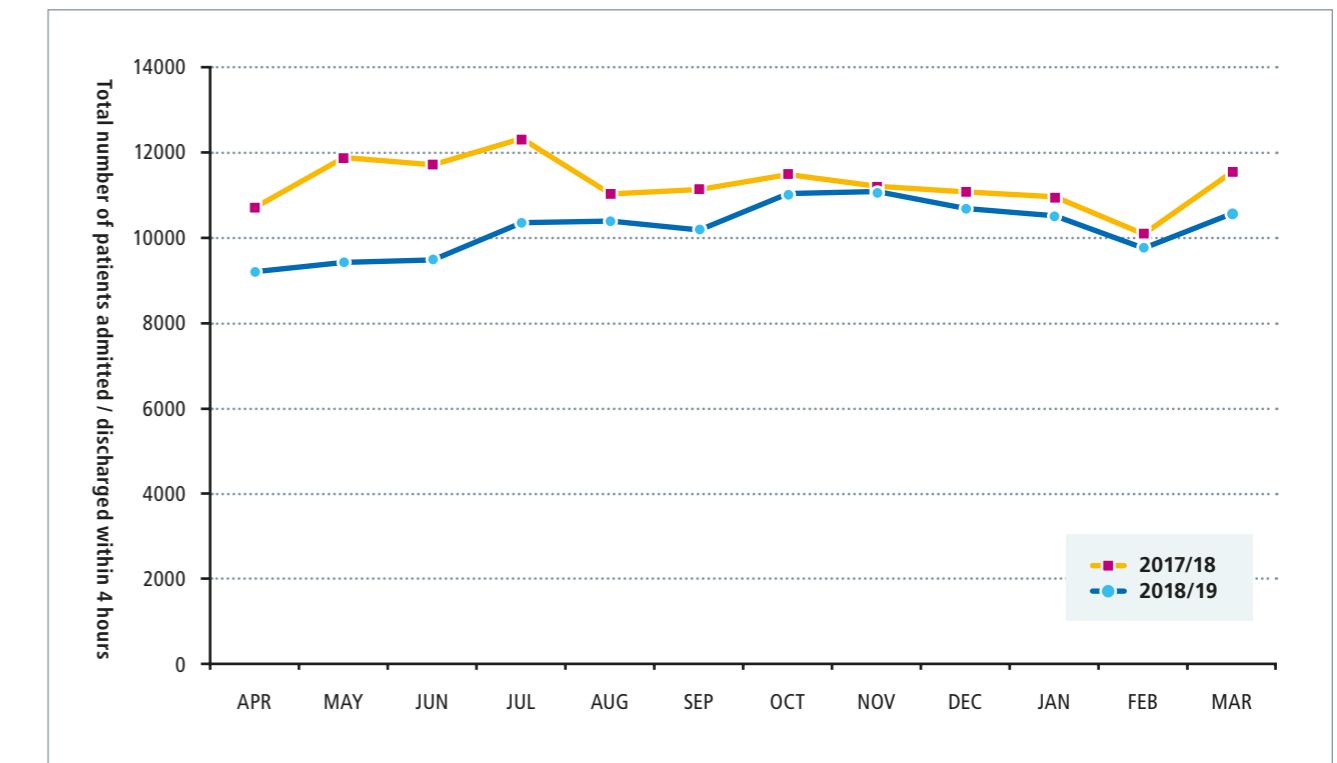


Figure 18: Emergency department 4 hour standard 2017/18 & 2018/19

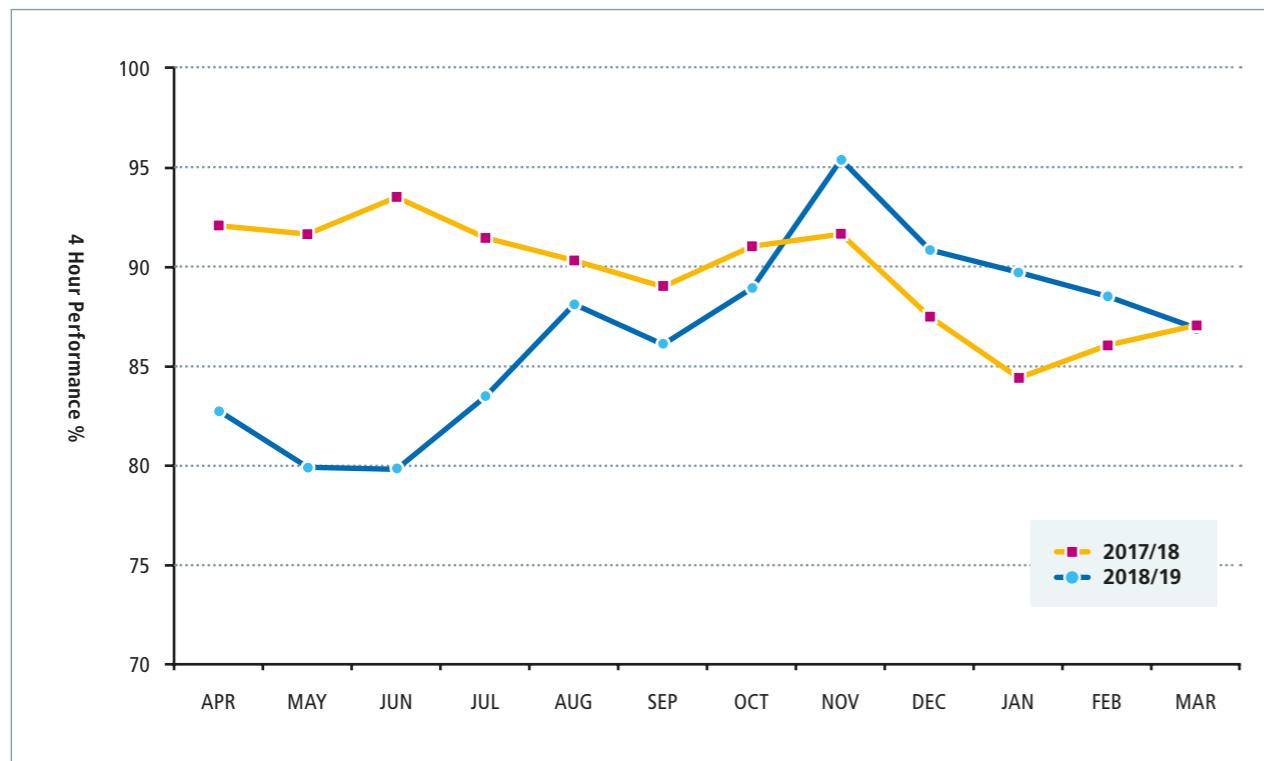
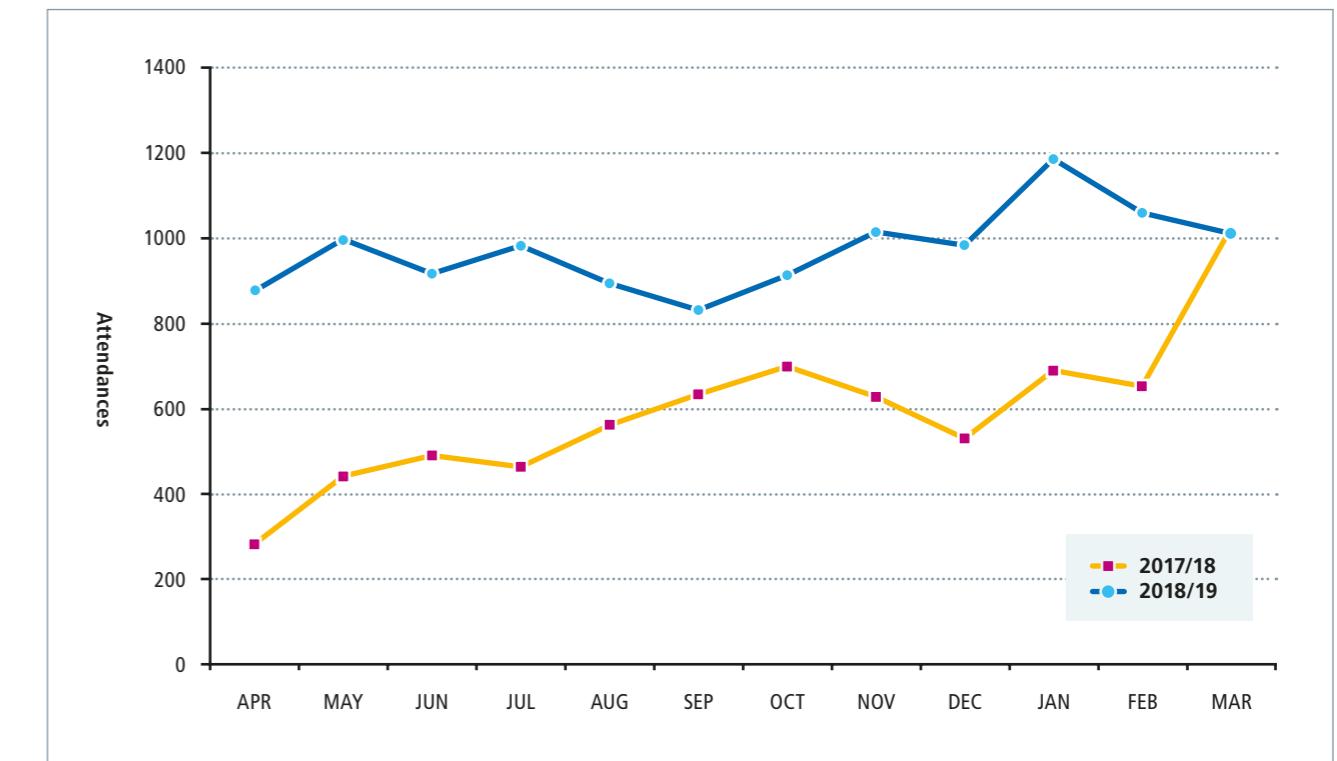


Figure 20: Total attendances to AEC/AMIA 2017/18 vs 2018/19



Delivering high quality urgent and emergency care:

Specialist input into care planning

Quality priority

Progress to delivering specialist input within 14 hours, daily consultant review every day, timely diagnostics and interventions (4 key standards in national programme)

Background

Early consultant review with rapid diagnostics speeds up decision making, ensures appropriate care plans are in place and delivers high quality care to patients. Medical patients are admitted to medical assessment units for review by consultants before they are transferred to the general wards. Patients admitted overnight are reviewed the next morning.

A consultant is present on the admission unit in Cheltenham General Hospital from 8am to 8pm Monday to Friday and from 8am to 5pm Saturday and Sunday. A consultant is present on the admission unit at Gloucestershire Royal Hospital from 8am-9pm Monday to Friday and from 8am to 5pm Saturday and Sunday. Consultants across a number of medical specialties are on-call 24 hours a day.

How have we performed

We participate in the national Society of Acute Medicine Benchmarking Audit (SAMBA) each year. The last audit was in 2018.

Results from the SAMBA audit show a Tier 1 medical review being completed within 4 hours at 81% in Gloucester and 94% in Cheltenham.

This has improved on the previous year where 58% of patients received a tier 1 medical review within four hours at Gloucester and 88% in Cheltenham.

In addition to this 64% of patients had a consultant review within 12 hours at Gloucester with 79% receiving a 12 hours consultant review at Cheltenham. Again both of these results showed improvement on the previous year.

Data

For data please see opposite page.

A 1-hour diagnostic target was introduced for the admission unit in Gloucestershire Royal Hospital in 2017. This will be extended to Cheltenham General.

The Ambulatory Emergency Care (AEC) centre was extended to weekend 8am to 6pm (4pm for last referral) in Gloucestershire Royal Hospital

in 2017. Hours will be extended to 8am to 10pm (8pm for last referral). The use of the AEC allows rapid early assessment, investigation and treatment frequently avoiding the need for a patient to stay overnight. Patients get a more rapid service and hospital beds are kept for the sickest patients.

Ambulatory Medical Initial Assessment (AMIA) has replaced the AEC in GRH and is open from 8am-10pm with last referral at 8pm. The AMIA sees an average of 35 (new) patients per day turning 85% of those around (home) on the same day.

A 1-hour troponin pathway (test to rule out a heart attack) will be introduced speeding up the treatment of patients who require it and facilitating the earlier discharge of patients who do not (who may be required to stay for 6-12 hours for repeat blood tests at the moment).

We are now using a 1h troponin pathway. A fallout from this has been an increase in the number of positive troponins with an increase in referral to the cardiology team and Rapid Access Chest Pain Clinic. It does speed up discharge for non-cardiac chest pain but we have not proven this.

An Acute Medical Initial Assessment unit (AMIA) will be opened at Gloucestershire Royal Hospital. This will enable the early rapid assessment of patients referred by their General Practitioner for a medical opinion by a consultant or other senior doctor.

As above but in addition cinapsis (a referral management tool) went live in 2018 which allows the acute physicians to manage the G.P referred medical take via AMIA and the Acute Medical Unit (AMU).

Plans for improvement 2019/20

We now have 9-5pm Respiratory Hot Clinic Service which runs across the acute floor.

We have a virtual chronic pain clinic which has two slots a fortnight for frequent attenders to use an alternate pathway. We would like to expand and formalise this process.

We have a new Frailty Assessment Unit attached to AMU at GRH. This is currently in development; with the proposal to ring fence beds for frail patients, introduce the Rockwood score the Medical Clerking Proforma. We may wish to develop this service in CGH.

In order to improve flow and quality of care within the acute floor, we would like to consider an in-

house liaison psychiatrist to be embedded within the acute medical unit. This would provide timely reviews both within the ED and Acute Floor.

Figure 21: Gloucestershire Royal Hospital patients were seen by a doctor within 4 hours

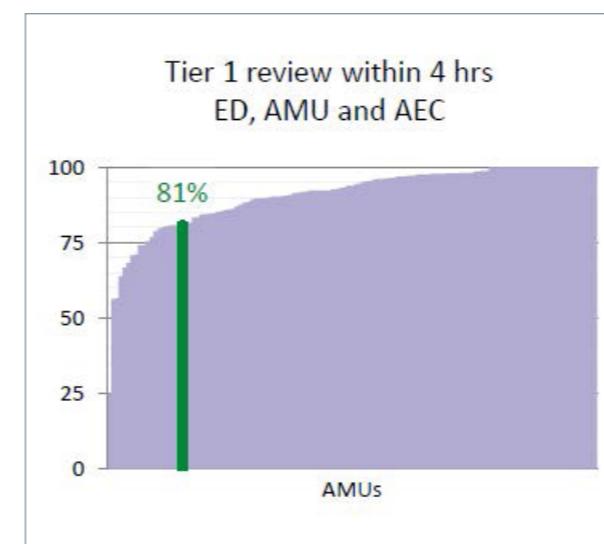
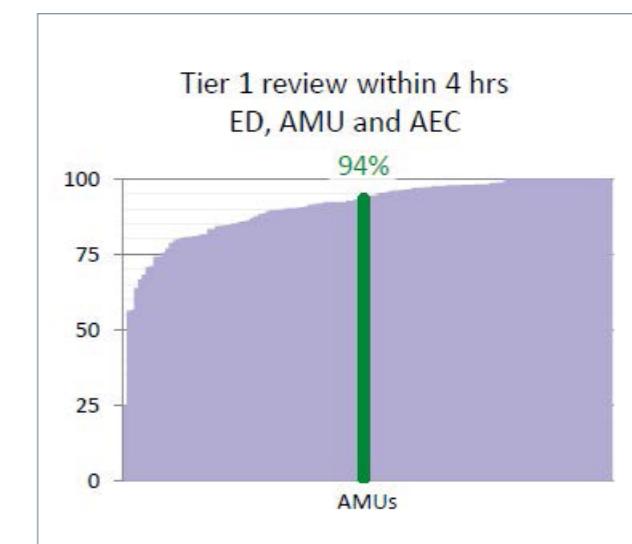


Figure 22: Cheltenham General Hospital patients were seen by a doctor within 4 hours



Delivering high quality urgent and emergency care:

Patients with mental health needs

Quality priority

Improving services for people with mental health needs who present to the Emergency Department

Background

Ensuring that people presenting at the emergency department with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at the Emergency Department. Patients with mental health problems coming to the Emergency Department in crisis will be aware that timely and quality treatment often remains difficult to deliver.

A Royal College of Emergency Medicine survey in 2016 showed that 31% of respondents felt that crisis care overall had improved whilst 26% felt it had got worse. 49% of respondents felt care had deteriorated for children and young people.

How have we performed

Through a person centred approach and collaborative working, there has been a 45% reduction in the attendance rate for specified frequent attendance patients.

The Mental Health Liaison team now provides a 24/7 support and care for 16-year-olds and above at both hospitals. They work closely with the Emergency Departments and 2gether NHS Foundation Trust and act as our psychiatric liaison service. They receive referrals from Emergency Departments and within the hospitals to provide specialist expertise and assessment. The service for under 16-year-olds is provided by the Children and Young Peoples Service (CYPS) and for a two-year pilot, it has expanded its scope and hours of availability, receiving referrals direct from the Emergency Department.

Standards for care delivered within the Emergency Department are described by National Institute for Health and Care Excellence (NICE), Royal College of Emergency Medicine (RCEM), the Royal College of Psychiatrists and the Care Quality Commission (CQC) and relate to mental state examination, assessment of risk, documentation, appropriate facilities, referral or follow up and time to assessments.

- ◀ Audit against Nice Guideline standards for care (NCG16) in September 2017 demonstrated 100% compliance.

- ◀ The interview facility at Gloucestershire Royal Hospital has been improved and now meet national safety standards and those set by Royal College of Emergency Medicine and the Care Quality Commission.
- ◀ Data submitted to the Care Quality Commission early in 2018 showed that in the preceding 12 months there were no patients admitted outside of Gloucestershire due to a lack of beds.
- ◀ The Mental Health Liaison Team facilitates discharge to community management for 95% of referrals.

Progress on 2018/2019 plans

The interview facilities at Cheltenham General Hospital Emergency Department have been upgraded to provide a safe space, which meets national standards and increases equity of facilities in both Cheltenham and Gloucester.

Work has been undertaken to examine the causes of time delays between arrival, having an Emergency Mental Health Risk Assessment completed and being seen by a mental health practitioner (if indicated). These are now well understood and additional training has been provided for our qualified Emergency Nurse Practitioners and Physician Associates to enable them to complete these risk assessments. Additional improvements have been identified in the triage process and will be implemented in the forthcoming year.

A High Intensity Network has now been established in Gloucestershire to focus on those patients who are repeatedly interacting with more than one public service. This predominantly requires close collaboration between the police and the mental health Trust, but the acute trust has been closely involved in the setting up of this initiative and is well acquainted with the initial cohort of patients.

The Mental Health CQuIN has, to date, exceeded required performance and attracted the full available tariff in year 1 and year 2 to date. However, it is unlikely to attract the full tariff for Q4 as Emergency Care Data Set (ECDS) has not yet been implemented within the Trust and therefore our coding returns will not meet the required quality. However, a point to note is that Gloucestershire has a much smaller percentage of repeat attenders with primary mental health problems than surrounding providers. This is partially due to demographic

differences and partially due to the longevity of the cooperation between GHT and 2gether and our joint monitoring of frequent attenders.

Plans for improvement 2019/20

2gether have just employed a Frequent Attender Manager for alcohol-dependent patients and we fully expect that this will make a significant impact on our alcohol dependant patients with mental health problems over the forthcoming year.

Unfortunately, the business case submitted by the Mental Health Liaison Team to increase the size and remit of the team has been turned down and therefore the planned improvements in service offer will not now be deliverable.

We are expecting the re-modelling of the Emergency Department at Cheltenham General Hospital to increase and improve the space utilisation and provision for patients with primarily mental health presentations. We will also be rolling out the improvements to the triage process which we have identified and anticipate that this will be embedded within the year.

Improving the use of medicines commissioned by specialised services

Quality priority

To optimise the use of medicines commissioned by specialised services

Background

Within Gloucestershire Hospitals NHS Foundation Trust, the prescribing and administration of a medicine is the most common therapeutic intervention that occurs to a patient.

Optimising the use of medicines provides an opportunity within the NHS to improve patient experience, pathways and outcomes, whilst reducing expenditure, wastage and unwarranted variation.

How have we performed

To improve productivity and performance in relation to medicine use, this Commissioning for Quality and Innovation (CQUIN) framework proposes the faster adoption of best value medicines with a particular focus on the uptake biosimilar biologics as they become available, thus allowing us to treat more patients for the same amount of money.

Working closely with clinicians within dermatology, gastroenterology, paediatrics and rheumatology, pharmacy has led on the successful delivery of 100% of targets for quarters 1, 2 and 3.

Data

Pharmacy has led on the successful delivery of 100% of targets for quarters 1-3. Delivery of our biosimilar biologics programme has progressed well, particularly for adalimumab where savings generated will exceed £800,000 for the full year.

The target of switching to the biosimilar biologic in 80% of cases was achieved early, within five months rather than the required 12 month period.

Plans for improvement 2019/20

During 2019-20, to further improve efficiency in the IV chemotherapy pathway from pharmacy to patient we will be looking to reduce chemotherapy waste which can occur when a patient specific dose is prepared in advance but then the patient's clinical condition changes which means this particular dose or drug is no longer required.

The NHS has focused on improving antibiotic stewardship which has proved successful in improving the use of antibiotics and limiting antimicrobial resistance. Building on these achievements, we will

be focusing on anti-fungal stewardship, to reduce inappropriate use of anti-fungal agents and prevent the development of resistance to antifungals through the development of anti-fungal stewardship.

Improving the use of medicines: standardised doses of anticancer therapies

Quality priority

To introduce standardised doses of anticancer therapies

Background

The single biggest service within NHS England's specialised commissioning services is the treatment of cancer via chemotherapy. It is estimated that NHS England spends approximately £1.5 billion on the routine commissioning of chemotherapy, with medicine costing 80% of this.

How have we performed

With an increasing aging population as well as advancement in chemotherapy treatments, the cost of chemotherapy is increasing by approximately 8% per year. Traditionally, chemotherapy doses have been calculated on an individual patient basis with a dose per kg of body weight. However such specific dosing has been demonstrated not to provide additional clinical or patient benefit, but it has significantly increased the time and costs in preparing the chemotherapy and leads to drug wastage.

Standardising chemotherapy doses across certain weight bands provides many advantages. It allows chemotherapy to be prepared in advance; it simplifies the process reducing risk and reduces waiting times for patients. Batch production within the Pharmacy Aseptic Manufacturing Unit (PAMU) can now occur, which minimises waste. Similarly, if a patient is unwell on the day and cannot receive chemotherapy, that product can be kept for the next available patient. Working nationally, we are now aligning our doses bands to have a standardised approach which means that some batches can be prepared externally and bought in ready to use. To date, the targets have achieved for all three quarters of 2018-19.

Data

To date, the targets have achieved for all three quarters of 2018-19.

Plans for improvement 2019/20

During 2019-20, to further improve efficiency in the IV chemotherapy pathway from pharmacy to patient, we will be looking to reduce chemotherapy waste which can occur when a patient specific dose is prepared in advance but then the patient's clinical condition changes which means this particular dose or drug is no longer required. The NHS has

focused on improving antibiotic stewardship which has proved successful in improving the use of antibiotics and limiting antimicrobial resistance. Building on these achievements, we will be focusing on anti-fungal stewardship, to reduce inappropriate use of anti-fungal agents and prevent the development of resistance to antifungals through the development of anti-fungal stewardship.

Responsive

Preventing ill health by risky behaviours: Alcohol and tobacco

Quality priority

To support healthier behaviours (CQUIN)

Background

We need to take action to address risky behaviours, with a focus on alcohol consumption and smoking. Smoking and harmful use of alcohol are amongst the most significant risk factors in the global burden of disease in England. Smoking and harmful alcohol consumption costs the NHS an estimated £2bn and £3.5bn a year respectively. Smoking causes almost 80,000 premature deaths a year, and contributes to 1.7m hospital admissions. Alcohol consumption is responsible for an estimated 23,000 premature deaths a year and contributes to about 1m hospital admissions. The costs to society are significantly higher. Evidence suggests that smoking and harmful alcohol consumption could cost c£13.8bn and c£21bn each year respectively.

Preventing ill health through smoking cessation and reductions in alcohol consumption can significantly reduce the burden on the NHS; premature mortality and morbidity; and will help to reduce health inequalities. This action can also contribute to the ambition set out in the Five Year Forward View (5YFV) around the need for a "...radical upgrade in prevention..." and to incentivise and support healthier behaviour.

Tackling these behaviours has a positive impact on the NHS

- ◀ Inpatient smoking cessation interventions are effective, regardless of admitting diagnosis; they lead to a reduction in wound infections, improved wound and bone healing, and longer term reduced risk of heart disease, stroke, cancer and premature death.
- ◀ Inpatient alcohol identification and brief advice (IBA) is effective in hospital settings and likely to have an impact on future hospital admissions, and chronic disease management such as hypertension.

This CQUIN incentivises non-specialist interventions for which there is sound evidence of effectiveness in reducing ill health and thereby the burden on health services, when delivered at scale.

The interventions are brief, and include components such as: short screening questions, brief or very

brief advice on the benefits of drinking less or stopping smoking, and where appropriate referral to specialist services. For example, a single intervention (including screening) should be between 30 seconds and 5 minutes depending on the complexity or interest of the patient.

How have we performed

Alcohol identification and brief advice

Alcohol identification and brief advice (IBA) aims to identify and influence patients who are increasing or higher risk drinkers (i.e. those who drink above low-risk levels).

The intervention is most impactful when it helps identify and advise patients who are not dependent but whose drinking is increasing their risk of a wide range of ill health linked to drinking alcohol (i.e. c.28% of population). In addition, the intervention will identify dependent drinkers who need further support.

Healthcare professionals can deliver the intervention as a short informal conversation, for example, while undertaking routine care or as part of assessment or discharge.

Very brief advice for smoking cessation: ASK, ADVISE, ACT

Very brief advice for smoking cessation (VBA) aims to identify and influence patients who smoke to make a quit attempt.

Healthcare professionals can deliver VBA in as little as 30 seconds. The intervention is made up of three core components: ASK, ADVISE and ACT; although public health benefits are maximised when healthcare professionals refer patients directly for an evidence-based smoking intervention (in the community or on site) with behavioural support and stop smoking medicines.

Healthcare professionals do not require a comprehensive knowledge about tobacco dependency to deliver VBA effectively, though some basic information may enhance the quality of delivery. In its simplest form, healthcare staff would:

1. ASK – and record smoking status - Is the patient a smoker, ex-smoker or a non-smoker?
2. ADVISE – on the best way of quitting - the best way of stopping smoking is with a combination of medication and specialist support.

3. ACT – by offering referral to specialist support and prescribing medication if appropriate. They are up to four times more likely to quit successfully with support.

Data

See below.

Plans for improvement 2019/20

We will continue to identify champions for the continued implementation of this CQUIN at all levels of the organisation, including our champion at Board level, the Director of Quality and Chief Nurse.

We will continue to identify a team of clinicians and managers who will be responsible for the continued success of the CQUIN; including, clinical specialists, data managers, those with responsibility for training, and smoking cessation/ alcohol care teams.

Figure 23: Tobacco; Screening, brief advice and referral/medication

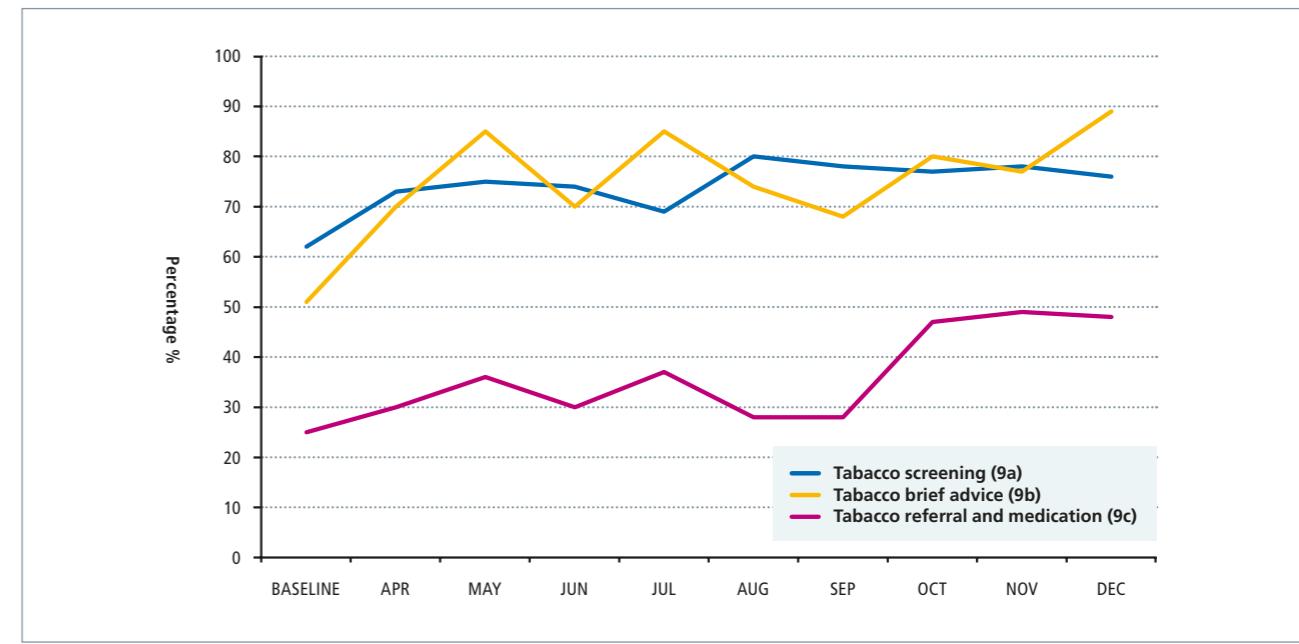
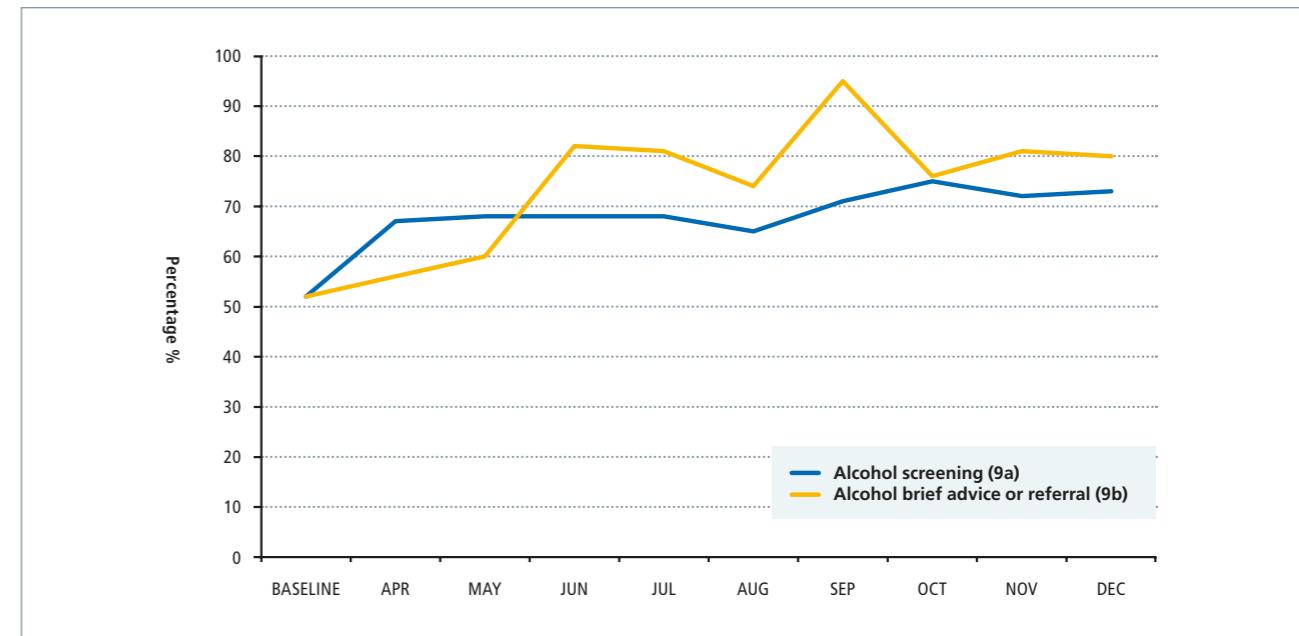


Figure 24: Alcohol; Screening and brief advice or referral



Preventing ill health: Health and wellbeing of our staff

Quality priority

Improvement of health and wellbeing of NHS staff – the goal was a 5% improvement in two of the three annual staff survey questions on health and wellbeing, musculoskeletal (MSK) problems and stress.

Background

Our goal is to improve the support available to our staff to help promote their health and wellbeing in order for them to remain healthy and well.

In 2015, Public Health England estimated the cost of sickness absence to the NHS at £2.4bn. Some reports have estimated this to be 27% higher than the UK public sector average, and 46% higher than the average for all sectors.

However, there are many reasons that sickness absence rates in the health sector may be higher than average. Work can often be physically, emotionally and psychologically demanding and the NHS is one of few organisations that work 24 hours a day, 365 days per year. Despite these challenges, there is much we can do as an employer to improve staff health and wellbeing.

The benefits to us of a healthier workforce are clear:

◀ **Improved patient safety and experience:** The NHS health and well-being review led by Dr Steven Boorman outlined the link between staff health and wellbeing and patient care. This includes improvements in safety, efficiency and patient experience from introducing employer led health and wellbeing schemes.

◀ **Improved staff retention and experience:** NHS staff retention rates are shown to improve when staff feel their employer cares about their health and wellbeing. Not only does better staff retention mean lower recruitment costs but it also often leads to improved team cohesion and better working environments.

◀ **Reduced costs:** Although the overall cost of sickness absence is estimated at £2.4bn, even small reductions in sickness absence can have a large impact across the NHS. If sickness absence was reduced by 1 day per person per year then the NHS would save around £150m, equivalent to around 6,000 full time staff. These financial savings do not even take into account the reduced use of agency staff or the costs of recruitment to tackle staff retention issues, and therefore are most likely to underestimate the overall impact on NHS finances.

◀ **Setting an example for other industries to follow:** The NHS should be leading the way in implementing a health and wellbeing strategy and providing an example that others can follow.

◀ **Re-enforced public health promotion and prevention initiatives:** NHS England's Five Year Forward View emphasises the importance of closing the health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be compromised. If we want to reinforce the message on health promotion and prevention then it is important that we are leading by example.

How have we performed

Staff survey 2018

Question 11a: Does your organisation take positive action on health and wellbeing? Answering "Yes, definitely"

Our scores declined to 22.3%, whilst this is a trend across all organisations surveyed, we unfortunately score below average on this indicator.

	2015	2016	2017	2018
Best	52.1%	52.2%	51.5%	46.7%
Your org	29.7%	29.1%	24.9%	22.3%
Avg	30.7%	32.0%	31.7%	27.8%
Worst	14.8%	18.2%	19.1%	15.3%

Question 11b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Answering "No"

Our scores for 2018 show a small increase in the number of staff reporting as experiencing MSK problems as a result of work activities. Staff answering "No" decreased from c.76% to c.74%.

	2015	2016	2017	2018
Best	33.5%	34.4%	34.6%	37.8%
Your org	22.3%	22.1%	24.2%	25.8%
Avg	25.1%	25.6%	25.8%	28.7%
Worst	19.2%	18.6%	19.7%	20.2%

Question 11c: During the last 12 months have you felt unwell as a result of work related stress? Answering "No"

2018 survey scores show a drop of 2% on the previous year, with more staff reporting that they have felt unwell as a result of work related stress and 60% stating that they have not felt unwell as a result.

	2014	2015	2016	2017	2018
Best	50.8%	44.9%	44.2%	45.9%	46.7%
Your org	36.0%	34.0%	32.7%	37.6%	40.5%
Avg	37.5%	36.0%	35.3%	36.7%	38.9%
Worst	27.5%	24.7%	25.3%	27.9%	28.9%

Unfortunately the scores in the 2018 staff survey associated with the preventing ill health CQUIN have all deteriorated. This reflects the national average trend from the 2018 survey.

Despite the deterioration in scores, there were a number of actions we set out to complete in 2018, which we have taken or are working towards completion of:

- ◀ Launched new approach to Talent Development/appraisals, including the launch of a new Advanced Development Pool.
- ◀ Launched range of J2O initiatives and engaged with staff as part of our CQC inspection preparation and improvement to staff and patient experience.
- ◀ Increased our use of social media engagement to promote great work using #J2O
- ◀ Established Staff and Patient Experience Improvement Steering Group (SEIG) to monitor and identify specific staff experience and retention initiatives; through improved triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention.
- ◀ Junior Doctor Mental Health programme launched August 18
- ◀ Launched combined staff and patient health-wellbeing group
- ◀ Launched and published Equality of Opportunity Action Plan for 18/19, delivered by Equality Diversity Inclusion Steering Group
- ◀ Launched Flu vaccine programme
- ◀ Relaunched Schwarz Rounds
- ◀ Launched monthly individual and quarterly team Gem Awards for colleagues to recognise one another who 'Go the Extra Mile'

◀ Launch of local staff recognition schemes in some areas

◀ Used 'Speak Up' month in October to continue promoting Freedom to Speak Up Guardian role and function

◀ Kitchen table events launched from November 2018

Plans for improvement 2019/20

In addition to this, there are a number of tasks we will continue to work on during 2019/20, including:

- ◀ Planned launch of our new 'one-stop shop' health and wellbeing hub (planned for May launch), making it easier for staff to access clear support pathways for a range of health and wellbeing issues.
- ◀ Rollout of new e-rostering system and new bank working options
- ◀ Build on the promotion, visibility and membership of the Trust Diversity Network
- ◀ Working with ICS partners to design and promote ICS-wide education/awareness campaigns around staff health-wellbeing
- ◀ A large range of health campaigns already delivered in 18/19, with more to follow in 2019.
- ◀ Continued work to triangulate key staff and patient experience indicators, to support the prioritisation of interventions and focus of the Staff and Patient Experience Group.

Preventing ill health: Healthy food options

Quality priority

Healthy food for staff, visitors and patients – changes to food and drink provision – focus on reducing sugars in drinks on sale.

Background

Gloucestershire Managed Service (GMS) is taking action on junk food and obesity by ensuring that healthy food options are available for our patients, visitors and staff, including those working night shifts.

GMS have been building on work completed by our Catering Department developing a set of patient and staff /visitor menus with reduced salt and sugar in the recipes, hydrogenated Trans fatty acids have been eliminated from the cooking process.

The Deli bar has salads, fresh soup, sandwiches, Paninis, jacket potatoes, fresh fruit and takeaway fresh fruit pots. The farm shops in Fosters, Blue Spa and the Glass House promote local produce and the homemade cakes are popular. At breakfast, we now have available porridge and low sugar, high fibre breakfast cereals. The hot breakfast option includes traditional fare as well as poached and scrambled eggs and except for fried eggs, all breakfast items are baked or grilled.

Traditional theme days promote different food types, throughout the year including BBQ in the summer, traditional Christmas fare; promoting national Nutrition and Hydration week. Menus now have calorie information for those customers who are watching their weight.

The introduction of freshly made to order fruit smoothies has been popular with our customers, especially in the summer. Unhealthier accompaniments like chips are available at a higher price than plain carbohydrates such as rice and new potatoes to encourage healthy choices.

To meet the CQUIN all chocolate bars are 250 calories (kc) or less, we have sourced a high quality sugar free chocolate which is popular and there are no price promotions on unhealthy food items. Increased healthier options at till points, and there are no unhealthy promotions. Increased the range of sandwiches to include Paninis.

All homemade sandwiches are 400kc or below and do not exceed the recommended fat levels. We have eliminated all sweetened hot and cold beverages in Fosters, Blue Spa and the Glass House.

CQUIN and government targets are reported regularly to the Trust Health and Wellbeing

Committee and the Healthy Workforce (NHS England).

The main focus is further compliance with the CQUIN primarily looking at the % and going beyond this where we can.

GMS demonstrates a strong commitment to health and wellbeing and have sustained the CQUIN over the past two years.

How have we performed

In Year Two (2018/19): The same three areas will be kept but a further shift in percentages will be required

- ◀ **80%** of drinks lines stocked must have less than five grams of added sugar per 100ml. In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk-based drinks (with sugar content of over 10grams per 100ml).
- ◀ **80%** of confectionery and sweets do not exceed 250 kcal.
- ◀ At least **75%** of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g¹.

We will be:

◀ **Working with our suppliers to improve offers in the vending services.** We have worked with our vending contractor to reduce the amount of cold beverages with less than five grams of added sugar per 100ml. Sweet snacks have also been reduced to just one run of chocolate in the vending machines which do not exceed 250kcal. 75% of made in house sandwiches Paninis and prepacked meal (wraps, salads, pasta salads) available in vending contain 400kcal (1680 kJ) or less per serving and not exceed 5.0g saturated fat per 100g.
All of the above exceeds 80% compliance

◀ **Reviewing further what is provided out of hours for staff and visitors.** GMS have a chilled food vendor on each site, filled and maintained by our staff, which offer a range of home cooked chilled ready meals, fruit, yoghurts, sandwiches, savoury snacks and salads

◀ **Looking at the patients' menu again in spring/summer.** Continuing with seasonal menus for patients, taking advantage of seasonal produce to reduce menu fatigue

Plans for improvement 2019/20

- ◀ Development of fruit and vegetable stalls
- ◀ Expansion of deli bar and chilled produce
- ◀ Recipes cards along with the ingredients to purchase

1. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419245/balanced-scorecard-annotated-march2015.pdf

Preventing ill health: Staff flu vaccinations

Quality priority

Improving uptake of flu vaccinations for frontline clinical staff.

Background

Influenza is a highly contagious upper respiratory tract disease causing significant morbidity and mortality among high-risk groups. Immunisation of frontline healthcare workers in the NHS is considered to be beneficial in reducing subclinical infection, staff sickness absences and protects patients. Each year Public Health England launches the Seasonal Flu Campaign to help reduce influenza transmission by reinforcing the message that it is vital that frontline staff to get vaccinated.

How have we performed

We have used many of elements recommended by NHS Employers to run our Flu campaign during 2018/19.

Communication

- ◀ We refreshed our communication campaign with a “takeover” of the National FluFighter Twitter account for a day during the weeklong national jabathon.
- ◀ Staff made pledges on placards and said why they got the vaccine to encourage others
- ◀ We ran a new email campaign targeting individuals that had not been vaccinated.

Our flu team

- ◀ Included staff from all parts of the organisation
- ◀ Matrons in all areas led as the peer-vaccinator for their area
- ◀ Our outstanding peer vaccinators were treated to Afternoon Tea and received awards for their hard work, kindly sponsored by one of our suppliers.

Supported – all hands on deck

- ◀ Champions at all levels of the organisation

Ran a peer vaccination scheme

- ◀ Peer vaccinators were our stars going the extra mile to make sure that the vaccination was available to as many staff as they could get to.

Myth busting

- ◀ Included myth busting in our communications
- ◀ Used clinical evidence to support our communications
- ◀ Challenged misconceptions

Accessibility

- ◀ Set up mobile flu vaccinations clinics on all wards including at night

Data

79.2% of our patient facing staff received the flu vaccination this year; this is a slight improvement on the previous year. We aimed to reach 85% of frontline staff as an internal target but did meet the external target of 75%.

Next year we are setting our sights high and want to ensure that at least 80% of our patient facing staff have received the flu vaccination. We are developing our plans to ensure ease of access for our staff alongside a vibrant campaign to help staff understand the benefits of protecting themselves and their patients.

Plans for improvement 2019/20

We plan to commence our peer vaccination training in the summer to ensure we are ready to deliver vaccinations as soon as they arrive in early October. We will again use our matrons as the star peer-vaccinators and make this a leader-led initiative. We will target the high performing peer vaccinators and ensure they are supported to go even further this year.

Patient experience

Best care for everyone: Time to care: care hours per day

Quality priority

To ensure safe staffing levels and implement the new approach to measuring Care Hours per Patient Day (CHPPD) on wards.

Background

From May 2016, all acute trusts with inpatient wards/units began reporting monthly CHPPD data to NHS Improvement. Since January 2019 we have collected daily CHPPD from all wards across both main sites. This will allow us to review the deployment of staff on a shift-by-shift basis. When looking at this information locally alongside other patient outcome measures, we will be able to identify how we can change and flex their staffing establishment to improve outcomes for patients and improve productivity.

Nationally, work has begun to consider appropriate application of this metric in other care settings and to include other healthcare professionals such as Allied Health Professionals (AHPs). As with other indicators, CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. The aim is to help ward sisters/charge nurses; clinical matrons and hospital managers make safe staffing decisions.

How have we performed

The CHPPD measure is validated daily by matrons and reviewed monthly by the senior nursing and midwifery team to ensure there is effective deployment of staff to meet the needs of patients and in our care.

The CHPPD are, by their very nature, variable depending on the clinical area and the types of patients being cared for. The CHPPD measure is also scrutinised monthly by the Quality and Performance Committee where the Director of Quality and Chief Nurse is held to account for the effective deployment of nursing and care staff.

Data

This table details the current funded CHPPD by division and provides the Safer Nursing Care Tool (SNCT) requirement based on the daily January acuity census.

Division	Funded CHPPD	SNCT CHPPD
Surgery	7.40	6.2
Medicine	7.57	8.0
Women's & Children (9A)	9.11	8.8

Plans for improvement 2019/20

Measurement of CHPPD 3 times per day by all wards is now underway.

Further embedding that and ensuring matrons are routinely validating the census is an area of specific focus for the senior nursing teams. Quarterly staffing summits are held by the Deputy Chief Nurse to review establishments against reported CHPPD to ensure the nursing workforce is deployed and utilised safely and ensures that we remain responsive to varying patient acuity. During the year we aim to ensure daily staffing meetings are based on reported CHPPD and that matrons, site team and the Temporary Staffing Service work together to respond efficiently and effectively to changing needs.

Recommendations from the staffing reviews are to be implemented across divisions and include an uplift to establishments using the new band 4 Nursing Associates, reduction in variation of nurse to patient ratio across the 24 hour period, re-introduction of ward leaders in to staffing numbers twice per week, introduction of matrons in to staffing numbers once per month and a review of other support roles available to ward teams.

Best care for everyone: Prevention of pressure ulcers

Quality priority

To prevent pressure ulcers.

Background

Avoidable pressure ulcers are a key indicator of the quality and experience of patient care. Despite progress since 2012 in the management of pressure ulcers they remain a significant healthcare problem and 700,000 people in the UK are affected by pressure ulcers each year. Treating pressure ulcers costs the NHS more than £3.8 million every day.

We know that many pressure ulcers are preventable, so when they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating (Moore et al 2009). Preventing them will improve care for all our vulnerable patients.

Pressure ulcers are skin and deep tissue damage due to the lack of blood flow due to pressure on the tissue, and underlying vascular structures, developing usually over bony prominences. Pressure Ulcers are classified by the European Pressure Ulcer Advisory Panel (EPUAP, 2009), as four 'grades' from one to four. One is the most superficial, and four is the deepest (including loss of muscle, and often extending to and exposing bone).

How have we performed

The Trust is committed to reduce the number of pressure ulcers developing in patients in our care. To achieve this, the Tissue Viability Team are developing a new programme of work comprising education, audit, equipment provision and learning from investigation.

Data

See below. This figure details the rate of newly reported pressure ulcers in hospital in-patients per month compared to the national average. The trust is consistently below the national average for most of the 2018 calendar year.

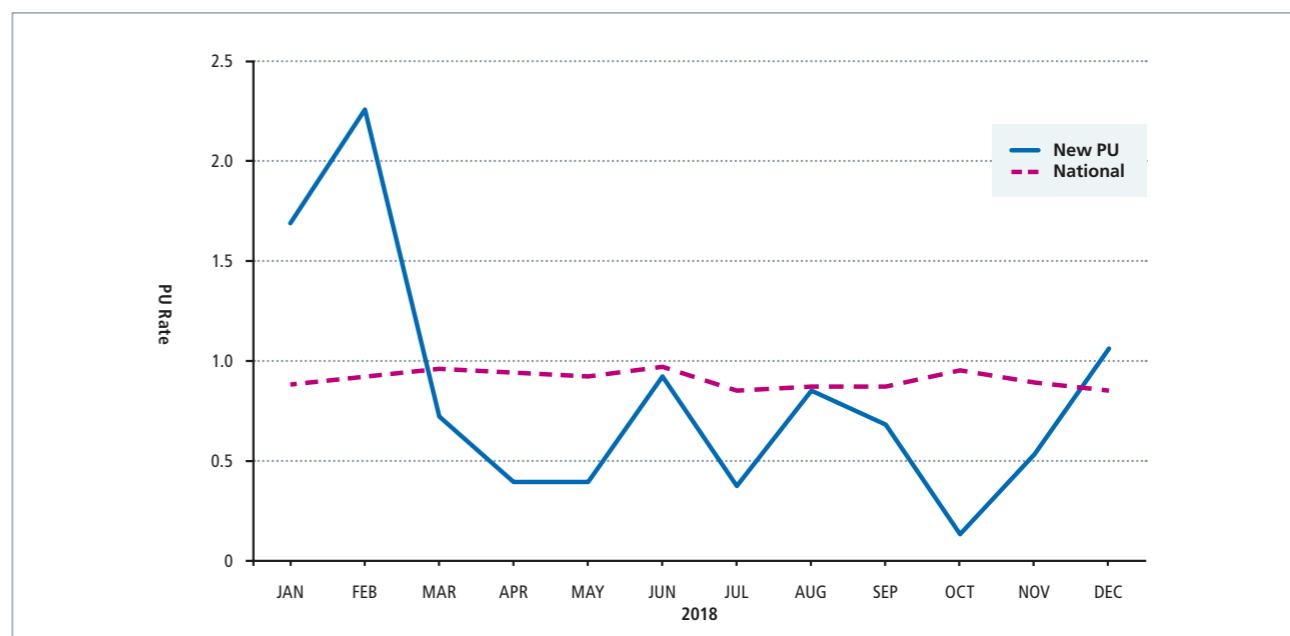
The React to Red innovation will continue into 2019/20, following a very successful Stop the Pressure focus day in 2018.

Plans for improvement 2019/20

The trust will appoint a new Lead Nurse for Tissue Viability, giving this important area a renewed focus at a senior level. The team are developing a programme of work to include improvements to the investigation and dissemination of learning from new pressure ulcers.

Continued work with our strong cohort of link practitioners. We are exploring ways in which a Registered Dietitian could input in to the team, further enriching our offer for patients.

Figure 25: New pressure ulcers



Best care for everyone: prevention of falls

Quality priority

To prevent falls

Background

Falls are the most commonly reported type of patient safety incident in healthcare. Around 250,000 patients fall in acute and community hospitals each year (NHS England, National Reporting and Learning System, 2016). Over 800 hip fractures and about 600 other fractures are reported. There are 130 deaths associated with falls. Although most falls do not result in injury, patients can have psychological and mobility problems as a result of falling.

Nationally there are more than 200 patient falls reported per month on the incident reporting system from which patients' experience moderate harm injuries (Duty of Candour) or become the subject of Coroners' Inquests. There is an inevitable rate of falls due to the challenges of rehabilitation and patient choice alongside an evidence base of actions that might prevent some falls occurring; the Trust approach so far has been to implement the evidence based practice through the nursing care plan process.

How have we performed

The current falls action plan has largely been completed with a new programme of work being developed by the Trust Falls Group. The programme plan is based on best evidence for the prevention of falls (NICE – Falls in Older People) and learning from incident investigation.

Data

Falls rates based on Datix reports

The Royal College of Physicians (RCP) report a fall rate of 6.6 per 1000 bed day rate taken from their college audit of acute hospitals. The National Patients Safety Agency (NPSA) historically report a 4.8 per 1000 bed day rate but include a wider group of Acute Trusts which would include hospitals with naturally low falls rates.

During 2018/19, we have further supplemented our specialist team with a Falls Prevention Specialist Nurse, who will work alongside members of the multidisciplinary team.

The data in Figure 26 shows all falls over the 2018 calendar year. There was a statistically significant decrease in average falls from July onwards.

The data in Figure 27 details harm from

falls categorised as moderate or above during the 2018 calendar year.

The Trust Falls Group have completed thematic reviews of the root causes of falls, looking at the trends and also for any learning. We are participating in the Royal College of Physicians National Audit of Inpatient Falls and this will be reviewed to support the development of our annual programme, which will be presented, to our Quality and Performance Committee in quarter 1 of 2019/20.

Plans for improvement 2019/20

All falls that are categorised as moderate harm or above will have a rapid review completed within three days with immediate feedback of any urgent learning points to the clinical areas. The most serious cases will be reviewed weekly by the Trust's established Executive Serious Incidents Panel.

We will commence a programme of teaching of staff groups involved in care giving such as porters, domestics and volunteers. We will also review the clinical staff training. To support the new CQUIN to reduce in-patient falls, we will focus on improvement of recording lying and standing blood pressure as part of the falls assessment.

Figure 26: All falls (2018)

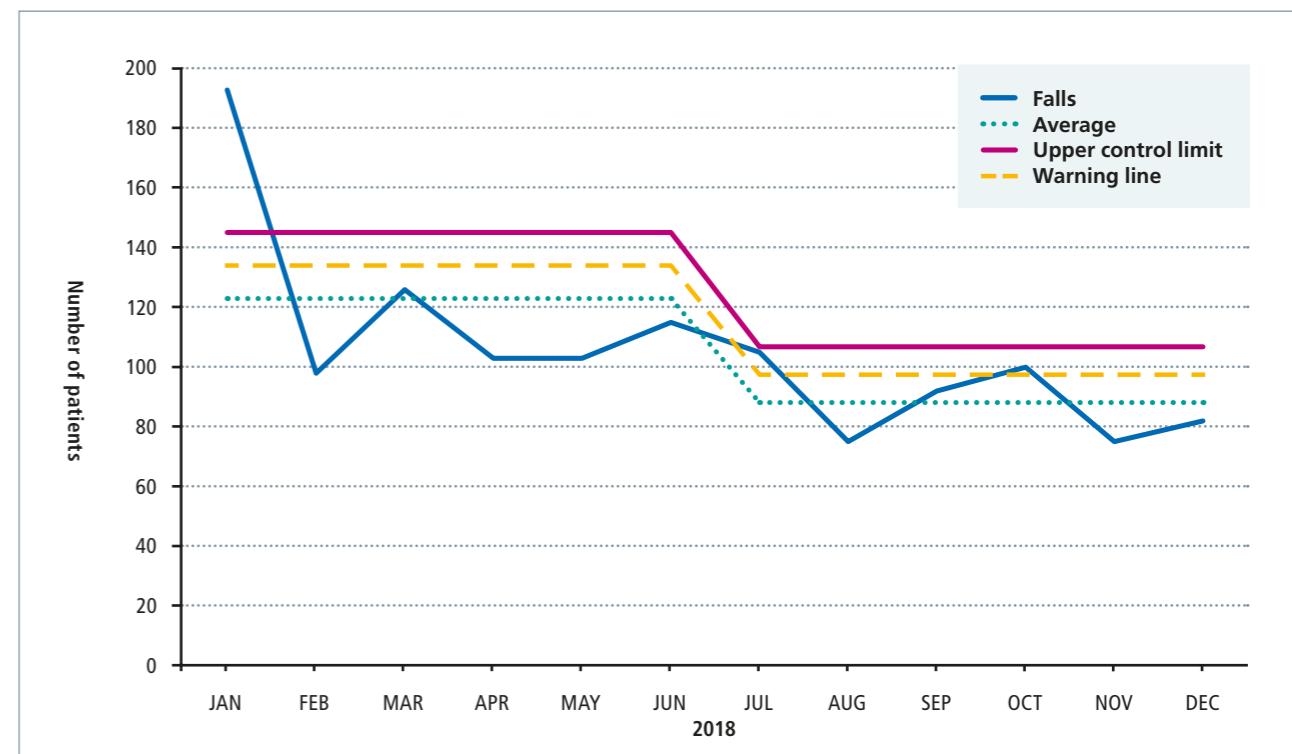
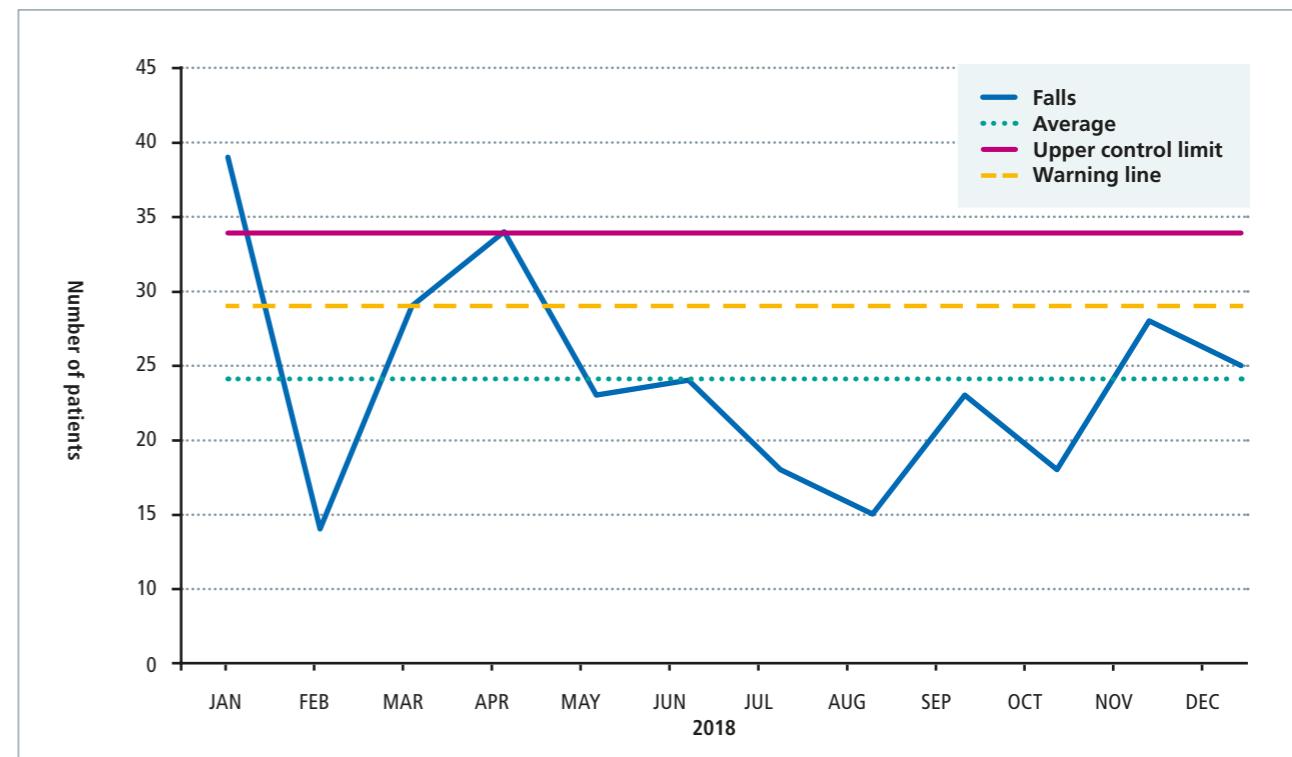


Figure 27: Patient falls moderate harm and above



Best care for everyone: to improve experience at the end of life

Quality priority

To improve end of life care

Background

In 2017, we launched Gloucestershire's End of Life Care Strategy. Our Trust Board were the first to sign up to the End of Life Care Charter, confirming a true organisational commitment to end of life care.

How have we performed

Since the launch, a number of departments have embraced the charter ranging from our Emergency Department, to Oncology and Clinical Physiology to the Library.

We successfully appointed a Clinical Lead Nurse for End of Life and a Specialist in Palliative Care, a brand new role to help co-ordinate, deliver and drive forward end of life care. Our Trust based webpages are up and running and our first staff email bulletin went out. This helps to share news on what is happening across the Trust, as well as feedback received from relatives and learning from incidents/complaints.

The End of Life Care Champions have a formal job description, agreed by their line managers and ensuring they are enabled to have time to enhance end of life care within their areas.

Our Clinical Commissioning Group has established a Clinical Programme Group for end of life care and we are one of only 11 CCG's across the country to have done this. One of our medical consultants is deputy chair ensuring that we are at the heart of countywide developments. We will be working to break down cross-organisational boundaries and explore societal changes. Projects have already included a pilot of Just in Case Boxes to improve access to medications and exploration of "Respect". Respect is a process that creates personalised recommendations for a person's clinical care in a future emergency when or if they are unable to make or express choices.

Gloucestershire held its most successful Dying Matters week with the highest number of contacts with the public the information bus has ever had.

In 2018, we were committed to all clinical areas being signed up to the End of Life Care Charter. Nursing Accreditation and Assessment System (NAAS) data is supporting this achievement.

A key goal of this year is to look at education provision for our staff ensuring that we are able to provide consistent training, which fulfils new

national standards for all healthcare professionals. The Trust has committed to supporting mandatory training around EOLC recognising it's cross-cutting importance for all. GHNHSFT was shortlisted as part of the EOLC Clinical Programme Group for a Health Service Journal award and this was highlighted as out-standing practice by the Health Service Journal Awards panel when feedback was given. We are continuing to work with the professional education team to ensure this is appropriate for all of the different professional groups – clinical and non-clinical across the Trust.

Through our End of Life Care Quality Group, we will be sending out quarterly emails to share learning around incident/concerns/complaints, as well as hearing about examples of best practice. We are also working with our Information & Technology colleagues to ensure key aspects of care are including within the new electronic patient record (EPR). There have been further delays to the EPR but we remain in discussion with the relevant teams. Recent introduction of Joining Up Your Information (JUYI) is enabling some access to documented care priorities and key clinical information across the One Gloucestershire system.

Our End of Life Care champions will be running their own event later in the year, showcasing their roles, how they can support colleagues and highlighting the growing resources available to all. Regular champions days have been held throughout this year with a range of outputs including ward information boards, updated information regarding overnight rooms and comfort measures to ensure relatives are given refreshments when visiting.

We will be continuing to work with the countywide Clinical Programme Group to forward established work programmes. Key projects which will be completed this year include a full review of shared care paperwork for the expected last days of life and a switch of standard medications prescribed at end of life which will result in more consistent supplies through more reliable drug company provision, as well as potentially producing a substantial cost saving without detriment to symptom relief. We will be holding events during Dying Matters week and looking at 'improving the conversation', through initiatives like the 'Knead to Know' project. This initiative encourages conversations to happen whilst an activity, bread making, is taking place.

Shared care plan was updated and launched countywide in June 2018 with a switch from diamorphine to morphine as standard opioid prescribed. The latter has ensured both a cost saving

and more ease of access to the medications. This has also tied in with the use of a 'Just in Case Box/Bag' across the county which provides a consistent 'format' for the medications dispensed and ease of checks.

Data

- ◀ We have received over 200 compliments from bereaved families over the care provided to their relatives.
- ◀ Our volunteers have made over 500 syringe pump bags for our patients.
- ◀ We have named End of Life champions for all clinical areas alongside many from non-clinical departments.
- ◀ We were shortlisted for the Health Service Journal Compassionate Patient Care Award.
- ◀ We made a change in our pain relief medication practices (opioid) and this has enabled us to save £40k per annum across the county One Gloucestershire area.
- ◀ We have received excellent feedback from staff regarding the our newsletters which have enabled dissemination of learning from incidents and complaints as well as learning from excellence in care.
- ◀ We have assessed all ward/clinical areas and they have scored green in the NAAS which demonstrates that we are providing high standards of care for our patients.
- ◀ Contributed to National Audit for Care at End of Life (NACEL) and our results showed that there were no significant concerns/ variation highlighted with our results when compared to other organisations.

Plans for improvement 2019/20

Within our continuous improvement plan we aim to:

- ◀ Further develop our programmes for the education programme for the Trust.
- ◀ Embed the Supportive and Palliative Care Indicators Tool (SPICT) prognostication tool into standard practice to improve identification of the likely last year of life.
- ◀ Work with One Gloucestershire to adopt ReSPECT plans (Recommended Summary Plan for Emergency Care and Treatment). We recognise that although not an End of

Life document, this is vital in supporting patient's to have a voice and a choice.

- ◀ A key priority for the coming year is supporting our multi-disciplinary teams to have conversation with people about their plans which will be promoted on Twitter using the hashtag #HaveTheConversation.
- ◀ Building on the EOLC Champions work to date with further public and staff events to support.
- ◀ Repeat the NACEL audit.
- ◀ Alongside countywide partners, develop robust guidance for application of fast track discharge and education around this process.

PART 2.2

Statements of assurance from the board

The following section includes response to a nationally defined set of statements which will be common across all Quality Reports.

These statements serve to offer assurance that our organisation is:

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

Information on the review of services

The purpose of this statement is to ensure we have considered quality of care across all our services. The information reviewed by our Quality and Performance Committee is from all clinical areas. Information at individual service level is considered within our divisional structure and any issues escalated to the Quality and Performance Committee.

Health Services

During 2018/19, Gloucestershire Hospitals NHS Foundation Trust provided and/ or subcontracted 107 NHS services.

Gloucestershire Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the NHS services reviewed in 2018/19 represents 86.7% of the total income generated from the provision of the NHS services by Gloucestershire Hospitals NHS Foundation Trust for 2018/19.

Information on participation in clinical audit

From 1 April 2018 to 31 March 2019, 35 national clinical audits and five national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 97% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. Where national audits could not be undertaken then local data was collected and reviewed.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in during 2018/19 are as follows:

- ◀ Adult Community Acquired Pneumonia
- ◀ BAUS Urology Audits: Cystectomy
- ◀ BAUS Urology Audits: Nephrectomy
- ◀ BAUS Urology Audits: Percutaneous nephrolithotomy
- ◀ BAUS Urology Audits: Radical prostatectomy
- ◀ Bowel Cancer (NBOCAP)
- ◀ Cardiac Rhythm Management (CRM)
- ◀ Case Mix Programme (CMP)
- ◀ Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)
- ◀ Diabetes (Paediatric) (NPDA)
- ◀ Elective Surgery (National PROMs Programme)
- ◀ Falls and Fragility Fractures Audit programme (FFFAP)
- ◀ Inflammatory Bowel Disease (IBD) programme
- ◀ Learning Disability Mortality Review Programme (LeDeR)
- ◀ Major Trauma Audit The Trauma Audit

and Research Network (TARN)

- ◀ Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection
- ◀ Maternal, Newborn and Infant Review Programme Clinical Outcome
- ◀ Myocardial Ischaemia National Audit Project (MINAP)
- ◀ National Asthma & COPD Audit programme
- ◀ National Audit of Breast Cancer in Older Patients (NABCOP)
- ◀ National Audit of Dementia
- ◀ National Bariatric Surgery Registry (NBSR)
- ◀ National Cardiac Arrest Audit (NCAA)
- ◀ National Emergency Laparotomy Audit (NELA)
- ◀ National Heart Failure Audit
- ◀ National Joint Registry (NJR)
- ◀ National Lung Cancer Audit (NLCA)
- ◀ National Maternity and Perinatal Audit (NMPA)
- ◀ National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)
- ◀ National Oesophago-gastric Cancer (NAOGC)
- ◀ National Ophthalmology Audit
- ◀ National Prostate Cancer Audit
- ◀ National Vascular Registry
- ◀ Sentinel Stroke National Audit programme (SSNAP)
- ◀ Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme

Participation in National Audits

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Audit title	Submission Information
Adult Community Acquired Pneumonia	New for 2018 data collection ongoing
BAUS Urology Audits: Cystectomy	122, 87% according to HES for 2015 2016 and 2017 combined
BAUS Urology Audits: Nephrectomy	237, 93.24% according to HES for 2015 2016 and 2017 combined
BAUS Urology Audits: Percutaneous nephrolithotomy	65 HES percentage not provided for 2015 2016 and 2017 combined
BAUS Urology Audits: Radical prostatectomy	399, 89.4% according to HES for 2015, 2016 and 2017 combined
Bowel Cancer (NBOCAP)	Patients diagnosed between 1 April 2017 and 31 March 2018.
Cardiac Rhythm Management (CRM)	Full submission 100%
Case Mix Programme (CMP)	100% of patients admitted to critical care areas
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Full Submission of Nationally mandated dataset.
Diabetes (Paediatric) (NPDA)	Data collection is ongoing it is anticipated that we will submit a whole clinic cohort
Elective Surgery (National PROMs Programme)	2017/18 (latest report) 809 were submitted for Hip Replacement and 907 for Knee Replacement

Audit title	Submission Information
Falls and Fragility Fractures Audit programme (FFFAP)	The Trust is participating and data collection is still ongoing.
Learning Disability Mortality Review Programme (LeDeR)	There have been 16 learning disabilities deaths reported to LeDeR in the last financial year.
Major Trauma Audit The Trauma Audit and Research Network (TARN)	Current case ascertainment rate is 100% +
Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection	100% of identified cases reported.
Maternal, Newborn and Infant Review Programme Clinical Outcome	21 cases between April 18 and Feb 19
Myocardial Ischaemia National Audit Project (MINAP)	75% entered (476 cases submitted for Quarter1-3) 70% required for minimum data standard
National Asthma & COPD Audit programme	COPD 351 for GRH and 210 for CGH
Asthma data collection ongoing from November 2018	100% (to March 2016) Primary Procedures 133 and Revisional Surgery 10
National Audit of Breast Cancer in Older Patients (NABCOP)	All data from COSD
National Audit of Dementia	CGH 33, GRH 48
National Bariatric Surgery Registry (NBSR)	All cases performed in Gloucester are submitted to NBSR.
National Cardiac Arrest Audit (NCAA)	137 to March 2019
National Emergency Laparotomy Audit (NELA)	Continued submission of emergency laparotomy patients to the audit with over 150 cases in 2018/19

Audit title	Submission Information
National Heart Failure Audit	Approx. 35% of cases entered to date. 70% required for minimum data standard
National Joint Registry (NJR)	A total of 1964 cases for 2017/18 (540 hips, 658 knees, 45 shoulders , other revision work)
National Lung Cancer Audit (NLCA)	340 Cases for the 2017 audit period
National Maternity and Perinatal Audit (NMPA)	100%
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	100%
National Oesophago-gastric Cancer (NAOGC)	100%
National Ophthalmology Audit	3754 (100%) of which 3453 were eligible
National Prostate Cancer Audit	699 for a rolling year to Feb 2019
National Vascular Registry	AAA 7, Carotid 62, 100% extraction from NVR database
Sentinel Stroke National Audit programme (SSNAP)	875, 100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	April 2018– March 2019 33 incidents reported to SHOT
UK Parkinson's Audit	40 patients

National Confidential Enquiries

Child Health Clinical Outcome Review Programme and; Medical and Surgical Clinical Review Programme	Cancer in Children, Teens and Young Adults Perioperative Diabetes Pulmonary Embolism Acute Bowel Obstruction Long Term Ventilation	Information returned for all national confidential enquiries
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Clinical audit reports

The reports of 35 of national clinical audits were reviewed (or will be reviewed once available) by the provider in 2018/19 and Gloucestershire Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
BAUS Urology Audits: Cystectomy	Individual clinician data is reviewed at a consultant level. The overall results are reviewed at audit meetings and used to highlight specific issues for more detailed review.	Cystectomy wound complication rate and results were reviewed. An improvement has led to the use PICO dressings and a push for enhanced recovery for these patients.
BAUS Urology Audits: Nephrectomy	Individual clinician data is reviewed at a consultant level. The overall results are reviewed at audit meetings and used to highlight specific issues for more detailed review.	Nephrectomy complications and transfusion rates are being reviewed in more detail. The first 20 robot renal cases have been reviewed, the data from which have been submitted as part of the 2018 BAUS.
BAUS Urology Audits: Percutaneous nephrolithotomy	Individual clinician data is reviewed at a consultant level. The overall results are reviewed at audit meetings and used to highlight specific issues for more detailed review.	Length of stay longer than national average, therefore move towards more mini PCNL to reduce length of stay.
BAUS Urology Audits: Radical prostatectomy	Individual clinician data is reviewed at a consultant level. The overall results are reviewed at audit meetings and used to highlight specific issues for more detailed review.	---
Bowel Cancer (NBOCAP)	Annual Report 2018 – Published in December 2018, the majority of the results in this report are for patients diagnosed 1 April 2016 to 31 March 2017. Reviewed at Clinical Governance Meeting on 10 Jan 2019.	Discussed that data ascertainment for CRM involvement was low and encouraged data for the next upload to be reviewed and amended whilst it is still possible to do so. This is felt to be a problem with the data from the GRH site rather than CGH. Rate of a negative CRM looks low compared to other Trusts but this is because this data field was not completed in a large percentage of patients (not a previously reported metric).

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
Cardiac Rhythm Management (CRM)	National Audit Report, Yearly from NICOR, Report February 2017	Data collected for national database of pacing/ICD/CRT. Report shows rates for pacing per million and also percentage of physiological pacing – a quality standard. We achieved national targets in terms of physiological pacing and number per million for pacing. Our CRT numbers for the last year were lower than expected due to the unexpected retirement of a colleague but are now back within range.
Case Mix Programme (CMP)	Yes at individual unit M&M. Lessons are shared between units at cross county quarterly meetings. The reports provide information on mortality rates, length of stay, etc and provide the Trust with an indication of our performance in relation to other ICUs.	Where trends are identified then these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society. On the GRH site, DCC is a substantial outlier compared with the rest of the country in terms of: 1. Delayed discharges due to lack of ward beds – outside our control. 2. Out of hours discharges with well documented increase in mortality of those patients – due to lack of ward beds – outside our control.
Coronary Angioplasty/ National Audit of Percutaneous Coronary Interventions (PCI)	Data is included in the annually produced National Audit Report from NICOR	Data collected both for national audit (see above) and to generate operator specific outcome reports. These are publicly available via BCIS or NICOR. Data for last complete calendar year show departmental performance is above expected for case mix using current risk model.
Diabetes (Paediatric) (NPDA)	The latest report is due to be published in May 2019 and will be reviewed within the governance meeting.	This year has seen many improvements within the Paediatric Diabetes team and these are outlined within this report.
Elective Surgery (National PROMs Programme)	Surgical review	---
Falls and Fragility Fractures Audit programme (FFFAP)	Data collection is still ongoing. Once published the report will be reviewed, monitored and discussed at the Trust Falls Steering group meetings that occur quarterly.	The report has not yet been published but actions are taken in real time, these consist of ward learning from the events around the fall and how it was managed.

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
Learning Disability Mortality Review Programme (LeDeR)	A focus has been placed on trying to work through a backlog dating back to 2017 (including community deaths). 2 Deaths have been reviewed and 2 deaths are about to be reviewed from this financial year.	Since 2017 there have been 13 hospital deaths reviewed. Feedback for improvement has included documentation standards, health records filing, completion of food charts, completion of fluid charts, documentation of capacity assessment, documentation of resuscitation status with patient and family/carers and timely referral to Dietitian. The learning is discussed at the Learning Disabilities steering group meeting. Documentation, especially food and fluid charts, is included in the learning disabilities face to face training with the newly qualified staff nurses and Acute Care ward staff.
Major Trauma Audit The Trauma Audit and Research Network (TARN)	Report is reviewed quarterly in the trauma network meetings.	Data completion has increased from 56% and is now 92.1%. The new TARN co-ordinator streamlined data transfer between the trauma unit and MTC and in conjunction with Business Intelligence Unit has modified the data collection system to improve data collection. The Trusts mortality rate continues to be in line with national averages.
Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection	Cases reported at board level on a monthly basis and discussed at the Trust infection control committee. The various improvements highlighted are reviewed at monthly Infection Control Committee meeting and bimonthly AMS committee.	A comprehensive trust wide C. difficile reduction plan is in place with a focus on reducing potential contamination and improving management of patients with C. difficile infection including the development of Nurse-led C. difficile ward rounds. Completion of comprehensive MDT post infection reviews of trust apportioned cases of C. difficile. Monthly assurance audits of CDI patient management and practice with CCG and Lead Nurse for IPC and AMS. Improved staff awareness and education programme; with a particular focus of hand hygiene and prompt stool testing and isolation and treatment patients for CDI. Comprehensive Antimicrobial Stewardship strategy which focuses on reducing inappropriate antibiotic usage, review of patients at 24-72hrs of antibiotic therapy, up to date and accessible trust antibiotic prescribing guidelines, staff education and public awareness of AMS.
Maternal, Newborn and Infant Review Programme Clinical Outcome	Yes, all losses over 22 weeks are reviewed at risk meeting then PMRT with results.	There has been no specific action but learning points are disseminated throughout the service.

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
Myocardial Ischaemia National Audit Project (MINAP)	Data included in the Annual National Audit Report from NICOR Formal report due out later in 2019	Achieved the minimum standard for data input. To look further at achieving the Best Practice tariff.
National Asthma & COPD Audit programme	The report has not yet been published.	---
National Audit of Breast Cancer in Older Patients (NABCOP)	Reviewed locally. There have been no concerns and the Trust is not an outlier.	No actions required
National Audit of Dementia	The report has not yet been published.	The report will be reviewed by the Dementia Committee when it is published.
National Bariatric Surgery Registry (NBSR)	Local review	---
National Cardiac Arrest Audit (NCAA)	The report is reviewed within the Resuscitation Department and then shared at the Deteriorating Patient and Resuscitation Committee meetings every quarter. The data is also reviewed at year end. The report itself is split into the two different sites for comparison.	We highlight areas where Simulation training would be beneficial, particularly looking at escalation of the deteriorating patient and effective communication of DNACPR decisions in place. We incorporate all data collected within mandatory training to raise awareness of expected survival to discharge from an in hospital cardiac arrest. Benchmarking our status nationally for different outcomes such as; number of CPR attempts, survival to discharge, demographics of patients, locations of arrests, time of arrests etc.
		We investigate potential non-arrests and unexpected non-survivors highlighted by NCAA. A project is just being commenced looking at why we are consistently above the national average regarding successful resuscitation attempts.

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database	Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
National Emergency Laparotomy Audit (NELA)	Yes – quarterly joint surgical and anaesthetic NELA meetings to review results and discuss deaths	<p>ELC collaboration continues and we continue to perform well with a mortality rate at CGH of <7%.</p> <p>We continue to strive for greater rates of HDU admission post-op across the trust and for even higher rates of consultant surgeon and anaesthetic-led care which is already high.</p> <p>We are soon to introduce new boarding cards to standardise pre-op work up.</p> <p>A new elderly care review system was introduced in November 2018 for > 80 year-olds post emergency laparotomy as like many centres we had very low rates of elderly care review post operatively.</p>	National Oesophago-gastric Cancer (NAOGC)	Local review	---
National Heart Failure Audit	National Heart Failure Audit Annual Report from NICOR later in 2019	There is a plan to increase data input and achieve the minimum standard. To look at achieving the Best Practice Tariff	National Ophthalmology Audit	This year's report is due to be published in August 2019 and will be reviewed at a national level by the Royal College of Ophthalmologists'.	The case complexity adjusted PCR rate was 0.8% and the case adjusted visual acuity loss rate was 0.6%, both of these are better than the national average.
National Joint Registry (NJR)	Data published in annual report (15th NJR report) Data has been discussed and used for individual surgeons' appraisal.	<p>The Trust received a national award for data quality again this year.</p> <p>Outlier identification and management was undertaken and a review process agreed with Jon Mutimer (Regional Clinical Coordinator for NJR).</p>	National Prostate Cancer Audit		<p>The Trust has not had the manpower to complete this audit annually except for the components that have been part of COSD.</p> <p>Since January 2019 we now have a new role in the CNS Admin team and have started to use the post to enter data so the quality and quantity of the data input will increase</p>
National Lung Cancer Audit (NLCA)	The outcomes are reviewed at the lung AGM.	Changes are being planned to amalgamate GRH and CGH MDT. Moving MDT to Wednesday afternoon will facilitate >95% surgical attendance.	National Vascular Registry	The data is regularly reviewed at governance meetings.	---
National Maternity and Perinatal Audit (NMPA)	The NMPA have delayed the production of the report, it is anticipated that it will be produced in the coming months.	---	Sentinel Stroke National Audit programme (SSNAP)	Ongoing regular reviews at Stroke/TIA business meetings-most recently on 19/3/19	<ol style="list-style-type: none"> 1) Regular reviews of front door targets arranged- these happen on a weekly basis with direct feedback to ED and radiology 2) The audit forms the basis of a therapy business plan for increasing therapists 3) The audit has indirectly helped with plans to open a new Stroke Therapy Unit at the Vale Community Hospital 4) The audit results are regularly used by the stroke team for service improvement planning e.g. thrombolysis and thrombectomy pathways
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	The information is reviewed at Paediatric governance and neonatal consultants meetings.	<p>Following last year's improvement work on temperature on admission and first consultation, data is now above target.</p> <p>A working group is being put together to further explore improvements for chronic lung disease.</p>	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	<p>When the SHOT report is issued it is reviewed by GHNHSFT Hospital Transfusion Committee (HTC) who look at the recommendations before any actions are taken by the Trust.</p>	<p>The SHOT 2017 report was published in July 2018</p> <ol style="list-style-type: none"> 1. The HTC is looking at the SHOT key recommendation for a pre transfusion TACO checklist and is gathering information about how best to proceed. This work is included in the QI Plan for 2019/20 for blood transfusion (the plan was sent to the QI manager in February.) 2. The SHOT key recommendation for implementing all available IT systems to support blood transfusion practice is being considered in the TrakCare development for the pathology modules. This is supported by the HTC. The SHOT report for 2018 will be published in July 2019.

Local clinical audit and quality improvement projects

The reports of 193 local clinical audits were reviewed by the provider in 2018/19 and these are reviewed and actioned locally. This includes 40 'Silver' quality improvement projects graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2018/19, some examples of actions associated with graduated QI projects are as follows:

Audit / quality improvement project	Example of actions
General admissions	Improvement in paperwork and processes for storing and recording patients property to reduce loses and improve patient experience and cost of claims
Medications	Facilitating the safe administration of insulin for patients with diabetes to maintain independence and improve patient experience
Learning from excellence	Development of a formal process for capturing excellence to allow learning from positive outcomes as well as from incidents that occur
Staff	Development of a positive staff culture in midwifery by using 'Restorative Clinical Supervision'
Carers	Increasing carers awareness of the support and services that can be accessed
Pharmacy	Improving communication between pharmacists and nursing staff in order reduce TTOs sent in the afternoon. Development of ward communication sheet.
Elderly care	Use of UP forms to facilitate timely patient engagement and decision-making around ceilings of treatment, multi-disciplinary team approach.
Oncology	Implementation of a scalp cooling service for patients at risk of chemotherapy-induced hair loss

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Gloucestershire Hospitals NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee: 1678.

Information on the use of Commissioning for Quality & Innovation (CQUIN) framework

A proportion of Gloucestershire Hospitals NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Gloucestershire Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at <https://www.england.nhs.uk/wp-content/uploads/2019/03/CQUIN-Guidance-1920-080319.pdf>.

For 18/19 the focus of the CQUIN scheme remained the same as 17/18 in that it is intended to deliver clinical quality improvements and drive transformational change. In 18/19 the scheme was updated to reflect the ambitions of the Five Year Forward View Next Steps, the NHS Mandate and the Planning Guidance. For 2018/19 the scheme shifted focus to prioritising STP engagement and delivery of financial balance across local health economies:

There were two parts to the scheme:

1. Clinical quality and transformational indicators

12 indicators (10 National, 1 local and 1 Armed Forces) have been defined which aim to improve quality and outcomes for patients including reducing health inequalities, encourage collaboration across different providers and improve the working lives of NHS staff.

2. Supporting local areas

1% of the CQUIN funding has been earmarked to support the development of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) – reinforcing the critical role local partners have to deliver system wide objectives. This looked like:

- ↳ 1.5% eligible contract value for National CCG commissioned CQUINS
- ↳ 1.0% eligible contract value for CCG STP
- ↳ 2.0% eligible contract value for Specialised Commissioned CQUINS
- ↳ 2.0% eligible contract value for Armed Forces

2018/2019 CQUINs

CQUIN	Description	18/19 Value (£)	Achieved
Medicine Optimisation (PSS)	To support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services.	499,802	499,802
Dose Banding (PSS)	Implementation of nationally standardised doses of SACT using the dose-banding principles and dosage	499,802	499,802
Spinal Hub (PSS)	To establish and operate regional spinal surgery networks, data flow and MDT for surgery patients. To promote the better management of spinal surgery by creating and supporting a regional network of a hub centre and providers	166,601	124,950
Enhanced Supportive Care (PSS)	Implementation of the Enhance Supportive care approach for cancer and non-cancer services- early referral to a Supportive Care Team to secure improved outcomes and avoidance of inappropriate aggressive treatment	166,601	166,601
Armed Forces Covenant	Embedding AF covenant	7,746	7,746
Health & Wellbeing (CCG)	Improving the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well: a) HR/staff survey questions b) Food c) Flu vaccinations	861,450	TBC: No Q4 outcome report from CCG
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) (CCG)	Timely identification, treatment and review of patients with sepsis in ED and acute inpatient settings, Reduction in antibiotic consumption per 1,000 admissions	861,450	TBC

CQUIN	Description	18/19 Value (£)	Achieved
Improving services for people presenting to A&E with MH issues (CCG)	Ensuring that people presenting at A&E with MH needs have these needs met more effectively through an improved, integrated service, reducing their future attendance at A&E	861,450	TBC
Advice and Guidance (CCG)	To improve GP access to consultant advice prior to referring patients in secondary care.	861,450	TBC
Supporting Proactive & safe discharge (CCG)	Supporting proactive and safe discharge. Emergency Care Data Set (ECDS). Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within seven days of admission by 2.5% points from baseline.	861,450	TBC
Preventing ill health by risky behaviours – alcohol and tobacco (CCG)	To help deliver on FYFV objectives particularly around the need for a '...radical upgrade in prevention...' and to '...incentivising and supporting healthier behaviour' (alcohol and tobacco). Also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving.	861,450	TBC

2018/19 Performance to date

CCG commissioned

- ↳ Q1–Q3 performances across the board were generally good with no financial impact due to the year-end contract agreement with GCCG – however the position is still unclear for SWCCG.
- ↳ Final Q3 position awaiting confirmation and no Q4 report from commissioners yet.
- ↳ With no block agreement we have incurred financial penalties but this is difficult to quantify.
- ↳ The WCCG CQUIN value overall is £203k of eligible contract value

CQUINs that missed their milestones Q1–Q3:

1. Reducing the impact of Serious Infections (Antimicrobial Resistance and Sepsis):

- ↳ 1a) Timely identification in ED and IP to include NEWS2 (target -90% within 1 hour by Q4) – achieved for Q1, Q2 and Q3 in all areas
- ↳ 1b) Timely Treatment within 1 hour in ED and IP (90% target –NEWS2 in Q3-Q4 must also be 90%):
 - ↳ Q1: partial achievement (ED 86%; IP 76%)
 - ↳ Q2: partial achievement (ED 76% ; IP 83%)
 - ↳ Q3: partial achievement (ED 84%; IP 82%)
- ↳ 1c) Review within 72hours (meet review criteria and IV oral switch assessment for antibiotic prescriptions)
 - ↳ Q1 and Q2: achieved
 - ↳ Q3: failed to achieve IV assessment target of 75% (51%)
- ↳ 1d) reduction in consumption: Q4 final assessment on consumption but indicative results show we are unlikely to achieve the overall reduction target of 3%

2. Improving services for people presenting to A&E with MH issues:

Good work between providers and requirements to maintain 20% reduction in attendances for this cohort of patients has been successful up to Q3, however ECDS data submission is part of reporting requirements and are currently not possible with Trak so Q3 was not achieved purely because of lack of ECDS reporting and not the good work with patients.

3. Advice & Guidance: 2 day (80%) and 5 day (95%) standards and rollout criteria for A&G were achieved in Q1; Not achieved Q2 as both targets were not met; Q3 both standards were met but rollout target was not met due to delay in Ophthalmology going live, therefore not achieved for Q3

4. Supporting Proactive and Safe Discharge: Q1 not achieved; Q2 achieved because a plan was submitted; Q3 was not achieved, despite work beginning, because there was no consistent improvement in core metrics.

5. Preventing ill health by risky behaviours

– **Tobacco and alcohol:** audits for each with targets against a baseline:

- ↳ Tobacco Screening
 - ↳ Tobacco Brief Advice
 - ↳ Tobacco referral & med offer
 - ↳ Alcohol Screening
 - ↳ Alcohol Brief advice & referral
- Q1 and Q2 – targets achieved
- Q3 – partial achievement because 3 elements –Tobacco Screening, Brief Advice and Alcohol Brief advice & referral – did not meet the minimum requirements of 10% improvement on previous quarter.

6. Health and Wellbeing:

- ↳ a) HR/staff survey questions: has not achieved the improvement required
- ↳ b) Food: waiting Q4 report
- ↳ c) Flu vaccinations: achieved the target of 75%

Specialised commissioned

Generally performing well:

1. **Medicines Optimisation:** significant effort has resulted in full achievement Q1–Q4
2. **Dose Banding SACT:** significant effort has resulted in full achievement Q1–Q4
3. **Spinal Hub** No Q1 report required; Q2 achieved; Q3 partial payment – Q4 achieved
4. **Enhanced Supportive Care** Q1–Q4 achieved
5. **Armed Forces** full achievement likely

2019/20 CQUINS:

From 1 April 2019, both the CCG and PSS schemes are being reduced in value to 1.25% and 0.85% respectively with a corresponding increase in core prices, allowing more certainty around funding to invest in agreed local priorities.

A maximum of five indicators have been prescribed nationally for each contract, however, for GHT we have agreed one PSS CQUIN and for GCCG – and WCCG and associates – we have agreed five schemes.

Medicines Optimisation (NHSE PSS)	Four areas to improve the management of medicines: <ul style="list-style-type: none"> ↳ Minimise chemotherapy waste ↳ Reducing unwarranted clinical variation between centres by auditing prior approvals (Blueteq) of NHSE commissioned drugs ↳ Faster adoption of prioritised best value medicines and treatment at local level ↳ Anti-fungal stewardship – reduce inappropriate use and prevent development of resistance to antifungals 	£581,869
CCG1: Antimicrobial resistance: 1a) lower UTI in older people; 1b) antibiotic prophylaxis in elective colorectal surgery	Prioritise AMR and stewardship: <ul style="list-style-type: none"> 1a) Reducing inappropriate antibiotic prescribing, improve diagnosis, treatment and management of p[patients with UTI 1b) Implement NICE guidance for Surgical Prophylaxis to reduce number antibiotic doses used for colorectal surgery and improve compliance with antibiotic guidelines 	£840,663
CCG2: Staff flu vaccinations	Achieving 80% uptake of flu vaccinations by frontline clinical staff as a crucial lever for reducing spread of flu during winter months, where it can have significant impact on the health of patients, staff, their families and the overall safe running of NHS services	£840,663
CCG3: Screening and Brief advice for tobacco and alcohol use in inpatient settings	Part of the ongoing programme to deliver the Long Term Plan and a key component of alcohol and tobacco users path to cessation: <ul style="list-style-type: none"> 3a) Alcohol & Tobacco screening 3b) Tobacco – Brief Advice 3c) Alcohol – Brief Advice 	£840,663
CCG7: Three high impact actions to prevent hospital falls	Taking three actions as part of a comprehensive multi-disciplinary falls intervention – resulting in fewer falls, reducing length of stay and treatment costs	£840,663
CCG11: Same Day Emergency Care (SDEC):	These conditions are from the top 10 conditions with which patients present in a SDEC setting. <ul style="list-style-type: none"> 11a) PE 11b) Tachycardia with AF 11c) Community acquired pneumonia 	£840,663
Armed Forces	Armed Forces CQUIN	£4,451

Care Quality Commission (CQC)

Gloucestershire Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Good". Gloucestershire Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2018/19.

Gloucestershire Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Secondary uses services data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- ↳ 99.8% for admitted patient care
- ↳ 100% for outpatient care and
- ↳ 98.9% for accident and emergency care.
- ↳ Which included the patient's valid General Medical Practice Code was:
- ↳ 100% for admitted patient care;
- ↳ 100% for outpatient care; and
- ↳ 99.3% for accident and emergency care.

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

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

High quality information is:-

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

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

- ↳ Identification, review and resolution of potential duplication of patient records
- ↳ Monitoring of day case activity and regular attenders
- ↳ Gathering of user feedback
- ↳ All existing reports have been reviewed and revised
- ↳ Routine DQ reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'Insight'
- ↳ The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.
- ↳ Gloucestershire Hospitals NHS Foundation Trust regularly send data submissions to SUS and via these submissions we receive DQ reports back from SUS. Based on SUS DQ reports we action all red and amber items highlighted in report to improve Data Quality.
- ↳ In data published for the period April 2018 to March 2019, the percentage of records which included a valid patient NHS number was:
 - ↳ 99.8% for admitted patient care (national average: 99.4%)
 - ↳ 100% for outpatient care (national average: 99.6%)
 - ↳ 98.9% for accident and emergency care (national average: 97.6%)

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

- ↳ 100% for admitted patient care (national average: 99.9%)
- ↳ 100% for outpatient care (national average: 99.8%)
- ↳ 100% for accident and emergency care (national average: 99.3%)

- ↳ A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly

- ↳ These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as:-

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

On a daily basis any missing/incorrect figures are highlighted to staff and added or rectified. Our Trust Data Quality Policy is currently under review.

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

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

Information Governance Assessment Report

NHS Digital have released a new Data Security and Protection Toolkit (which replaced the Information Governance Toolkit) during 2018/19. All organisations that have access to NHS patient data and systems must use the toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The standards assessed within the Data Security and Protection Toolkit are based on the National Data Guardian's ten published Data Security Standards and provide an overall test of the quality of data systems, standards and processes within an organisation.

The Trust's 2018/19 self-assessment published 31.03.2019 has a status of "Standards not Met". There were two areas of non-compliance:

- ◀ The Trust achieved 87% against a mandatory target of 95% for staff completing annual Information Governance refresher training
- ◀ A specific requirement that a Penetration test be conducted in the previous 12 months to confirm that all networking components have had their default passwords changed was accidentally omitted from the test specification

An Improvement Plan to deal with these issues before 30 September 2019 has been developed and submitted to NHS Digital and will form the basis for the Trust's Information Governance immediate work plan during 2019 /2020.

Approval of the improvement plan by NHS Digital is awaited – at this point the publication status will be changed to 'Standards not fully met (Plan Agreed)'.

In addition to monitoring against the DSP toolkit self-assessment tool, risks to data security within our Trust are managed through multiple technical, process and governance controls. We use the National Security Centres "10 steps to Cyber-Security" as a framework for our data risk management.

Technical controls include software applications for anti-virus (server and desktop), anti-spamming, firewall protection, internet filtering and software patching for IT infrastructure (servers, networks, and PCs.). New technical controls for 2018/19 have included implementation of vulnerability scanning and asset discovery.

Process controls include subscription to national CareCERT alerts and a process for tracking the implementation of these alerts. A major cyber incident response plan is in place (countywide as network is across STP partners), and is part of ongoing review.

Governance controls include monthly countywide cyber security forums, risks review through monthly IM&T boards, and quarterly Information Governance forums. Risk escalation is as per the Trusts risks management policy.

The Trust's continuing improvement plans for 2019/20 include achieving Cyber Essentials Plus accreditation. This is a government-supported, industry-led scheme to assess and manage levels of protection against on-line threats.

During 2018-19, key Information Governance policies have been reviewed for compliance with the General Data Protection Regulation including the introduction of a specific Data Protection and Confidentiality Policy.

The effectiveness and capacity of these systems is routinely monitored by our Trust's Information Governance and Health Records Committee.

Information governance incidents are reviewed and investigated throughout the year and reported internally through the Trust's Information Governance and Health Records Committee.

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

A large number of the near miss reported incidents relate to lost SmartCards which are disabled or reported as missing.

Examples of non-reportable breaches were documents left insecure in a public place, incorrect information documented and information sent to the wrong destination. Process reviews of trends of incidents are planned for 2019/20 to identify areas and opportunity for improvement.

Summary of Incidents reported to the Information

Commissioner's office in 2018–19 under Article 33 GDPR

Summary of breach	Category
3rd party sensitive information disclosed in error, as part of request for copy of patient record.	Confidentiality
Unavailability of record resulting in distress and repeated test	Unavailability
Adopted child's new name disclosed in error.	Confidentiality

Summary of confidentiality / incidents internally reported 2018–19

Reportable breaches (detailed above)	3
Number of confirmed Non-reportable breaches	123
Number of no breach / Near miss incidents.	225
Total number of confidentiality incidents internally reported	351

Clinical coding

Gloucestershire Hospitals NHS Foundation Trust was not subject to the "Payment by Results clinical coding audit" during 2018/19.

Learning from deaths

During 2018/19, 1949 of Gloucestershire Hospitals NHS Foundation Trust patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

- ↳ 460 in the first quarter
- ↳ 463 in the second quarter
- ↳ 475 in the third quarter
- ↳ 551 in the fourth quarter

These quarterly results are broken down by Division in the table below.

- ↳ The total number of deaths across all Divisions for the reporting year 2018/19 is 1949 of which 100% are reviewed by the Medical Examiner as per Trust policy.
- ↳ Of these 1949 deaths, 272* were subjected to a detailed investigation by way of satisfying the criteria to trigger a Structured Judgement Review (SJR).
- ↳ Of these 272* SJRs carried out, 20* identified that the cause of death is judged to be more likely than not to have been due to problems in the care provided to the patient.
- ↳ Therefore, across all four Divisions for Quarters 1 – 3:
 - ↳ The percentage of deaths which resulted in an SJR = 5.8%.
 - ↳ Out of all 272 SJRs conducted, the percentage of deaths identified as having sub-optimal care as a contributing factor = 8.1%.
 - ↳ 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 = 0.2%.

Learning themes from all deaths reported, with particular focus on any sub-optimal care, are brought on a monthly basis to the Hospital Mortality Group by the Divisional Mortality representative from where recommended suggestions for improvements are passed on to the relevant committee or group. A summary of recent learning themes can be seen in Table 2. It should be noted that excellence in care is also reported and that learning from this is valued and shared.

The above data is taken from the following sources:

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

Additional information is provided in the supporting tables, overleaf:

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

Division	Q1 Total	Q2 Total	Q3 Total	Q4 Total	Divisional Year Total
Surgery	82	88	76	112	358
Medicine	344	344	367	394	1449
D&S	26	23	31	38	118
W&C	8	8	1	7	24
TOTALS	460	463	475	551	1949

Data Quarters 1 – 3 only, Quarter 4 not yet available

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

Surgical division

	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Q1	82	82	9	0
Q2	88	88	29	1
Q3	76	76	30	1
Q4	112	112	*	*
Year totals	358	358	68*	2*

Medical Division

	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Q1	344	344	43	2
Q2	344	344	46	8
Q3	367	367	81	7
Q4	394	394	*	*
Year totals	1449	1449	170*	17*

D&S Division

	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Q1	26	26	15	1
Q2	23	23	6	0
Q3	31	31	13	0
Q4	38	38	*	*
Year totals	118	118	34*	1*

W&C Division (N.B – Paediatrics follow their own review process)

	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Q1	8	8	0	0
Q2	8	8	0	0
Q3	1	1	0	0
Q4	7	7	0	0
Year totals	24	24	0	0

2018/19 Summary by Division

Division	No. of deaths	Total No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Surgery	358	358	68*	2*
Medicine	1449	1449	170*	17*
D&S	118	118	34*	1*
W&C	24	24	0	0
Totals	1949	1949	272**	20**

In percentage terms, by Division

Division	Total no. of deaths for Quarters 1 – 3	% of SJRs vs total number of deaths – Qs 1 to 3	% where sub-optimal care was identified vs no. of SJRs undertaken	% of sub-optimal care identified vs total number of deaths – Qs 1–3
Surgery	246	27.6	2.9	0.8
Medicine	1055	11.9	16.11	1.6
D&S	80	42.5	2.9	1.2
W&C	17	0	0	0
Totals	1398	5.8	8.1	0.2

An assessment of impact is that this work has been significant as many service changes and improvements have resulted from death reviews within this reporting period and our areas for improvement and the areas where we have achieved high standards of care are evidenced in Table 2 below.

Learning Themes for Service Changes for Hospital Mortality Improvement Group to focus on

Summary of learning and improvement area themes / learning points from SJRS reporting sub-optimal care

1. Recognising the possible negative effect on possible outcome of:
 - ↳ Loss of notes
 - ↳ Inadequate documentation
 - ↳ Delayed referral to other Specialties
 - ↳ Delayed reviews or inadequate reviews at weekends.
2. Failure to review DS from previous admission which might have led to more aggressive treatment.
3. Importance of holistic approach to complex elderly patients.
4. NIV to only be delivered by adequately trained staff in respiratory high-acuity bay (if at GRH).
5. Nursing staff should be advised on how to manage (and document care of) interventions such as femoral catheters.

Learning Themes for Service Changes for Hospital Mortality Improvement Group to focus on that need to be replicated and spread

Summary of learning and improvement area themes / learning points from SJRS reporting sub-optimal care

1. Early prescription of symptomatic medications and given in line with palliative care wishes.
2. Early implementation of shared care plan in frail terminal patient
3. UP forms filled out appropriately.
4. Early recognition that the patient was in the terminal phase of life.
5. No anticipatory medication used but always documented in notes that patient was comfortable.
6. Good communication with family at all stages.
7. Learning point – in situations where large doses of strong analgesics are being used consider further patient review, examination and investigation
8. Prompt assessment and management.

The number of case record reviews in 2016/17 was not recorded.

The number of case record reviews 2017/18 was 998 (48%).

The number of case record case record reviews for 2018/19 was the total number of deaths across all Divisions for the reporting year 2018/19 is 1949 of which 100% are reviewed by the Medical Examiner as per Trust policy.

We did not collect this data for 2017/18 in this format but will be able to report this in the next Quality Account.

Seven day services

The seven day services (7DS) programme is designed to ensure our patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

What do seven day services mean for patients?

We are working to meet the four standards identified as being 'must do' by 2020.

This will ensure our patients admitted to hospital in an emergency:

- ↳ do not wait longer than 14 hours to initial consultant review
- ↳ get access to diagnostic tests with a 24-hour turnaround time — for urgent requests, this drops to 12 hours and for critical patients, one hour
- ↳ get access to specialist, consultant-directed interventions
- ↳ with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

NHS England changed the process on 24 October 2018, whereby they are replacing the self-assessment survey for 7 day services with the Board Assurance Framework.

The formal requirements were outlined to the Trust on the 28 November 2018. A compliance report was submitted for assurance to our Quality and Performance Committee in February 2019 as the requirement was to complete a trial run by February 2019, with full implementation planned of the new framework by June 2019.

Freedom to Speak Up (Gosport)

Gosport Inquiry recommendations

Effective speaking up arrangements protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a CQC well-led Trust. We have been rated in the Well Led Domain as "Good" and our improvement work in this area was acknowledged.

Our Freedom to Speak up Guardian is Suzie Cro. Freedom to Speak Up Guardians are appointed and employed by the Trust, though their remit requires them to act in an independent capacity. Guardians are trained, supported and advised by the National Guardian Office.

All Guardians are expected to support their Trust to become a place where speaking up becomes business as usual.

The role, supporting processes, policy and culture are there to meet the needs of workers in this respect, whilst also meeting the expectations of the National Guardian's Office.

Key issues to note

- ↳ The Freedom to Speak up Guardian (FTSUG) has one day a week allocated to lead this work but the workload has significantly increased.
- ↳ Each appointment is one hour long and people often need one or two follow up appointments.
- ↳ Engagement activities have continued across the sites, promoting the role as much possible but this has been significantly reduced because of capacity issues.

Data reported to the National Guardian's Office (NGO).

See page opposite.

Themes and trends

Staff groups Q4

- ↳ 0 Medical Staff
- ↳ 6 Nurses
- ↳ 0 midwives
- ↳ 2 HCAs
- ↳ 1 AHP
- ↳ 1 Corporate staff

- ↳ 0 Admin staff
- ↳ 0 GMS staff
- ↳ 4 other

Themes

- ↳ Bullying and harassment is the most common reason to request to see the FTSUG.
- ↳ The next common reason this quarter was the lack of consultation through organisation change (Winter Pressures).
- ↳ There were no anonymous cases in Q4 and 3 cases in Q3 were
 - ↳ Infection control practices
 - ↳ Staff behaviours x 2

Data reported to the National Guardian's Office (NGO)

Concerns	End of year 2017/18	April – June Q 1	July – Sept Q 2	Oct- Dec Q 3	Jan – March Q 4	Totals 2018/19
Number of people raised directly with the Freedom To Speak Up Guardian	31	9	20	25	11	65
Number of issues raised anonymously	4	9	3	3	0	15
Nature of issue						
Patient quality issues	17	1	10	8	2	20
Staff experience – unacceptable behaviour (bullying / harassment)	19	3	12	23	9	47
Action	Support and advice	Yes	Yes	Yes	Yes	All staff provided with support and advice
Outside referral	0	0	0	0	0	0
Number of case where people indicate detriment	1 case	None	None	None	None	0
Of the people asked in this quarter who would speak up again	The majority of individuals would speak up again	Yes: 100%	Yes: 100%	Yes:100%	Yes: 100%	Yes:100%

Case studies

Case study 1

A band 5 member of staff (non-nursing) came to see the FTSUG about alleged bullying in the workplace. The staff member had tried to raise concerns with the individual directly but this had made no impact. The staff member raised concerns with their line manager who expressed that this was way the individual always acted so advised that they should learn to cope. The line manager was thought to have taken no actions.

The staff member came to see the FTSUG to talk about their concerns as they felt that they were not being listened to.

Support

The staff member was very distressed as the alleged bullying had continued for many months. The FTSUG listened.

The FTSUG advised about staff support services but advised there was currently a three month delay in obtaining an urgent appointment. Advice was given about seeking support from their own GP.

Advice

The Dignity at Work Policy was reviewed together and the next steps that the individual could take. They choose to go back and speak to their line manager. They were invited to come back and have a second appointment after their meeting.

They were advised about leadership development opportunities and the coaching opportunities available to them.

They were offered HR support and advice for investigation of their concerns.

Follow up

The FTSUG contacted the individual to ask for an update after their meeting on several occasions and got no reply.

Investigation

There was no investigation into the alleged issues but this was at the request of the individual even though this was available through the Dignity at Work Policy.

Outcome and resolution

- ◀ They apologised for not getting back to the FTSUG sooner.
- ◀ Unfortunately they felt that the issues that they discussed with the FTSUG (with all the will) would not ever have changed.
- ◀ For these reasons, they chose to leave the Trust and have taken employment elsewhere. They advised the FTSUG that they were not alone with their thoughts and suggested that people have left before them for the same reasons and they knew that a few more people are considering the same.

Feedback for the FTSUG

They took the opportunity to thank you the FTSUG for the "wonderful work" that they do.

As much as in this instance, their situation did not resolve, it was still nice to have someone to speak with and they will certainly take away with them all of my advice. They thanked the FTSUG once again.

Case study 2

The FTSUG had a call from a distressed member of staff and they asked to see the FTSUG urgently about alleged bullying and harassment in the workplace. The staff member had not yet raised concerns with their line manager as they were the one who they were having issues with.

Support

The staff member was very distressed as felt that they had had the "wind knocked out of their sails". They had lost all confidence in their abilities. They had not been sleeping for a month. They were very stressed and were considering going off sick due to stress. The FTSU listened and then offered advice.

Advice

The Dignity at Work Policy was reviewed together and the next steps that the individual could take.

They choose to go back and speak to their line manager but before they did they agreed to go and have some coaching with the Leadership and OD team to enable them to have a "difficult" conversation with their line manager.

The aim of the coaching was to give them the confidence to do this.

Follow up

The individual contacted the FTSUG after their first coaching conversation and the first conversation with their line manager had gone really well.

They contacted the FTSUG after their second coaching conversation and they were very happy as again the conversation again had gone well.

Investigation

There was no investigation into the alleged incident but this was at the request of the individual even though this was available through the Dignity at Work Policy. They chose to manage this through local resolution and informal processes.

Outcome and resolution

The issues have been resolved for them with the outcome they wanted.

Feedback for the FTSUG

Overall, they now feel that they have closure and can move forward now.

They wanted me to know helpful the FTSUG and their leadership coach had been. It has helped immensely to know that they have a voice in what sometimes can feel a very overwhelming organisation – one of many staff.

To be listened to and supported has been enough to give them the ability and confidence to rectify the situation.

Learning and feedback

The FTSUG requests closure for each case and any learning from the case is shared with appropriate staff members.

Publication of National reports and Trust response

The Gosport War Memorial Independent Review was published in this year and there is a gap analysis paper written in response to this review which went to the Quality Delivery Group (QDG) in April 2019.

Expected national changes in 2019 in response to Gosport

1. CQC is reviewing how it assesses the statutory duty of candour.
2. The Government will place listening to and learning from feedback at the heart of care and improving care with a new strategy to be published this year.
3. NHSI – A new Patient Safety strategy this Autumn to make it easier for staff to report risks and for action to be taken.
4. NHSE – A review of the governance and leadership of the Controlled Drug Accountable Officer role in NHS England;
5. NHSE – A review of the operation of the lead Controlled Drug Accountable Officers in NHS England, including the effectiveness of Local Intelligence Networks.
6. NHSE - An assurance process to assess how 'Designated Bodies' (which include NHS Trusts and Foundation Trusts) are reflecting on the learning from the report and reviewing arrangements in their organisation in the light of it.
7. NHSE - An assurance process focused on the appropriateness of anticipatory prescribing guidelines and that they are being followed.

Overview of our speaking up system and processes

- ↳ We are developing our 'Speaking Up' strategy which has been co-produced with staff after a month of conversations with staff in October 2018 and will be part of the enabling quality strategy due for publication in May/June 2019.
- ↳ We have set up clear governance structures with lines of accountability and reporting with an Executive Lead and also a Non-Executive Director lead.
- ↳ We have a steering group that monitors the delivery of the strategy and guides the work plan and reports in to the People and Organisational Development Delivery Group.
- ↳ We appointed a Freedom to Speak Up Guardian (FTSUG) two years ago. The allocated resource is one day a week (can be two days if the need arises).
- ↳ We have developed an intranet site for staff so that they can find out information.
- ↳ We have produced a policy so that staff can follow clear systems.
- ↳ We have many ways that staff can speak up and include this in a short guide for staff:
 - ↳ Who can you speak up to for quality or staff experience concerns?
 - ↳ Your line manager in the first instance (if appropriate)
 - ↳ An Executive or Non-Executive Director (NED) – Claire Feehily is our named NED
 - ↳ Freedom to Speak up Guardian 07789 864970
 - ↳ Report the incident on Datix web
 - ↳ If you don't have access to a computer or Datix, call the minor incident line on ext: 5757
 - ↳ Raise your concern anonymously by signing up online to the Speak in Confidence System
 - ↳ Report the incident to HR
 - ↳ Approach your Trade Union representative
 - ↳ If the concern relates to potential fraud or corruption, contact our Counter Fraud Team

Find out more

Our Speaking Up/Raising Concerns Policy and more information about how you can raise your concerns, is available on our staff intranet. Contact Suzie.Cro@nhs.net or call her on: 07789864970

- ↳ We also have developed an anonymous reporting system.
- ↳ Each person who speaks up is given feedback about how the issue was handled and any outcomes.
- ↳ We have a video for staff to watch if they want to understand what speaking up is about.
- ↳ Everyone is asked if they would speak up again and this is recorded.
- ↳ All staff are advised if they suffer detriment that they must come back and report this to the FTSUG or the NED Lead.
- ↳ We review the National Guardian Office Case Reviews of other organisations and complete a gap analysis exercise against any of the recommendations. We have an action plan for any gaps which is reviewed by the steering group.
- ↳ We work with staff with the premise that all concerns are investigated (but only if they give permission).
- ↳ An Annual Speaking Up report is taken to the board (last report November 2018) and quarterly reports to the People and Organisational Development Committee (sub board).
- ↳ We undertook a survey of staff views on Speaking up in July 2018 and we are working on making improvements in response to the survey.
- ↳ Every member of staff who speaks up is thanked by the FTSUG and is asked whether they would speak up again.
- ↳ In 18 months of reporting only one staff member has reported suffering detriment after speaking up (1/85 cases).

National Guardian Office

Our Speaking up data is shared with the National Guardian Office on a quarterly basis and all Trust data can be found on the National Guardian Office website for benchmarking purposes.

The National Guardian Office (NGO) had October as "speaking up" month and there was a range of national activities.

CQC

In October 2018 CQC visited the Trust for their Well Led review of services. In the narrative produced for the Trust nurses and midwives were well aware of the FTSUG role but medical staff were less so. The FTSUG will ensure that there are more engagement activities with medical staff over the 2019-20 year.

FTSUG Regional Forum

In October the South West Regional Freedom to Speak up Guardians had their meeting in Gloucestershire and this was attended by the National Guardian Dr Henerietta Hughes.

Trust Steering Group

- ↳ The NHSI Speaking Up Board self-review tool has been completed and will be reviewed at each Steering Group meeting.
- ↳ October was #SpeakUpToMe month and there were many activities throughout the month to support this initiative.
 - ↳ Kitchen tables
 - ↳ Walkabout activities
 - ↳ FTSUG Tweetathon (31 tweets)
- ↳ The Speaking up Survey has an action plan which has been updated for this quarter. Not all actions will be completed by the deadlines due to capacity issues for the Guardian.

Future priorities

- ↳ Recruitment of additional Guardians to resolve the resource/capacity issues.
- ↳ Publication of the speaking up strategy within the Quality Improvement Strategy.
- ↳ Continue to monitor the action plan for the speaking up survey and implement the actions in as timely way as possible.
- ↳ Training package for Ambassadors to be developed working with Gloucestershire Care Services (March 20th first workshop).

Rota gaps

Statement NHS doctors in training rota gaps

Doctors in Training rota gaps

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive and patient feedback about the care provided. As part of our Quality Account 2018/19 we are providing a statement on our Trust Doctors in Training Rota Gaps, which we are required to report on annually through the following legislation schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

Monitoring, Delivery and Assurance

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

Improvements (2018/19)

Through analysis of our data and knowing what issues are in 2018/19 we took the following steps to make improvements

1. Discussion with departments to ascertain supply and demand requirements ensuring our rotas are recruited to.
2. Prospective approach to filling gaps, where known, to reduce reliance on agency staff.
3. Guardian of Safe Working proactively involved with rotas to ensure these maintain safe working hours along with good training and education opportunities, encouraging future applicants.

Next Steps (2019/20)

In 2019/20 we intend to improve our approach to long term (five-year) workforce planning, to support forecast rota gaps. Rota gap information will underpin workforce plans, triangulating this information with other workforce, activity and quality indicators and with consideration of known labour market supply issues. In addition to this, our Guardian of Safe Working will seek to improve the information dashboard relating to rota gaps, enabling a more proactive response and improving collaborative working with our clinical Divisions.

PART 2.3

Reporting against core indicators

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

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

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	Explanation of why GHNHSFT considers that the data from the HSCIC are as described	Actions GHNHSFT intends to take to improve indicator and quality of services
a) The value and banding of the Summary Hospital level Indicator SHMI for trust for the reporting period	2015/16	1.13	1.00	1.178	0.68	2018/19 data period: Jan18-Dec18 (latest published data as at 20/05/2019)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17	1.12	1.00	1.23	0.73		
	2017/18	1.09	1.00	1.11	0.89		
	2018/19	1.0453	1.00	1.2264	0.6993		
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	2015/16	20.90%	28.50%	54.60%	0.60%	2018/19 data period: Jan18-Dec18 (latest published data as at 20/05/2019)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group & End of Life Steering Group (delivery) and Q&P Committee (assurance).
	2016/17	21.00%	31.10%	58.6%	11.20%		
	2017/18*	26.10%	No data	No data	No data		
	2018/19	32.00%	34.70%	60.00%	15.00%		
Number of patient safety incidents / number which resulted in severe harm or death	2015/16	11,517 / 40	9,465 / 39	23,990 / 60	3,510 / 26	2018/19 data period: Apr18-Sept18 (latest published data as at 04/04/2019)	The actions to be taken have already been described within this report and are monitored by the improvement group Safety and Experience Review Group (delivery) and Q&P Committee (assurance).
	2016/17	6,932/22	4955/19	23,990/60	3,510/26		
	2017/18*	14,762/1	No data	No data	No data		
	2018/19	7,045/28	5,583/19	23,692/87	566/3		
Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	Explanation of why GHNHSFT considers that the data from the HSCIC are as described	Actions GHNHSFT intends to take to improve indicator and quality of services
Rate per 1000 bed days of patient safety incidents resulting / rate per 1000 bed days resulting in severe harm or death	2015/16	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	From 2014/15 the rate is calculated per 1,000 bed days instead of per 100 admissions, and the figures are drawn from all non-specialist acute trusts.	The actions to be taken have already been described within this report and are monitored by the improvement group Safety and Experience Review Group (delivery) and Q&P Committee (assurance).
	2016/17	41.82/0.13	39.89/0.15	71.81/0.6	21.15/0.06		
	2017/18	n/a	n/a	n/a	n/a	2018/19 data period: Apr18-Sept18 (latest published data as at 04/04/2019)	
	2018/19	44.0/0.2	44.1/0.1	107.4/0.2	13.1/0.1		
Rate of C diff (per 100,000 bed days) among patients aged over two	2015/16	11.4	15	62.6	0	2017/18 data period: Apr17-Mar18 (latest published data as at 04/04/2019)	The actions to be taken are within an improvement plan and are monitored by an improvement committee The Infection prevention and Control Committee (Delivery) and Q&P Committee (assurance).
	2016/17	12.5	13.2	82.7	0		
	2017/18	17.3	13.7	91.0	0.0		
	2018/19	No data	No data	No data	No data		
Percentage of patients risk assessed for VTE	2015/16	93.30%	96.10%	100.00%	88.60%	2018/19 data period: Apr18-Dec18 (latest published data as at 04/04/2019)	The actions to be taken are that we have a Task and Finish Group set up to improve this indicator been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17*	93.50%	95.60%	100.00%	78.70%		
	2017/18	90.00%	95.30%	100.00%	77.00%		
	2018/19	93.73%	95.55%	100.00%	70.94%		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	Explanation of why GHNHSFT considers that the data from the HSCIC are as described	Actions GHNHSFT intends to take to improve indicator and quality of services
Percentage of patients aged 0-15 readmitted to hospital within 28 days of being discharged	2011/12*	9.88%	10.26%	14.94%	6.40%		
	2012/13	N/A	N/A	N/A	N/A		
	2013/14	N/A	N/A	N/A	N/A		
	2014/15	N/A	N/A	N/A	N/A		
	2015/16	N/A	N/A	N/A	N/A		
	2016/17	N/A	N/A	N/A	N/A		
	2017/18	N/A	N/A	N/A	N/A		
	2018/19						
Readmissions within 28 days: age 16 or over	2011/12*	10.52%	11.45%	13.80%	9.34%		
	2012/13	N/A	N/A	N/A	N/A		
	2013/14	N/A	N/A	N/A	N/A		
	2014/15	N/A	N/A	N/A	N/A		
	2015/16	N/A	N/A	N/A	N/A		
	2016/17	N/A	N/A	N/A	N/A		
	2017/18	N/A	N/A	N/A	N/A		
	2018/19	N/A	N/A	N/A	N/A		
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	2017/18 data period: Apr17–Mar18 (latest published data as at 04/04/2019)	
	2016/17	67.7	69.6	86.2	58.9		
	2017/18	65.8	68.6	85.0	60.5		
	2018/19	No data	No data	No data	No data		
Staff Friends & Family Test Q12d (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2015/16	69%	65%	85.40%	46%	2018/19 data period: Survey in Sept18–Dec18 (latest published data as at 04/04/2019)	The actions to be taken are monitored by the improvement group Staff and Experience Improvement Group (delivery) and People and OD Committee (assurance).
	2016/17	64%	70%	84.80%	48.90%		
	2017/18	61%	70%	93%	42%		
	2018/19	65%	70%	87%	41%		

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) collect information on the effectiveness as perceived by the patients themselves of the NHS care they have received.

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

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

The figures we have reported in the figure below are the percentage of patients reporting an improvement in their health and well-being after their procedure as measured by each of the questionnaires.

The figure for the Trust is shown against the England average improvement rate for comparison.

Figure: Patient Reported Outcomes Measures

Procedure	EQ-5D		EQ VAS		Condition-specific measure	
	Trust %	England %	Trust %	England %	Trust %	England %
Groin						Data no longer published
Hip	88.0%	90.0%	67.8%	68.3%		
Knee	86.0%	83.0%	58.0%	60.0%		
Varicose veins						Data no longer published

PART 3

Other information

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

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

Indicator	2017/18	2018/19	National target (if applicable)	Notes/ Other information
Maximum 6-week wait for diagnostic procedures	0.56%	0.54%	<1%	Apr18–Mar19
Clostridium difficile year on year reduction	56*	56	<=3 per month	Apr18–Mar19
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	4*	6	0	Apr18–Mar19
MSSA	100*	164	TBC	Apr18–Mar19
Never events	6*	1	0	Apr18–Mar19
Risk assessment for patients with VTE	83.98%*	93.20%	>97%	Apr18–Mar19
Crude mortality rate	1.20%	1.09%	No target	April 18 to March 19
Dementia 1a: Case finding	0.80%	1.90%	>=90%	Apr18–Mar19
Dementia 1b: Clinical assessment	65.00%	27.90%	>=90%	Apr18–Mar19
Dementia 1c: Referral for management	11.00%	2.80%	>=90%	Apr18–Mar19
% patients spending 4 hours or less in ED	86.70%	92.8%	>=95%	Apr18–Mar19

Indicator	2017/18	2018/19	National target (if applicable)	Notes/ Other information
Number of ambulance handovers delayed over 30 minutes *(≤1hr)	506	664	< previous year	Apr18–Mar19
Number of ambulance handovers delayed over 60 minutes	16	14	< previous year	Apr18–Mar19
Emergency readmissions within 30 days - elective & emergency	6.90%	6.90%	<8.25%	Apr18–Mar19
% stroke patients spending 90% of time on stroke ward	89.3%*	90.80%	>=80%	Apr18–Mar19
% of women seen by midwife by 12 weeks	89.50%	89.80%	>90%	Apr18–Mar19
Number of written complaints	1031	898	No target	Apr18–Mar19
Rate of written complaints per 1000 inpatient spells	6.26	5.65	No target	Apr18–Mar19
Max 2 week wait for patients urgently referred by GP	82.30%	90.00%	>=93%	Apr18–Mar19 (unvalidated)
Max 2 week wait for patients referred with non cancer breast symptoms	90.40%	95.80%	>=93%	Apr18–Mar19 (unvalidated)
Max 31 days decision to treat to first definitive treatment	96.30%	94.60%	>=96%	Apr18–Mar19 (unvalidated)
Max 31 days decision to treat to subsequent treatment: surgery	94.80%	95.30%	>=94%	Apr18–Mar19 (unvalidated)
Max 31 days decision to treat to subsequent treatment: drugs	99.80%	99.90%	>=98%	Apr18–Mar19 (unvalidated)
Max 31 days decision to treat to subsequent treatment: radiotherapy	99.10%	99.30%	>=94%	Apr18–Mar19 (unvalidated)

Indicator	2017/18	2018/19	National target (if applicable)	Notes/ Other information
Max wait 62 days from urgent GP referral to 1st treatment (excl. rare cancers)	75%	74.80%	>=85%	Apr18–Mar19 (unvalidated)
Max wait 62 days from national screening programme to 1st treatment	92.20%	96.50%	>=90%	Apr18–Mar19 (unvalidated)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	Not reported in 2017/18	79.75%	92%	Mar 19
Delayed Transfer of Care rate	3.16%	3.15%	No target	Mar 19
Number of delayed discharges at month end	30*	43	No target	Mar 19

* 017/18 data is up to Feb-18 only

ANNEX 1

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

Statement from NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2018–19.

The past year has continued to present major challenges across both Health and Social care in Gloucestershire and we are pleased that GHNHSFT have worked jointly with partner organisations, including the CCG and colleagues within the local authority during 2018/19 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers.

Following the CQC inspection in October 2018 GHNHSFT were awarded an overall rating of 'Good' demonstrating the Trusts commitment to making improvements and developments from the previous CQC inspection.

The CCG wishes to add their congratulations to the Trust and commend all the hard work undertaken. The CCG recognise the comprehensive action plan that has been developed in response to the recent inspection and welcome the Trusts ongoing commitment to ensuring that the actions identified by the CQC inspection are being appropriately taken forward. The CCG have good visibility of the action plan and the progress that is being made against the deliverables.

The 2018/19 Quality Report is a comprehensive document which identifies how the Trust performed against the agreed quality priorities for improvement for 2018/19 and also outlines their priorities for improvement in 2019/20.

The report is open and transparent and it is noted that the Trust have acknowledged the areas where the achievements have not been realised as quickly as they had aimed for.

The CCG endorses the quality priorities that have been selected for 2019/20, whilst acknowledging the very difficult financial challenges and workforce pressures that GHNHSFT have to address in the coming year.

The CCG are particularly pleased to see as part of the quality priorities for 2019/20 work to include improving patient experience on discharge processes and improving mental health care for patients.

Continuing the trend of last year the Trust have again faced another very challenging winter period with unprecedented numbers of patients attending the Emergency Department. The CCG recognises

the significant pressures that GHNHSFT have experienced and commend them on the continued focus on the delivery of the 4 hour target during these testing times. The specific work around the Ambulatory Care Unit and the Surgical Assessment Unit is proving to have a significant impact on assisting timely patient assessment and overall experience for patients requiring urgent care.

The CCG understands the issues that have arisen in relation to the implementation of Trakcare and recognise the progress being made on the recovery plan, in particular the focused work on clinical validation. The CCG will continue to monitor how this work can improve the quality of care for patients and the effectiveness of communication with the wider health community in Gloucestershire.

The CCG are aware of a number of Serious Incidents that GHNHSFT have reported in the last year and the Never Event reports as they occur. The CCG continue to work with the Trust in relation to the management of these incidents/events in order to ensure that all learning and improvement actions are embedded within clinical environments and wider system learning is shared. The Trust's Safety & Experience Review Group, with representation and challenge from the CCG, continues to retain detailed oversight of all serious incidents, complaints and never events. There is a clear and robust system in place for ongoing monitoring of all action plans and recommendations.

The CCG are pleased to see the improvement plans that aim to reduce infection rates at GHNHSFT, in particular C-diff which continue to take effect. The enhancement of the infection control team has shown a significant impact on patient care. The CCG continues to work closely with the Trust to provide support where required and monitor improvements.

The CCG also work closely with the Trust to monitor the Influenza outbreaks and the promotion of staff flu vaccinations, acknowledging the significant efforts that went into last year's campaign. The CCG were extremely pleased to see such a large increase in the uptake of flu vaccinations amongst frontline staff.

The CCG acknowledges the content of the Trusts Quality Account and in particular the staff survey results. The CCG found the recent staff survey results again to be disappointing but recognise the wider work planned to address this. The CCG will continue to work with the Trust to deliver acute services that provide best value whilst having a clear focus on providing high quality, safe and effective care for the people of Gloucestershire.

Gloucestershire CCG confirms that to the best of our knowledge we consider that the 2018/19 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT. During 2019/20 the CCG will work with GHNHSFT, all stakeholders including the people of Gloucestershire, to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the acute hospital services provided to the residents of Gloucestershire and beyond.

Julie Symonds

**Deputy Director of Nursing
NHS Gloucestershire CCG**

Statement from Healthwatch Gloucestershire (HWG)

Healthwatch Gloucestershire welcomes the opportunity to comment on Gloucestershire Hospitals NHS Foundation Trust's quality account for 2018/19. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment. Over the past year we have continued to work with Gloucestershire Hospitals NHS Foundation Trust to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously.

We are pleased to see that the Trust continue to focus on the experiences of patients with mental health issues who are inpatients in the hospitals and those patients who have mental illness and access services through the Emergency Department. Mental health is a priority for Healthwatch over 2019/20 and therefore, we would be happy to share with the Trust, any relevant, anonymous feedback that we gather during our engagement.

The continued work on the Gloucestershire Safety and Quality Improvement Academy (GSQIA) is welcomed. In particular, the commitment to further expanding this into patient experience. We look forward to hearing more about the outcomes of the work over the coming year.

The Trust has continued to actively engage with and build on its existing relationship with local Healthwatch in 2018/19.

We acknowledge the Trust's continued commitment to patient and public engagement and their efforts to build on relationships with local Healthwatch and look forward to working with the Trust over the coming year to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

Bob Lloyd-Smith

**Chair of Healthwatch Gloucestershire
Steering Group**

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Quality Account 2018/20.

I welcome the report's openness in identifying where improvement is needed and the planned changes in response to these challenges.

The committee notes the dedication to implementing and embedding the 'Getting it Right First Time' standards within the Trust which is reflected in the recruitment of a new Clinical Lead and a Service Improvement Lead to undertake this work.

The Committee recognises that this is a period of substantial change for the Trust with a number of service reconfiguration pilots and temporary changes in progress. For example reconfiguration of estate for the Urology service is almost complete enabling completion of a number of actions including timely assessment for patients with suspected cancer.

The committee will look to scrutinise these proposals and act as a critical friend in relation to these changes. Members have expressed concern about the way in which change has been communicated and how it fits with the 'Getting it Right First Time' model.

It is clear that good workforce planning is important in ensuring the success of these changes to ensure better outcomes for patients. The report outlines the steps taken in 2018/19 to identify the supply and demand requirements across departments and the next steps for 2019/20 identifying the intention to further improve long term workforce planning.

It is pleasing to see that progress has continued to be made in terms of embedding the Trust's approach to Quality Improvement with this being recognised externally by being shortlisted for 2 Health Service Journal awards.

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

Cllr Carole Allaway Martin

Chair
Health and Care Scrutiny
Overview and Committee

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

We have been engaged by the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of Gloucestershire Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

This report is made solely to the Trust's Council of Governors, as a body, in accordance with our engagement letter dated 14th May 2018.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our examination, for this report, or for the conclusions we have formed.

Our work has been undertaken so that we might report to the Council of Governors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the Trust.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- ◀ % of patients with a total time in A & E of 4 hours or less from arrival to admission, transfer or discharge
- ◀ % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and Ernst & Young LLP

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- ◀ the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' (published on 6 November 2018), which is supported by NHS Improvement's 'Detailed requirements for quality reports 2018/19' (published on 17 December 2018) issued by NHS Improvement;
- ◀ the Quality Report is not consistent in all material respects with the sources specified in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19' and
- ◀ the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the 'Detailed Guidance for External Assurance on Quality Reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the other information sources detailed in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19'.

Continued overleaf

These are:

- ◀ Board minutes for the period April 2018 to 24th May 2019;
- ◀ Papers relating to quality reported to the Board over the period April 2018 to 24th May 2019;
- ◀ feedback from commissioners;
- ◀ feedback from governors;
- ◀ feedback from local Healthwatch organisations;
- ◀ feedback from Overview and Scrutiny Committee;
- ◀ the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- ◀ the national patient survey, dated 13/6/18;
- ◀ the national staff survey; dated November 2018;
- ◀ the Head of Internal Audit's annual opinion over the trust's control environment, dated 1/4/2019; and
- ◀ Care Quality Commission inspection report.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Gloucestershire Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Gloucestershire Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included, but were not limited to:

- ◀ evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- ◀ making enquiries of management;
- ◀ limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- ◀ comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2018/19' to the categories reported in the Quality Report; and
- ◀ reading the documents.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Report. The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance. The scope of our assurance work has not included governance over quality or non-mandated

indicators, which have been determined locally by Gloucestershire Hospitals NHS Foundation Trust.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Gloucestershire Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement;
- the Quality Report is not consistent in all material respects with the sources specified in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19'; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement .

Maria Grindley
Ernst & Young LLP,
Apex Plaza, Forbury Road, Reading, RG1 1YE

28th May 2019

The maintenance and integrity of the Gloucestershire Hospitals NHS Foundation Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

ANNEX 2

Statement of directors' responsibilities for the quality report

Statement of directors' responsibilities for the Quality Account

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 2018/19 and supporting guidance Detailed Requirements for Quality Reports 2018/19 and; 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 2018 to March 2019
- ↳ papers relating to quality reported to the board over the period April 2018 to March 2019
- ↳ feedback from commissioners dated 02/05/2019
- ↳ feedback from governors dated 28/04/2019
- ↳ Our Governors have contributed to identifying the priorities for next year 2019/20 and have also provided us with feedback on this year's Quality Account.
- ↳ feedback from local Healthwatch organisations dated 09/05/19
- ↳ feedback from overview and scrutiny committee dated 01/05/2019
- ↳ the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2018
- ↳ <https://www.gloshospitals.nhs.uk/contact-us/feedback-and-complaints-pals/>
- ↳ the 2017 national patient survey published by CQC 13/06/2018 (<https://www.cqc.org.uk/provider/RTE/surveys>)
- ↳ the 2017 national staff survey published November 2018
- ↳ <https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/>
- ↳ the Head of Internal Audit's annual opinion of the trust's control environment dated 01/04/2019
- ↳ CQC inspection report dated 07/01/2019: <https://www.cqc.org.uk/provider/RTE>

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

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

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

The trust is currently not reporting performance against the indicator Referral to Treatment times (RTT) due to the implementation of a new digital patient administration system TrakCare, the directors have a plan in place to remedy this and return to full reporting by May 2019.

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 Lee, Chief Executive

Peter Lachecki, Chair

Glossary

Care bundle: A care bundle is a set of clinical interventions that, when used together, significantly improve patient care.

Care Quality Commission (CQC): the independent regulator of health and social care in England

CGH: Cheltenham General Hospital

Chemotherapy: This is a cancer treatment which uses medication to kill cancer cells.

Clinical Commissioning Group: In 2013, our commissioners became the Gloucestershire Clinical Commissioning Group. Commissioning is the process of assessing the needs of a local population and putting in place services to meet those needs. Commissioners are those who do this and who agree service level agreements with service providers for a range of services.

Clinical outcomes: These are broadly agreed, measurable changes in health or quality of life that result from the care received.

CQUIN: This stands for the Commissioning for Quality and Innovation payment framework. The motivation behind CQUINs is to reward excellent performance by linking a proportion of providers' income to the achievement of local quality improvement goals.

Electronic Health Record (EHR): this is a digital version of a patient's health record. A health record in our hospital will contain all clinical information about a patient's care, including x-rays, treatments received or ongoing, allergies, medications, long-term conditions, test results, personal data such as name and date of birth and admission and discharge notes.

Emergency Care Data Set: this is a new collection of data which will help us understand how and why people access urgent and emergency care over the winter to help improve planning and reduce pressure.

Emergency Department: Otherwise known as A&E

Emergency laparotomy: this is a surgical operation that is used for people with severe abdominal pain to find the cause of the problem and in many cases, to treat it.

GRH: Gloucestershire Royal Hospital

Health Foundation: this is an independent charity committed to bringing about better health and healthcare for people in the UK.

Healthy Workplaces: This is a toolkit which aims to support NHS organisations to improve staff health and wellbeing.

Healthwatch Gloucestershire: Healthwatch was established in April 2013 and is the consumer champion of health and social care in England, giving children, young people and adults a powerful voice

HCOSC: Gloucestershire Health and Care Overview and Scrutiny Committee. This is a body which scrutinises the decisions of local health organisations

Infection prevention and control interventions: These are steps taken by our infection prevention and control team to prevent the spread of infection.

Length of Stay (LOS): This is the amount of time that a patient stays in a hospital bed from the point of admission to the time they are discharged.

Nerve blocks: These are used to treat and manage pain and work by interrupting the pain signals sent to your brain.

Oncology: This is a branch of medicine which deals with the prevention, diagnosis and treatment of cancer. A medical professional who practices oncology is an oncologist.

Pathway: This is the route that a patient will take from their first contact with an NHS member of staff, such as a GP, through referral to hospital, to the completion of their treatment.

Peri-operative: This generally refers to the three phases of surgery – preoperative, intraoperative and postoperative. The goal of perioperative care is to provide better conditions for patients before, during and after their operation.

Public Health England: This is an executive agency of the Department of Health. Its formation in 2013 came as a result of the reorganisation of the NHS in England as outlined in the Health and Social Care Act (2012).

Site management: This is a team of staff who manage the bed availability across our hospitals.

Tissue viability: This is a clinical specialty that considers all aspects of skin and soft tissue wounds, including surgical wounds, pressure ulcers and all forms of leg ulceration.

World Health Organisation: This is a specialised agency of the United Nations that is concerned with international public health.

