Gloucestershire Hospitals
NHS Foundation Trust

AGENDA

Meeting: Council of Governors - Public

Date/Time: Wednesday 17 June 2020 at 14:30

Location: Virtual meeting via Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and Apologies	Chair		14:30	
1.	Declarations of Interest	Chair		14:31	
	ITEMS FOR DISCUSSION				
2.	Chair's Update	Peter Lachecki	Information	14:35	
3.	Report of the Chief Executive	Deborah Lee	Information	14:40	YES
	REPORTS FROM BOARD COMMITTEES				
4.	Chairs' Reports from: - Finance and Digital Committee - Estates and Facilities Committee - People and Organisational Development Committee - Quality and Performance Committee - Audit and Assurance Committee	 Rob Graves Mike Napier Balvinder Heran Alison Moon Claire Feehily	Assurance	14:50	YES
5.	Annual Quality Account 2019/20	Steve Hams	Assurance	15:15	YES
6.	Digital Quality and Benefits Report	Mark Hutchinson	Assurance	15:25	YES
7.	Covid-19 Temporary Service Change Update	Simon Lanceley	Information	15:40	YES
	ITEMS FOR INFORMATION				
8.	Governor's Log	Sim Foreman	Information	15:55	YES
9.	Any Other Business	Chair		16:00	
CLOSE				16:05	

Date of the next meeting: Wednesday 19 August 2020 in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital at 14:30

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS - JUNE 2020

REPORT OF THE CHIEF EXECUTIVE

1.1 As the number of patients with COVID-19 has reduced significantly in our hospitals, the focus for the last month has been preparing for the resumption of services that were paused, or more limited, during the first phase of the pandemic. At an extraordinary meeting (in public) on the 2 June, the Board considered and approved the final proposals for temporary service changes in response to the next phase of the pandemic. The overarching goals of these changes are to reduce the risk of transmission of COVID-19 to patients and staff, to support the restoration of services and increases in activity, to remain prepared (at all times) for a subsequent surge and to promote public confidence in the safety of both our hospitals. The Board were assured that the model proposed, in contrast to others explored, provided the greatest opportunity to achieve these goals.

1.2 Understandably, there has been a degree of public concern about whether these changes are temporary, and not least because of the *One Gloucestershire Fit for the Future* programme which (although currently paused) is also proposing service change, some of which is similar to that being proposed on a temporary basis. In Gloucestershire, the Integrated Care System (ICS) partners have a Memorandum of Understanding (MOU) with the Gloucestershire Health Overview and Scrutiny Committee (HOSC) which sets out our collective approach to service change and these COVID-19 proposals fall under the emergency (temporary) service change component and are therefore subject to review after an initial three months. Commitments have been sought (and provided) with respect to the future of Cheltenham Emergency Department and its restoration to a Type 1 service during day time opening.

1.3 As described above, being prepared for a further surge of the virus is critical and especially so following the Government's latest announcement of the Reproduction (R) number which shows the South West to have the second highest R number of all the English regions at an average of 1, in a range of 0.7 to 1.3. In light of this context, the Trust continues to proceed with caution as described below.

1.4 Changes were implemented from Tuesday 9 June 2020 and clear public communications were a key priority, alongside supporting staff as they accommodate changes to the way their services are delivered. A contemporary update will be provided to Governors at the Council meeting.

1.5 As the Government begins to ease its lockdown measures, the Trust is also adapting to different ways of working and new guidance has been issued on a number of fronts, including the wearing of face masks and face coverings for non-clinical staff and visitors. From Monday 15 June, when non-clinical staff are not working in socially distanced areas, such as their offices, they will be required to where a surgical face mask whilst any visitors (including outpatients) will be required to wear face coverings. The requirement for Personal Protective Equipment (PPE) in clinical areas is unchanged. With respect to patient visiting, our approach remains one of caution with restricted visiting in place however visiting on compassionate grounds continues to be facilitated, wherever safe to do so.

1.6 Our communications team have been working closely with colleagues in infection prevention and control (IPC) to refresh our campaign aimed at ensuring all staff, patients and visitors to the Trust adhere to best practice with respect to social distancing, hand hygiene and personal protective equipment. A range of eye catching

materials will be appearing around our sites in the coming week and can be previewed at Appendix 1.

1.7 In addition to our communications campaign, we are also making physical changes to our wards and departments in support of good infection prevention and control practice. This will include the introduction of transparent screens between bed spaces which will enable us to restore many of the beds removed during the first phase of the pandemic, as our activity increases, whilst maintaining our current very low levels of nosocomial (hospital acquired) COVID-19 transmission and the removal of additional desks and workspaces from administrative offices to ensure staff can work effectively whilst being socially distanced – if the latter is possible, there is no need for staff to wear face masks

1.8 In my last report, I updated on our progress to offer COVID-19 antigen testing to staff and patients; a swab test that confirms whether a person currently has COVID-19. In the last week, we have also led the way through the roll out of COVID-19 antibody testing; a blood test that confirms that someone has previously had COVID-19, through the detection of antibodies. Importantly, the antibody test does not confirm whether an individual has developed immunity to future exposure to the virus but it is providing important information to aid with developing the understanding of the spread and pattern of the disease. It is anticipated that we will test all NHS staff throughout the county, within the next four to six weeks. Testing for other key workers and patients is expected to follow.

1.9 On Thursday 28 May 2020, the Government announced its programme to track, trace and isolate anyone who is confirmed as COVID-19 positive and anyone who has come into close contact with them. Given the potential implications on the availability of NHS staff, associated with the 14 day isolation requirements, NHS organisations have been working closely with Public Health England (PHE) to understand the impact of the programme on NHS and other staff who may be regularly in contact with COVID-19 positive patients. The implications on the workforce, once the programme is widely rolled out, is not yet understood but we are preparing for a range of scenarios. Some Trusts have already reported a considerable impact.

1.10 In recent weeks, we have taken every opportunity to join national celebrations acknowledging the huge contributions of individual staff groups. In June we have already celebrated our dieticians and biomedical scientists – the latter group having made a unique contribution to our COVID-19 response through the establishment of a COVID laboratory testing unit. At the beginning of the month we also had the chance to thank and celebrate another special group of colleagues - our volunteers; many of whom have not been so visible in recent times due to the impact of the pandemic. They have been hugely missed by us all and we look forward to welcoming them back to our hospitals, when the time is right.

1.11 Last month I reported on considerable reductions in the number of patients presenting to our emergency departments, to GP practices and the numbers of suspected cancer patients being referred into the hospital. Activity continues to increase but we remain some way off our pre-COVID levels in elective care. A national campaign, supported by a local campaign, ran in late May to communicate the key message that the “NHS is open for business” and this will continue to run over the coming weeks. Analysis is underway to better understand if particular groups of patients or communities are likely to have been more adversely impacted than others and to ensure this knowledge influences the pattern of service recovery. However, initial analysis has shown that members of the BAME community had hospital admissions rates in line with expected and positively, BAME patients have experienced a considerably lower mortality rate than expected. This information has been very positively received by BAME colleagues in the Trust given the national picture which has indicated that BAME communities are at greater risk of poor outcomes from COVID-19. Work on other groups who we know experience health inequalities, is also underway. Of particular note, there is a growing

focus on the model of recovery in relation to mental health services and what is expected to be a new, and significant, burden of disease presenting as direct consequence of the pandemic.

1.12 Finally, no CEO update in current times would be complete without expressing a huge debt of gratitude to my colleagues throughout the Trust. Having moved on from the first phase response to the pandemic, colleagues have equally embraced the need to make further changes through the temporary reorganisation of some of our services to ensure that, should a second surge occur, we do not experience the same degree of service disruption that was an inevitable part of the first phase of the pandemic. We remain committed to maintaining support for staff health and wellbeing (in all its current guises) and are immeasurably grateful for the contribution of local communities and colleagues throughout the organisation, including colleagues in Gloucestershire Managed Services, and the wider health and care system.

THANK YOU.

Deborah Lee
Chief Executive Officer

10 June 2020

NHS
Gloucestershire Hospitals
NHS Foundation Trust

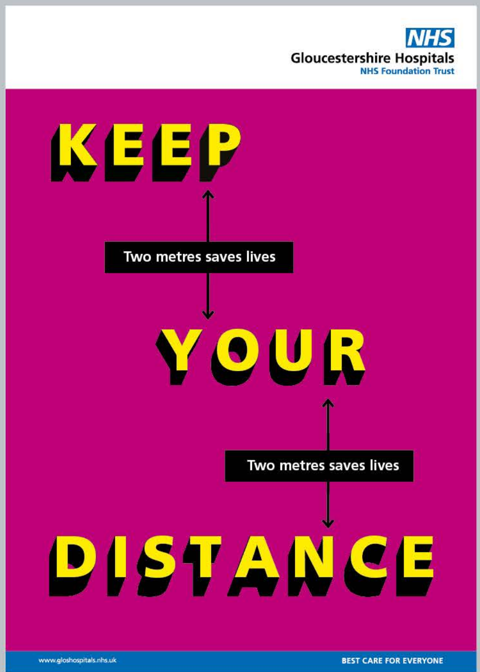
Social Distancing, Hand Washing and PPE Campaign

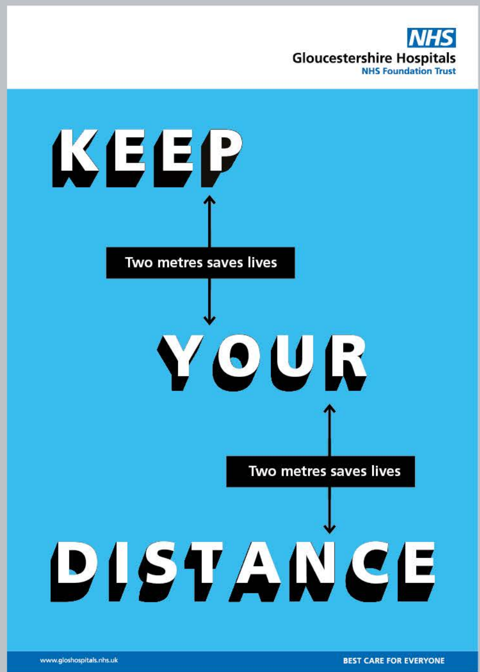
Version Two

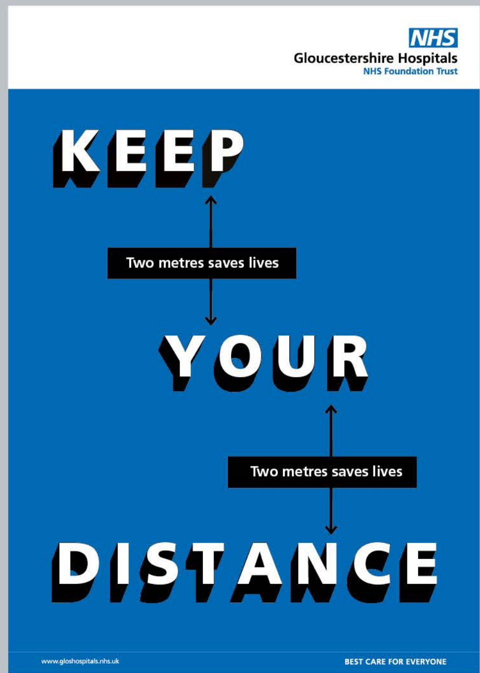
June, 2020

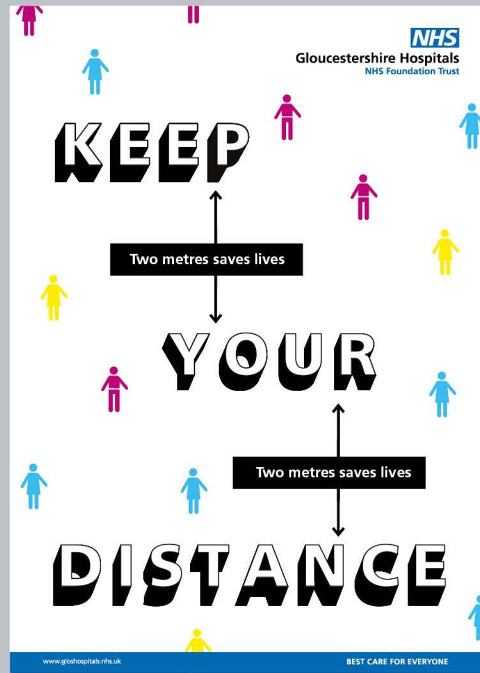
Social Distancing

Social Distancing: Typographic Posters







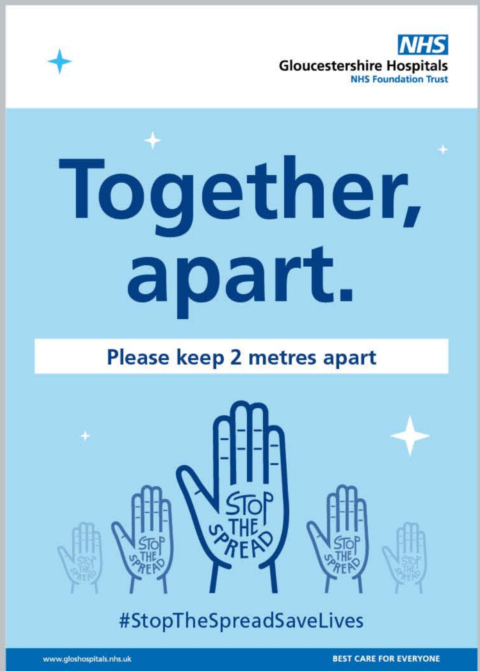


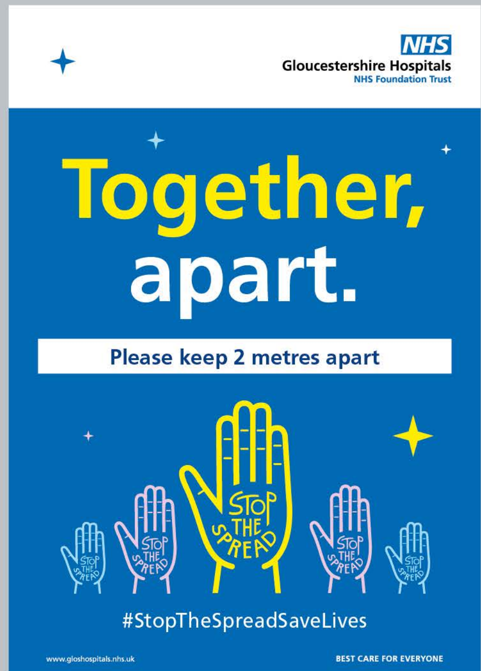
↑ We have checked the contrast ratio using a tool developed by the Government Digital Service and have found them to be of sufficient contrast

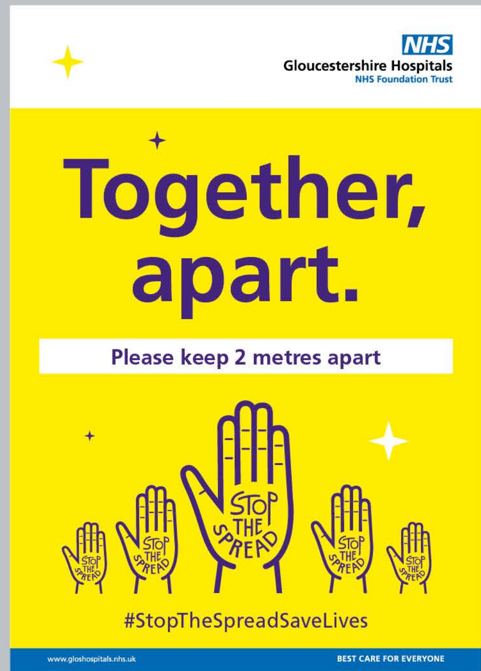
Social Distancing: 2 Metres Posters

↑ The removal of the 3D elements in the '2' has been trialled and resulted in a less legible and less impactful design on larger scale formats (such as a A3 & A2 posters). However the '2' will be flattened on smaller scale elements to ensure that it can be read clearly.

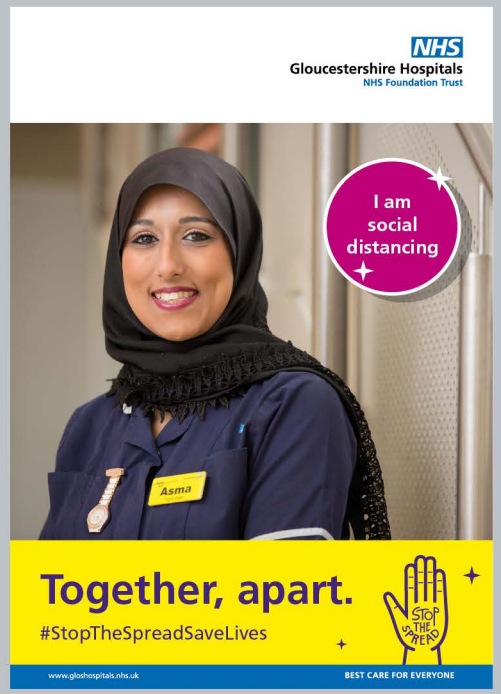
Social Distancing: Typographic Posters

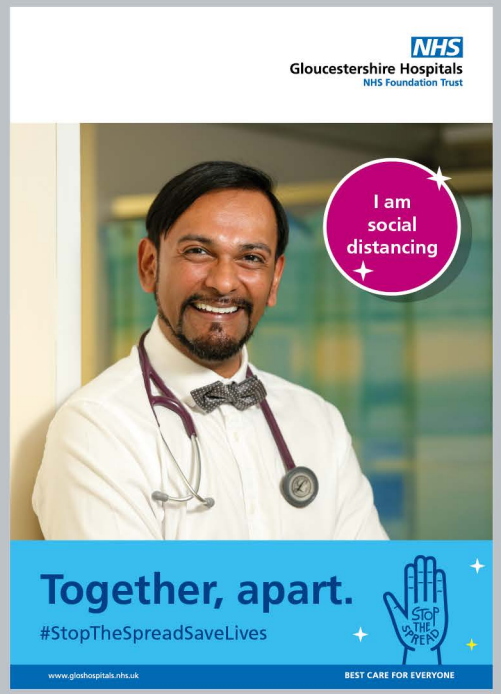




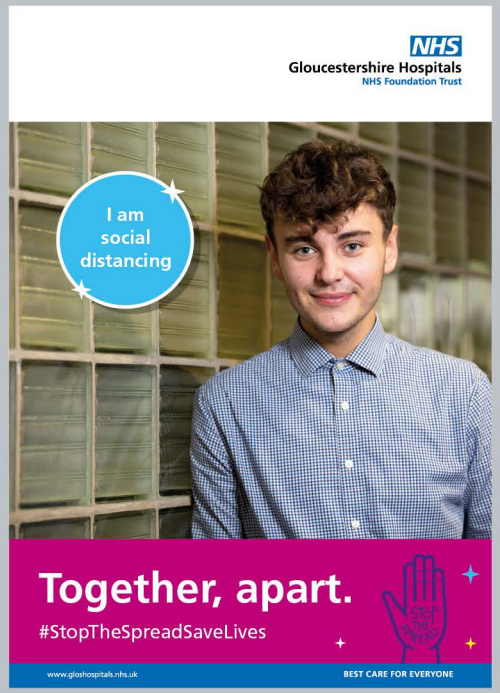


Social Distancing: Photographic posters



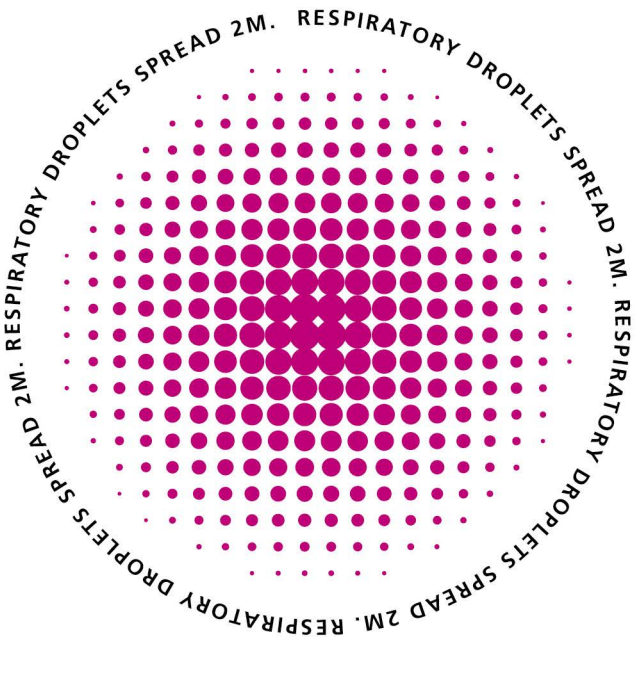


↑ Clinical staff



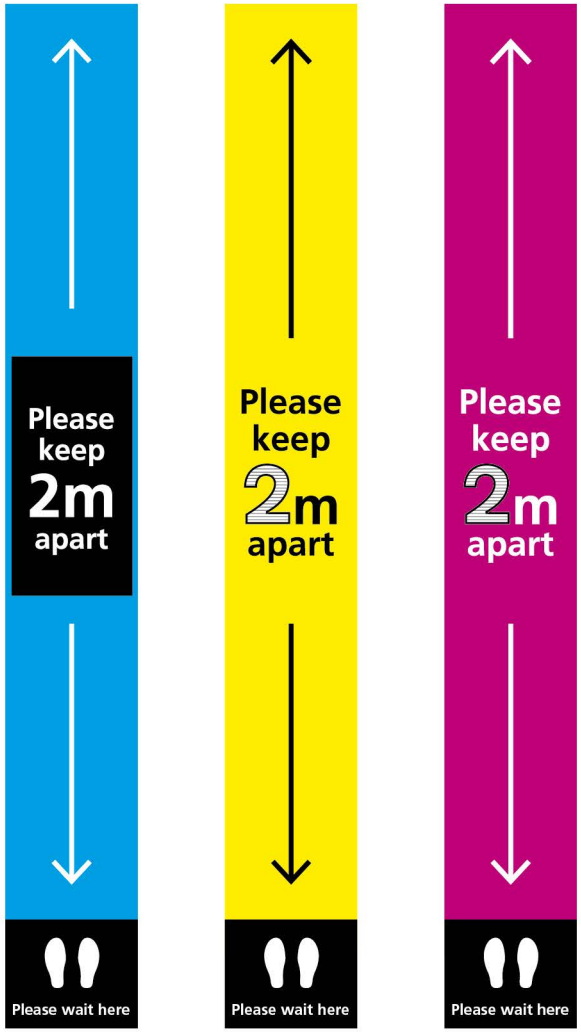
↑ Non-clinical staff

Round Floor Vinyls

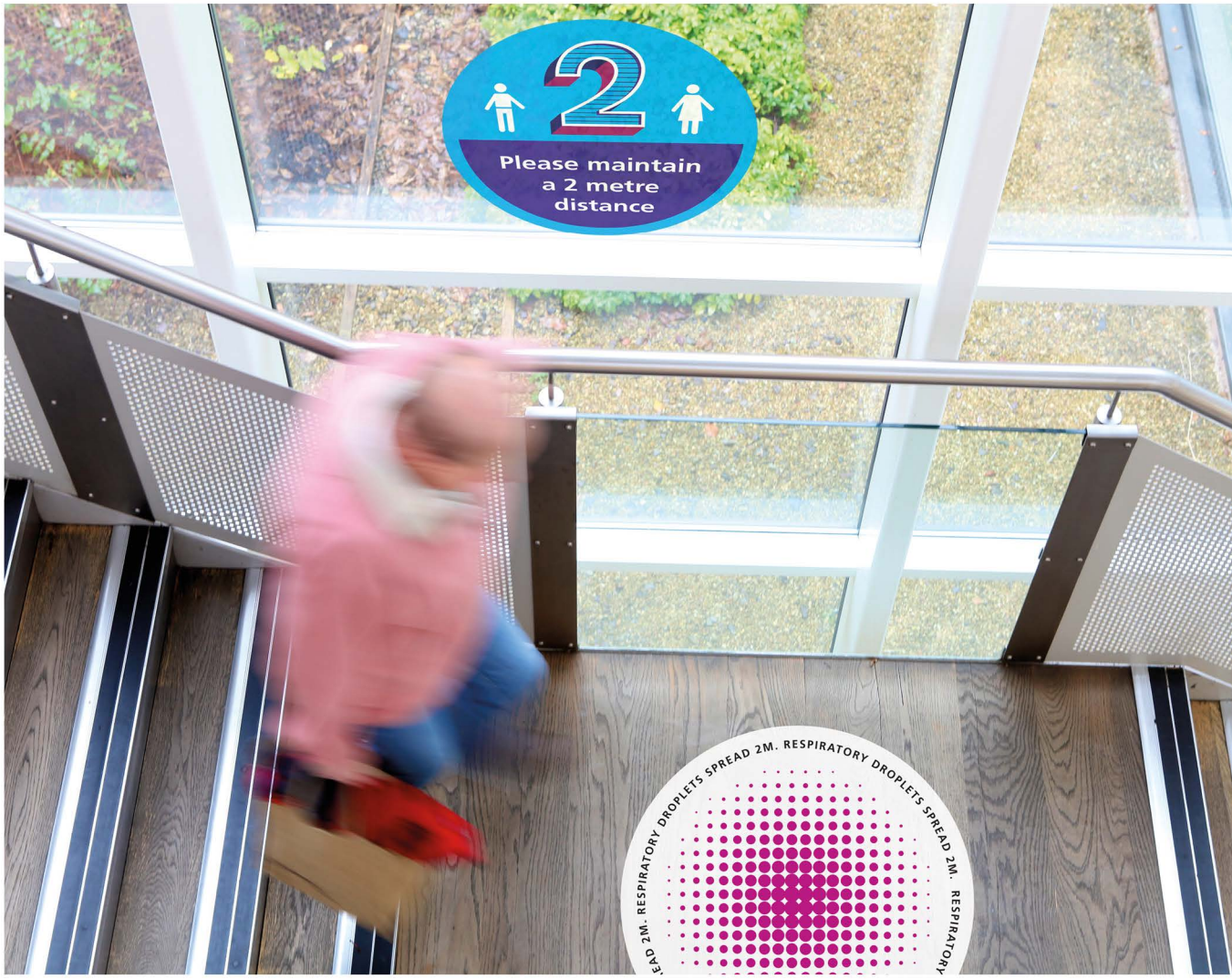


Floor Vinyls (in situ)

2 Metre, long floor vinyls



Social Distancing - Window Sticker



Social Distancing (in situ)

Social Distancing - Chair Cover

Hand Washing

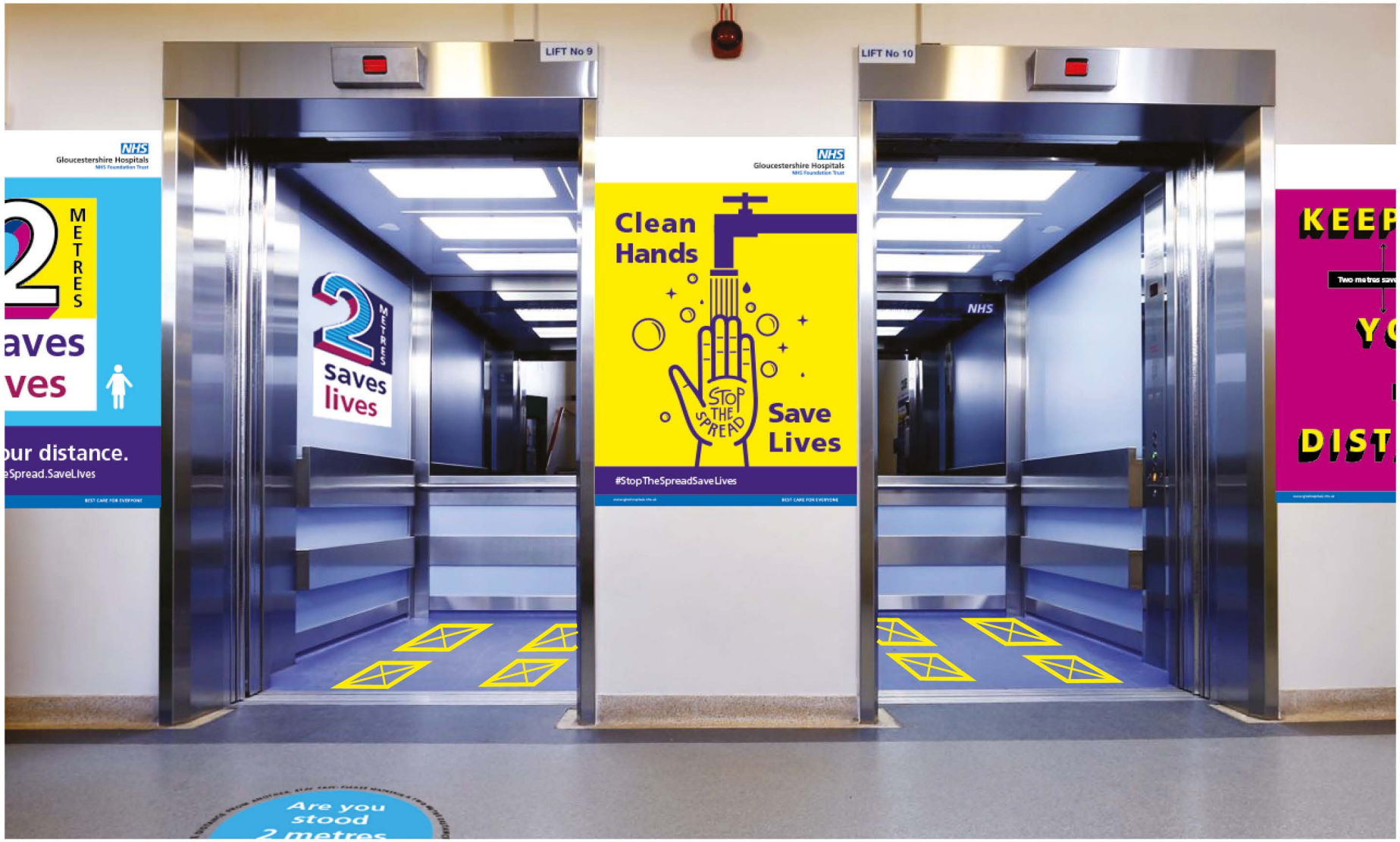
Hand Washing Posters

↓ Staff facing communications: **Hand sanitiser**

↑ Patient facing communications: **Soap and water**

Hand washing (in situ)

Overall collateral



Thank you

Kate Jeal
Communications Manager

Ottilie Baker
Graphic Designer

Duncan Stevenson
Senior Graphic Designer

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO MAIN BOARD – JUNE 2020

From Finance & Digital Committee – Rob Graves, Non-Executive Director

This report describes the business conducted at the Finance and Digital Committee meetings held on 28 May 2020 and 03 June 2020, indicating the NED challenges, the assurances received, and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
COVID-19 Update	The Finance Director updated the Committee on the latest directives concerning COVID-19 cost collection and reimbursement and agreed to share the fact sheet that had been disseminated to Divisions to ensure clear communication and compliance. The Committee was advised of the revised capital expenditure approval requirements and the resulting communication with NHSE/I aimed at establishing a quicker process to address urgent schemes.		The Committee was assured of the Trust's compliance with national reporting requirements and entirely satisfied with the grip on the process.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Financial Performance Report	The Finance Director presented the Financial Performance Report to the Committee, highlighting that: - The Trust would breakeven for Month 1-4, due to national income changes during the Covid-19 pandemic. This was by way of 3 income streams: 1) A block payment of money from commissioners based on the average monthly amount paid up to month 9 in 2019/20, uplifted for inflation 2) A top up payment so that the Trust received enough income to cover its expected average costs (based on an average of M8-10 in 2019/20) 3) A true up payment for the difference in	With lower levels of regular activity were spending levels appropriate? Agency spend while lower than 2019 is above budget – why? Will agency spend in May be lower? Can a detailed review of debtors over 120 days be prepared? Overall the Committee recorded their appreciation of the level of detail produced in	The Finance Director is satisfied that spending levels are generally appropriate and opportunities are not being missed. It was noted that a significant proportion of the costs e.g. pay, are fixed in the short term. This will be the subject of continued scrutiny. While divisions are encouraged to recruit substantively this has not yet been achieved at budgeted levels. Additionally the COVID-19 requirements and associated re-configuration had influenced agency. Yes – but note that the message from regulators has been to focus on patient care and staff safety not savings	To be added to the work plan

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	funding streams received vs actual costs - To maintain clarity, the Trust would report against two positions: 1) The Trust's internal financial plan for 2020/21 (business –as-usual budget vs actuals) 2) The NHSE/I average run rate (always breakeven) - For Month 1 the Trust was reporting a breakeven position against the NHSE/I run rate, and a £432k surplus against budget. Both of these numbers included the costs of Covid-19 in the accounts. - The Trust was potentially looking at a £3.6m deficit compared to the plan for breakeven. This assumed no changes to activity or cost bases and was	exceptionally demanding circumstances		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	merely to provide a view of how far adrift from the Month 12 expected breakeven position the current run-rate is. - The Trust's contribution toward COVID-19 expenditure was 400k. - The cash balance is unusually high because of favourable timing of receipt of the April block payment. - Excluding COVID-19 expenditure all divisions had exercised good cost control.			
Capital Programme Update	The Finance Director presented the draft capital programme for 20/21 and the detailed approach to funding that will be applied to comply with NHSE/I directives. The level of spend and funding approach were approved.	Are Gloucestershire Managed Services fully aligned with the programme? Are challenges from the regulator expected on any individual schemes?	Yes – GMS are fully involved on the Infrastructure Group and are aligned with the plans although would prefer additional funds allocated to backlog maintenance Challenges are not expected as Public Dividend Capital has been allocated	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Cost Improvement Programme Update	The Cost Improvement Programme (CIP) update was presented to the Committee, highlighting that: - At Month 1 the Trust had delivered £168k of CIP against the Trust's Cost Improvement target of £513k. Within the month this was an under performance of £345k. - Under-delivery of CIP for Month 1 was partly due to the impact of COVID-19 on the delivery of implemented schemes as well as stretched operational resources and capacity to be able to drive the implementation of further planned schemes. - To date £6.7m of divisional schemes and £6.6m of Trust wide schemes and further opportunities had been identified leaving an unidentified gap of £2.5m. Of the identified schemes and opportunities,	What is the consequence of missing the target in the first month? Acknowledging the need to not lose focus on CIP initiatives can the top 6 schemes be covered in detail in the next report	The block funding arrangement in place for the first 4 months of the year mean there is not an adverse consequence of missing this target. This detail will be incorporated in the next report	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	currently £2.9m were rated green and a further £3.2m rated amber indicating a risk of full delivery in year due to operational priorities. The Trust's annual CIP plan was made up of 53% recurrent and 47% non-recurrent financial savings. - The CIP team would be investigating how to monetise the silver linings of COVID-19.			
Confirmation of 2019/20 PSF/FRF Achievement	Formal documentation recording the Trust's 19/20 financial accomplishment which resulted in award of an additional £1.5 million Financial Recovery Fund (FRF) allocation. This results in the Trust reporting a surplus position for the year 19/20.	Acknowledged by the Committee to be an excellent outcome as a result of the efforts of the whole organisation.		
Digital Programme Report	The IT Director presented a detailed programme update by major project together with a sub-report on the quality and benefits impact of the Sunrise Electronic Patient Record (EPR).	The early production of the data driven report on the Sunrise EPR system was praised. Given the productivity improvements it is highlighting what is the expected impact	Work is underway to fully assess the quality and productivity impacts and correlate them to the Trust's strategic objectives and Journey to Outstanding.	Further iterations of this analysis expected to cystallise the impact evaluation.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
		on staffing levels? What is being done to ensure understanding of the positive impact throughout the organisation? The post implementation analysis shows a continuing proportion of inefficient activities - what can be done to lower this level?	There is already widespread awareness of and enthusiasm for the next stages. Given that the implementation of EPR was brought forward and has only recently been completed it is acknowledged that work is still to be done on identifying and eliminating inefficiencies arising from paper and telephone based practices that pre-date the system	
Order Commncations	The IT Director presented a paper on Order Communications to the Committee to provide an update on the impact of COVID-19 on the proposed expansion of Sunrise EPR to include radiology and pathology requests and results (known as order comms).In particular, MH highlighted that: - The planned programme of process mapping had been delayed due to COVID-19 and the availability of clinical staff	Full acceptance of the importance of the initiative and the reality of the situation associated with the loss of momentum arising from the COVID-19 demands. Agreement in principle to the proposed alternative approach.		Detailed plan to be presented ASAP

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	across the organisation, but particularly in Pathology. - Successful implementation of Order Comms was also reliant on the delivery of several other major digital upgrades. These included a new Pathology Lab system called TCLE (replacing IPS), and further upgrades to TrakCare. The Trust needed to consider alternative ways to deliver an effective order comms programme this year, implemented in stages, to reduce the risk of failure from lack of staff engagement and resource, during the COVID-19 pandemic.			
June 3rd Meeting **Financial Implications of the Temporary Changes**	Under delegated powers the Committee scrutinised the analysis of the financial implications arising from the proposed temporary service change in response to the next phase of the COVID-19 pandemic. A narrative supported by detailed financial appendices was	Detailed questions covering: - The methodology used to establish the cost impact - The basis of the base case - The reason for changes in the iterations of the	The Committee concluded that it was able to assure the Board that the financial implications of the change are both reasonable and affordable	Monthly Financial Report to include analysis to monitor the actual impact

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
	presented by the Finance Director.	analysis - The robustness of the staffing assumptions - The impact on capital expenditure - The impact on. Gloucestershire Managed Services		

Rob Graves - Finance and Digital Committee

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – JUNE 2020

From Estates and Facilities Committee Chair – Mike Napier, Non-Executive Director

This report describes the business conducted at the Estates and Facilities Committee held 28 May 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
COVID-19 Update	Trust reported that GMS had provided great support throughout the pandemic crisis. Learning had been taken around stock management processes within Materials Management. Committee had commended the GMS role and response.	What is the morale and wellbeing of the GMS staff, and are they being supported in the same way as Trust staff?	GMS Chair reported that regular welfare checks and calls had taken place, and that morale remained high. There had been peaks in staff absences as staff self-isolated. Two GMS staff had been hospitalised and both were recovering.	
GMS Chair's Report	GMS Board had agreed a 5% cost-of-living increase for staff on GMS terms and conditions effective 1 April 2020. This was the first pay increase since GMS was formed in early 2018.	How could Committee be assured that the right people were receiving the right levels of pay? How would this award be communicated and how would it be received by staff on other terms?	An executive group had been established within GMS to ensure focus on workforce T&Cs over the coming year. There had been significant discussion within GMS on how to communicate this and HR are being consulted on wider messaging.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
GMS Contract Management Group (CMG) Report	All contractual KPIs were being met, but that cleaning remained a key area of focus. The PFI life cycle costs are under review, to assess actual spend versus budget/contract.	What cleaning standards are being followed – Trust's or National? This was welcomed, and could there be a similar review of the parking contract to provide assurance on effective contract management and value for money?	Standards are currently the Trust standards, in line with contract. The gap to national standards would probably incur a cost of c. £1mln to close.	Committee asked for this matter to be referred to the Quality and Performance Committee to consider whether they deemed it sufficient for higher risk areas to be in the action plan. These two contracts' life cycle spend will be reported to Committee via the CMG at a future meeting.
Strategic Site Development Programme	The Outline Business Case had been approved by the Board in January and had subsequently been submitted to NHSE/I. The OBC was due for approval in May, but this has now slipped to June. In the meantime, the Full Business Case is being progressed.	In the light of COVID-19 changes in working arrangements, will there be any material impact on design scope? Is there learning from remote and virtual working that could positively impact on ICS Estates	At this stage, existing scope will be retained, but there will be an internal checkpoint to reassess the situation prior to handover to Kier. There has been some shared learning related to social distancing and the impact of flexible working, but this requires further development.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		Strategy?		

Mike Napier
Chair of Estates and Facilities Committee
4 June 2020

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – MAY 2020

From the People & Organisation Development Committee Chair – Balvinder Kaur Heran, Non-Executive Director

This report describes the business conducted at the People and Organisational Development Committee on 28 April 2020 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	New linked risks relating to recruitment and retention from Divisions added to the risk **C2803P&OD:** relating to retention. COVID risks reviewed	Will there be a risk relating to BAME staff and the emerging evidence about the disproportionate impact of COVID-19 Why is there no COVID- risk relating to mental health post the pandemic?	Committee was assured at the dynamism of the risk register Data suggests that there is no disproportionate impact of COVID-19 on in patients in the county but there is anxiety amongst staff and comms are being prepared to reassure staff The risk is in draft and has to be reviewed by the People and OD department before being added to the risk register.	RG to progress risk to Finance and Digital Committee

	GMS risk of Industrial Action remains unchanged Datix risks have been separated into 2 relating to system capability and quality of data	How are GMS staff engaged and feeling at this time? Is the business case to resolve the system issue still underway	GMS colleagues are part of the POD teams. The HR team hold weekly meetings with Staff side. Staff are engaged by the Trust and also GMS management. The case is in the final draft and will be submitted to the IMT group for review initially	
COVID-19 People and Organisational Development Response	The Committee complemented the People and OD teams on the support provided for colleagues and were assured by the programmes of work and governance.	How do we ensure we build on the solutions in non COVID time?	The Senior Leadership Team will assess the services provided and consider which colleagues value and the feasibility and affordability of continuing with some. This exploration will also link to Divisional and Trust wide priorities for the future	

		What worries you regarding the People and OD response to COVID ?	Colleague expectation vs ability to deliver when the Pandemic ends and impact if the Trust cannot meet new service standards consistently. Also the impact on mental health.	
Staff Survey Results and Inclusion plan	Key successes outlined and overall a positive picture	How can we improve medical and dental engagement?	There is a plan to engage Medical and dental staff under a unique piece of engagement and research. This was paused with COVID.	
		Do we understand what staff mean when they say they are being bullied and harassed?	Links to how staff are treated in terms of civility, or lack of. This is why 'civility saves lives' and new behaviours are so important to embed including the description of what staff do not want to experience in the workplace.	A specific agenda item on bullying and harassment across demographics will be scheduled in the future
	Agreed two year plan to enable better traction 4 priorities welcomed	How do we ensure we do not lose sight of issues during COVID 19 How can we check the pulse of the staff now in COVID-19.	Issues on action plans will be tracked and some matters are addressed as part of business as usual, such as driving safety culture through centralising risk resources. The Senior Leadership Team	

		It would be interesting to see how strands have moved on with COVID such as colleague engagement	has considered how we could conduct such a survey and the best time to do so and content.	

Board note/matter for escalation

None
Balvinder Kaur Heran
Chair of People and OD Committee, 28 April 2020

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – June 2020

From Quality and Performance Committee – Alison Moon Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee held on 27th May 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Risk Register including comprehensive COVID risk report	One risk added regarding risks of lab failure due to ageing equipment. Two risks downgraded regarding risk of poor patient experience and safety issues due to lack of capacity in ED.	Is the system holding any risks concerning either delayed treatment or residential care home position and if so what mitigations in place to e.g. resource backlog activity? How may we see the risks of clinical harm play through into the register?	Commitment to review and refresh the system risks at next ICS executive meeting Any harm may not be known immediately, clinical harm policy has been refreshed for all Divisions, shared with committee, need some weeks to note what the reviews produce.	Paper to July committee on clinical harm policy implementation and progress to date.
	Incident numbers decreased, incident rate increased.	Outstanding action from action log which asked for the detail provided at committee.		
Serious Incident (SI) report	No further never events or serious incidents noted,	How do we know that there have been no	Medical Director has already asked for a	Conclusions and learning to be shared with committee at future

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	noting significant reduction in patient contacts within reporting period.	serious incidents and that governance functions have been working properly during this period? Why are there action plans due for review at SERG in March/April and May which are not colour coded? i.e. have they been reviewed?	review/analysis of data from mid-February to mid-May which will include wider safety considerations Normal process of SERG and SI panel in place, adapted for COVID, weekly incident review meeting added to review non SI incidents. Reduction in major interventions such as surgery and ED attendance Assurance given that SERG has reviewed and will review version of paper shared with committee	meeting
Clinical harm policy	Updated version shared, regarding patients waiting in excess of national waiting times, outlining clinical oversight, risks and mitigations	How do we know the policy is embedded in practice? Descriptor of harm focussed on physical aspects, what about any harm to mental health? Have we the right resources across the system to focus on clinical harm reviews? How is the learning of	Work in progress by executives to review the output of harm reviews in Divisions Further review agreed to consider mental health aspects Linked to potential system risk of delayed treatment	Paper to committee in July

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		patient experience and communications progressing?	Good examples, including Clinical Nurse Specialist work which can be built on. Acknowledgment there is more to do.	
COVID-19 update and recovery	Decreasing numbers of inpatients noted, focus on restoring activity safely. Severn critical care summit awaited. Work progressing on social distancing (164 beds removed from system) and testing. Comprehensive overview of context and planning to restore planned services, including innovations and challenges	Difficult to have insight into how communicating with patients, their understanding and consideration of their experience?	Very good assurance received of planning, noting complexity and degrees of difficulty within the Trust and scale of recovery needed. Commissioning and system inputs needing to be aligned and supportive.	Consideration of sharing with Governors Addition of principle of patient experience in section 3.2 to be considered.
Brief on service changes implemented as a result of COVID-19	Detail and assurance on the governance process to oversee the changes, impact assessment of changes and clinical validation process used to triage cancer and outpatient patients	Is there professional unanimity? Were there alternative views and/or potential for disagreements at a later stage?	Very good assurance received on the changes. Evidence of a robust process. High level of support for the changes which have occurred. Any future stages of service discussions will continue to focus on a consistent/ standardised approach,	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			Divisions working together and focus on cultural and leadership aspects of change. Usual to have different views and disagreements., important to listen and consider in the round	
Annual Quality Account	Final draft presented, noted slippage in national reporting timescale to Dec 2020, Trust ambition for Board approval in Aug 2020.	As the year in question ends in March when COVID-19 became an issue, expected to see mention of the risk to patients delayed/ waiting for care	Draft very well received, high quality and comprehensive. Narrative to be added.	
Annual screening programme report	Comprehensive report detailing governance and performance of all Trust led screening programmes x 6 (Diabetic eye, cervical, breast, bowel, abdominal aortic aneurysm, antenatal and newborn)	Large change in clinical leads noted within year, does this provide any risks?	Good assurance received on performance of the screening programmes. All posts filled, no risks identified.	
Quality and Performance report	Quality delivery group, noting end of year c diff performance within limits set, continuity of carer work pause during phase 1 of COVID-19, now			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	progressing. Review of stillbirths figures for April CCG correspondence regarding derogation of single sex standard. Planned care delivery group 52 week wait standard not met with increase in numbers of patients waiting, RTT unvalidated at 73.61% Cancer delivery group, 2 week wait referrals had dipped by 75%, now rising again. Currently a backlog of patients awaiting diagnostics Urgent care delivery group, A&E 4 hour performance 87.46% with a 47%	Are there any issues about the ay services were delivered? Is there any benchmarking data available? What immediate actions / learning has been taken (72 hour reports)?	Review will explore and include benchmarking data where possible, no immediate service issues identified. Important to note that patients will be treated by clinical priority order and not necessarily by length of time waiting. Clinical validation processes crucial as part of this. Assurance on detailed knowledge and leadership of operational data and issues.	Detail of derogated areas to be included in next quality and performance report Further update at future meeting

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	reduction in attendance. Operational flow an issue within current context.			

Alison Moon
Chair of Quality and Performance Committee
27th May 2020

Gloucestershire Hospitals NHS Foundation Trust

REPORT TO MAIN BOARD – JUNE 2020

From Audit and Assurance Committee Chair – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee on 19 May 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Counter-Fraud Progress Report	Regular update report covering range of counter-fraud activities, including: - Self-review exercise that will be reported in detail to the next Cttee. - Results of Association of British Pharmaceutical Industry Payments Review. Amber rating for conflicts of interest system. - Open counter-fraud cases.	The Cttee commended the quality of the counter-fraud report and the assurance it provided. Areas highlighted for further focus are in the future work plan. Why is there such a relatively small number of cases in this period?	National decrease in counter-fraud referrals attributable to COVID-19.	
Trust Risk Register	Update report on work of the Risk Management Group, including a focus on: - Covid-related risks (reduction to risk	Are there any areas of specific concern arising from the audit?	Differential approach and capacity, regarding risk management processes between divisions.	Progress against outstanding actions will be reported to future Cttee meetings.

	score) - Covid related incidents (recent reduction) - Audit of Trust's Risk Register		Assurance given that additional support being provided by risk team where necessary Governance reviews are to incorporate oversight of risk management arrangements Surgery division has recently appointed a quality lead, which should strengthen the position.	
Annual Accounts Update	Good progress was reported with completion of year-end returns and accounts. The annual audit is progressing well, albeit remote working presents some challenges. DoF reported that good liaison, progress and oversight was being maintained with external audit team (EY).	Have we resourced the end of year programme adequately?	DoF confirmed that this is being monitored very closely. There have been great efforts within the team and resources will be increased in near future especially to address risk of single point of failure around one key staff member.	
Internal Audit (IA) Progress Report	Regular update report from Internal Audit (IA), indicating intentions for 2020/21 and progress on 2019/20 plan. Good progress has been maintained throughout.	Is there anything in the 2020/21 plan that might be changed in the light of Covid-19?	A flexible and contingent approach will be taken to the plan with options to amend in the light of changed circumstances eg there might be greater focus on business continuity, working from home and data security.	Future reporting of revisions to IA plan.

		Will the planned internal audit GMS contract review take place in June?	Yes, still subject to scoping and confirmation of terms of reference.	
GMS Cash-handling Review	Report received and discussion of use of safes. IA confirmed that they had given the Trust a moderate assurance opinion for the 2019/20 annual report and that the Trust was making good progress towards a substantial assurance rating.		Impact assessment of future use of cash on trust sites to be undertaken.	
External Audit update.	The Cttee was briefed by EY about the good progress that has been achieved with the audit review of the Trust. It was clear that good liaison and communication had been maintained throughout. There appear to be no impediments to achieving target reporting dates at this stage. The Cttee was briefed on the changes to the audit programme that have been necessitated by Covid-19.	The Cttee congratulated the respective teams on the excellent progress that has been achieved in challenging and extraordinary circumstances.	The Cttee was assured that EY had resourced the audit adequately to deliver their programme and mitigate risks of staff sickness.	

Claire Feehily Chair of Audit and Assurance Committee, June 2020.

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS – JUNE 2020
Via MS Teams commencing at 14:30

Report Title
Quality Account 2019/20

Sponsor and Author(s)	
Author:	Suzie Cro, Deputy Director of Quality, Freedom to Speak Up Guardian, Katie Parker-Roberts, Head of Quality, Freedom to Speak Up Guardian
Sponsor:	Steve Hams, Director of Quality and Chief Nurse

Executive Summary

Purpose

Our Quality Account is our annual report to the public about the quality of services we deliver. The primary purpose of our Quality Account is to assess quality across all of the healthcare services we offer. It allows us (leaders, clinicians, governors and staff) to demonstrate our commitment to continuous, evidence-based quality improvement, and to explain our progress to the public.

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining both what we are doing well and where improvement is needed. But, crucially, they also look forward, explaining what we have identified as our priorities for improvement over the coming year.

Key issues to note

Due to changes in legislation, there is no fixed deadline for the Quality Account in national guidance, but NHSI are recommending that Quality Accounts are signed off and ready for publication on NHS Choices website by 15 December 2020, after being reviewed and endorsed by Quality and Performance Committee, our external stakeholders and finally the Trust Board. To meet this timeline, NHSI are recommending that stakeholders have commented on the Quality Account by 15 October.

This is the final draft of the Quality Account 2019/20 for review by the Council of Governors members and comments back to the Deputy Director of Quality by 25th June 2020. There are some sections where we are waiting for Q4 data, but this will be completed before it is circulated to stakeholders to complete their statements, including Governors, HCOSC, Healthwatch and the CCG. The timetable below has been proposed by Quality Delivery Group, and is within the recommended timelines from NHSI:

Action	**Date**
Final draft of Quality Account endorsed by Quality and Performance Committee	27.05.20 (Q&P)
Circulation of final draft of Quality Account to external stakeholders to submit their statements	01.06.20
Deadline for return of stakeholder statements	30.06.20
Final version of Quality Account approved by the Quality and Performance Committee	22.07.20 (Q&P)
Final version of Quality Account endorsed by the Board	13.08.20 (Main Board)

Submission of Quality Account to NHS Choices	17.08.20

Conclusions
The Committee are asked to review this final draft and share any comments before the draft is updated with remaining data and circulated to external stakeholders for statements.

Implications and Future Action Required
Pending approval, the Quality Account will be circulated to stakeholders and returned to Quality and Performance Committee for final approval in July.

Recommendations

The Committee are asked to review this final draft and share any comments back to the Deputy Director of Quality by 25th June 2020.

Impact Upon Strategic Objectives

Our Quality Account will enable the Trust to report publically on our progress to meet our strategic objectives 2019-24 (Outstanding Care, Compassionate Workforce, Quality Improvement and Involved People, Care Without Boundaries, Centres of Excellence, Effective Estate, Digital Future, Driving Research).

Impact Upon Corporate Risks

None

Regulatory and/or Legal Implications

The publication of the Quality Account is a regulatory obligation

Equality & Patient Impact

This will show greater visibility of our improvement work

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision	**X**	For Assurance		For Approval		For Information	

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
				X MAY 2020			

Outcome of discussion when presented to previous Committees/TLT

Note contents and progress. Support delivery plan.

Gloucestershire Hospitals
NHS Foundation Trust

Our Quality Account 2019/20

Best Care for Everyone

Gloucestershire Hospitals NHS Foundation Trust

Our Quality Account 2019/20

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

Contents

Quality Account 2019/20

Our Trust

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. Maternity Services are also provided at Stroud Maternity Hospital. Trust staff also provide outpatient clinics and some surgery from community hospitals throughout Gloucestershire. The Trust is the major provider of secondary care services in the area; the Trust has a £500m annual operating income, 960 beds, over 125,000 emergency attendances and nearly 800,000 outpatient appointments each year. The trust has 8,000 members of staff who are committed to providing high quality acute elective and specialist services under its vision of 'Best Care for Everyone' to a diverse population of over 620,000. Gloucestershire Royal Hospital provides general hospital services. Gloucestershire Royal Hospital has a 24-hour Emergency department, a state of the art Children's Centre and a women's centre. The hospital also has a range of operating theatres, inpatient wards and provides outpatient services from a dedicated outpatient department.

Gloucestershire Royal Hospital

Cheltenham General Hospital

Cheltenham General Hospital provides general hospital services. Cheltenham has state-of-the-art critical care facilities and is home to the specialist Oncology Centre as well as breast screening facilities at the Thirlestaine Breast Care Centre. This hospital also has an Interventional Radiology operating theatre; surgical robot used in treating prostate cancer and provides a wide range of outpatient services. Cheltenham Birth Centre is also located on the site.

The trust also provides services from community hospitals in Stroud, Berkeley Vale, Forest of Dean, Tewkesbury and North Cotswolds, Cirencester, Evesham and Ross on Wye and there is a midwife led birth centre in Stroud.

Our priorities and statements of assurance

Part 1: Statement on quality from the Chief Executive of Gloucestershire Hospitals NHS Foundation Trust

Chief Executive's welcome to the Quality Account

I am delighted to introduce this year's Quality Account, which sets out how the Trust has performed against the quality standards and priorities set both nationally by Government and locally by the Trust Board, in partnership with the *One Gloucestershire* Integrated Care System (ICS). Whilst NHS Trusts are required to publish a Quality Account, we aim to make this so much more than just a mandated report. It is about celebrating our achievements from the last year, showing where we have learnt and improved the experience of our patients, their families and our staff. Equally, it is an opportunity to shine a spotlight on our approach to Quality Improvement which, increasingly, is the way in which we support and enable our staff to address the challenges and seize the opportunities they encounter.

Inevitably, given the context in which the NHS is operating as I write this year's report, it is a Quality Account with a difference but equally, it feels important not to lose sight of what we have already achieved as well as prepare for the unprecedented times ahead.

The Year Just Gone

For many of us, 2018/19 was the year in which we achieved our Care Quality Commission (CQC) 'Good' rating. Following on from this theme, this last year has very much been characterised by the progress we have made on *Our Journey to Outstanding.* Whilst for many, *outstanding* is associated with the 'official' recognition by our regulator, the CQC, but for the Trust Board it is about living up to our own sense of what "outstanding" means to all of us. Personally, I like to think of the CQC *outstanding* rating as the minimum standard we should strive for, not a target to be met!

In the pages ahead, this quality account sets out the many, many things that we achieved in the last year but, as is always the case, there are a number of things that stand out in my mind, which I'd like to highlight.

Given the very busy nature of healthcare and acute hospitals in particular, taking time to look ahead to ensure that we have a bright and sustainable future is vital. With this in mind, under the leadership of Simon Lanceley, Director of Strategy and Transformation, we listened to the views of more than a 1000 colleagues to develop a new five-year strategy for the organisation, and out of this came not only a clear

direction and sense of ambition for the organisation but ten new strategic objectives. The team went above and beyond to ensure that these ambitions and priorities were clearly communicated and I'm especially proud of some of the ways we achieved this – a particular favourite is the cartoon-like animation which brings them to life!

One of the ten objectives describes our ambition for the way hospital services in Gloucestershire might look in the future and co-designing services, by involving and engaging the public, our patients and our staff, has been a feature of the past year particularly in our *Fit for the Future* programme. This programme of activities, under the banner of *One Gloucestershire,* brings together the thinking of all organisations in our Integrated Care System (ICS) to ensure that our urgent and emergency care services are joined up and respond to the needs of local people; this sits alongside an exciting strand of work, being led by this Trust, to work with local people and staff to explore what is the best configuration of services across our two acute hospital sites in Gloucester and Cheltenham. We have captured and expressed this thinking in a vision described as our *Centres of Excellence* - two thriving hospitals, each with their own distinct identity, bringing together related services, making the best use of scare resources and organised to ensure that you receive the very best care, in a timely way and with the aim of ensuring the very best outcomes for your health.

From my viewpoint, it feels like we are finally making real and significant progress towards our vision of developing best in class services, which embrace the opportunity that comes from having two separate hospital sites, whilst addressing the many challenges that run alongside this model such as increasingly scarce specialist staff and equipment. Experience tells me that we will encounter the inevitable 'bumps in the road' as we progress towards our goal but last year, firmly set us on our way.

It may feel like an overused adage but it remains as relevant today, as it ever has: "our staff are our greatest asset". With this at the forefront of my mind, 2019/20 was a year when the Board and leadership team gave unprecedented amounts of thought to how we further develop our culture to reflect one within which staff flourish and patients receive the very best care. We refreshed our values and, perhaps more importantly, worked with our teams and individual colleagues to understand the sorts of behaviours which should underpin our values; taking this work forward will be a huge priority in 2020. Alongside this, never has the health and wellbeing of our staff mattered to me more. Increasingly, we are asking our teams to do more, and to do things differently, as demand for our services continues to increase. One of the highlights of last year was the launch of the 2020 Staff Health and Wellbeing Hub, which has been operating since May 2019. Very much the "brainchild" of Emma Wood, Director of People, the Hub was a response to feedback from the previous year's national staff survey when colleagues told us that they lacked access to information and advice to remain well and provide support them when the need arose. Since its launch, the Hub has provided support to 3,503 colleagues, a

staggering 43% of our workforce. Latest figures show that the Hub website and online resources have had 27,759 hits since its launch – all in all, an incredible resource that is supporting teams across our organisation. I'd like to say a special big thank you to Michele Pashley and Emily Hoddy at the Hub for their passion and drive to ensure the Hub was established so successfully and for their ongoing, wider focus on staff health and wellbeing.

Given our recent history with respect to information systems, I am immeasurably proud of what the Trust has achieved in the past year under the leadership of our Chief Digital and Information Officer, Mark Hutchinson. Mark and his team, working closely with our clinical leaders, set out not just to recover from the legacy of our previous IT deployment but to seize the opportunity to go further, faster. With this goal driving our approach, this year we developed and approved our first ever Digital Strategy but more impressively, we also implemented two keys elements of it, in super quick time. Just a few months in, this new system is realising our original vision of creating a fully electronic patient record (EPR) which enables increasingly safe and reliable care to be delivered to our patients, whilst releasing time for our clinicians to care and lead. The launch has been an unequivocal success and this is undoubtedly due to the phenomenal amount of engagement between the digital team and our clinical teams. Of particular note, in this first phase, has been the engagement and enthusiasm from nursing colleagues – one particular highlight for me has been the extent to which our Health Care Assistants (HCAs) have embraced this agenda and as a result have been drivers of our success. We now have the seven key nursing assessments live on EPR on all of our wards and, despite the timing, we held our nerve and implemented electronic observations in mid-March which gave us sight of our sickest patients, at a time when we most needed it. Although we are still on our digital journey, this year has been a "game changer" in respect of our progress and has made more difference to the safety and quality of care, than anything I can remember – a HUGE thank you to everyone involved in making this happen for their engagement, hard work and enthusiasm.

One of the legacies from the IT challenges described above, was a significant increase in the numbers of patients waiting for care, both inpatients and outpatients. Under the leadership of Rachael De Caux, Chief Operating Officer, with phenomenal support from operational managers and their teams, we have transformed this picture. These teams have worked tirelessly alongside clinical colleagues to redesign pathways of care, to validate tens of thousands of patient records and treat more patients (in more innovative ways). As a consequence, last year we achieved and sustained for six consecutive months, the national standard for the two-week cancer wait which, given 90% of patients will have cancer excluded following this initial assessment, is a huge boost to cancer patient experience. December 2019 also saw the first month that we achieved the standard in all specialties, not just at an aggregate Trust level, since May 2013. From a high of 120 patients in August 2018,

who had waited more than 52 weeks for their treatment, we achieved a reduction of 73.1% from January 2019 to January 2020. Finally, the seemingly intractable issue of backlogs in follow-up outpatient care is at long last moving forward considerably thanks to everyone's efforts in 2019/20. Our longest waiting patients overdue follow up, without a booked appointment, has reduced from a staggering 57,213 in January 2019 to 5,071 in January 2020. The total number of patients now on an active follow up has also reduced significantly (30,271) reflecting the focus on discharging those patients who can be safely cared for outside a specialist setting or for whom follow up is no longer necessary. We know, from our work with patients and local communities, that NHS waiting times remain one of the biggest public concerns and it is especially heartening therefore that we have achieved so much in this past year.

Exciting plans to transform our two hospitals as part of a £39.5m investment took a big step forward last year, when the Trust Board approved the Outline Business Case (OBC); I think it may only be, with the benefit of hindsight, that we appreciate what a huge milestone this was. Under these plans, Cheltenham General Hospital (CGH) will benefit from better day case surgery facilities with the development of two additional theatres and a Day Surgery Unit. The new facilities will improve patient experience, reduce waiting lists and result in fewer operations being cancelled. Gloucestershire Royal Hospital (GRH) will benefit from an improved Emergency Department and acute medical care facilities designed to speed up diagnosis, assessment and treatment. There will be a redesigned outpatients and fracture clinic accommodation for orthopaedic outpatients, additional x-ray capacity and a programme of ward refurbishment.

Once completed, colleagues will have a more modern, spacious environment in which to work, enabling them to achieve their ambitions of delivering even better patient care. In particular, the work at GRH will help to relieve crowding at ED during busy periods which is something both patients and staff have flagged as a priority.

The Full Business Case will be submitted to the Trust Board and NHSE towards the end of the year. Assuming that's successful, we anticipate construction work to begin in 2021 with the new facilities opening to patients in 2022/23 – exciting times ahead!

Thanks to the efforts of one very brave young woman, Greta Thunberg, 2019/20 felt like a watershed year when globally and locally people appeared to wake up to the threats facing us from climate change, with many commentators describing it as the greatest public health issue of the 21st Century. I was especially proud therefore to be a member of a Board that not only recognised the threat but, in declaring a *climate emergency,* pledged to do something about it. Under the leadership of Steve Hams, Director of Quality and Chief Nurse, the Trust held two "big green conversations" to explore what more it could do to contribute to the County's ambition of reducing carbon emissions by 80% by 2030. Colleagues from right across the Trust have engaged with this agenda in an unprecedentedly exciting way

and numerous initiatives are already in place to make our Trust a cleaner, greener place to work and receive care.

Finally, nobody could have predicted the way in which 2019/20 would end with the advent of the COVID-19 coronavirus outbreak; the consequences of which will be felt for years to come. Sadly, with months to run it feels premature to comment too much at this time but equally it would feel wrong not to take the opportunity to acknowledge the phenomenal and unprecedented response from colleagues, partners and even strangers inside and outside the Trust. I am immeasurably proud of how this Trust has responded; under the superbly calm, clear and compassionate leadership of Medical Director, Professor Mark Pietroni, the Trust is well prepared for what lies ahead. Whilst none of us would ever have wished to encounter such difficult times, there will be some important *silver linings* which emerge from these times, which I am determined we embrace as we move into recovery and back to some form of "normal" - from the innovations that have surfaced through necessity to the sheer scale of human kindness I have seen my colleagues and communities show to each other. I couldn't be prouder to be associated with such a phenomenal institution as the NHS and such a caring community of people as I have encountered in Gloucestershire.

The Year Ahead

Given the current context, the next year looks uncertain and the usual description of aims and goals feels at odds with the time we are in, and the times which lay ahead. However, there will be a number of constants and one very important one will be the care of our staff and the compassion that we show to each other, during the most difficult times.

Before, the COVID-19 pandemic, the Board had signalled the importance of furthering the work on developing a culture that enables staff to be the very best version of themselves and this enables us to provide truly compassionate care, to everyone. Our recent staff survey confirms we are making positive progress in this regard but we have more to do to engage all of our teams and colleagues on our *Journey to Outstanding*. Having spent a lot of time in 2019/20 developing our new strategic objectives and vision, our focus for 2020/21 will be not be on the "what" but rather on the "how". Our values of caring, listening and excelling underpinned by the behaviours developed from the Board's work with *culture guru* Professor Michael West of attending, understanding, empathising and helping have been co-designed with colleagues, and provide a clear focus on kindness and compassion to ourselves, our colleagues and our patients. I asked Michael how he judges success, and what success might look like for me as an NHS Chief Executive; he shared his personal definition of culture which, for me, said it all *culture is the way we do things around here, when nobody is looking*.

Thank you

It serves for me to thank you the reader for everything that you have brought to the Trust, whether as a colleague, a governor, a partner, a public member or patient. We have achieved such a lot in the last year but are undoubtedly facing some of our greatest challenges in the year to come. I thank each and every one of you, from the bottom of my heart, for what you have done but moreover what you will do for us in the year to come.

Formal bit

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

Deborah Lee,
Chief Executive Officer

Part 2 and 3: Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following 2 sections are divided into four parts:

Part 2

- Part 2.1
    - What our priorities for 2020/21 are: explains why these priorities have been identified and how we intend to meet our targets in the year ahead.

    - How well we have done in 2019/20: looks at what our priorities were and whether we achieved the goals we set ourselves. Where performance was below what was expected, we explain what went wrong and what we are doing to improve

- Part 2.2
    - Statements of assurance from the Board

- Part 2.3
    - Reporting against core indicators

Part 3

- The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

Part 2.1: Our priorities

Our priorities for improving quality 2020/21

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

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

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

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

As a result, we are confident that the priorities we have selected are those which are meaningful and important to our community. Progress against these priorities will be monitored through the Quality Delivery Group, chaired by the Executive Director of Quality and Chief Nurse, and by exception to the Quality and Performance Committee (a Governor sits on our Quality and Performance Committee).

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

Table: Our priorities for improving quality

Priority quality indicator goals 2020/21
WELL LED - continuous improvement
Our COVID response
IMPROVE EQUALITY, INCLUSION and DIVERSITY
To improve how we meet the NHSI **learning disability** and autism standards.
To improve the numbers **safeguarding assessments** completed on our Electronic Patient Record (EPR)
EXPERIENCE - enhancing the way staff and patient feedback is used to influence care and service development
To improve **cancer patient experience**
To improve **children and young people's** experience of transition to adult services
To improve **maternity** experience
To improve **Urgent and Emergency Care (ED)** experience
To improve **Adult Inpatient** experience
IMPROVE SAFETY
To enhance and improve our **safety culture**
To improve our **prevention of pressure ulcers**
To prevent **hospital falls with injurious harm**
To improve the **learning from our investigations into our serious medication errors**
To improve our **infection prevention and control standards** (reducing our Gram-negative blood stream infections by 50% by 2021)
To continue our **learning from deaths** programme
CLINICAL EFFECTIVENESS / RESPONSIVENESS
To improve our **care of patients whose condition deteriorates**
To improve **mental health care** for our patients coming to our acute hospital
To improve our care for **patients with diabetes**
To improve our care of patients with **dementia**
To improve **outpatient care**

Priority quality indicator goals 2020/21
To improve access to care by delivering the 10 standards for **seven day services**

How well have we done in 2019/20?

Summary

Priority quality indicator goals 2019/2020
1. **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) **How have we performed in 2019/20?** • 682 colleagues trained in Bronze • 81 Silver projects started • 11 new Gold QI coaches • Quality Framework developed **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21 • Develop and roll out Human Factors faculty • Continued roll out of Quality Framework across specialties • Increasing number of Gold coaches – ambition to have 90 across the Trust
2. To continue to develop our speaking up systems and processes through **Freedom to Speak Up** **How have we performed in 2019/20?** • Recruited three new Guardians • Further developed links with Leadership and OD teams • 56 number of contacts from colleagues **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21 • Recruit two consultants to join the team as Freedom to Speak Up Guardians • Review speaking up training for colleagues • Deliver improvement plan
3. To improve patient experience of our **discharge processes** **How have we performed in 2019/20?** • The National Inpatient Survey 2018 showed that we are performing below average on a number of areas relating to discharge • One particular area of the focus for the Trust this year has been about reducing Delayed Transfers of Care (DTOC), as this has a huge impact on patient outcomes and experience. The Trust has a target to keep DTOC under 3.5% and this has not been achieved in recent months due to lack of flow across the system and ward closures due to infection control. December 2019 to February 2020 were particularly challenging months for the Trust. • National benchmarking around DTOC shows our position more favourably, with us ranking in the top third of Trusts check for accuracy

Priority quality indicator goals 2019/2020
Plans for 2020/21: • This will continue as a Quality Indicator for 2020/21, as although national benchmarking has shown a more positive picture, our initial findings from the National Inpatient Survey 2019 results show that discharge is still an area of patient experience that we need to improve. • There will be continued focus on reducing DTOC in 2020/21, in addition to the latest Inpatient Survey results being used to coordinate an improvement plan across the Trust focussed on improving discharge experience, particularly around the information provided to patients.
4. To improve **cancer patient experience** **How have we performed in 2019/20?** • The latest Cancer Patient Experience Survey 2018 scores were published in September 2019; the Trust scored 'about the same' as other organisations for 41 of the questions, above the upper limit in two questions and below the lower limit in eight of the questions. • One of the challenges of the Cancer Patient Survey is the timeliness of the data, with the results being published a year after being collated. • A new Lead Cancer Nurse has been appointed whose focus is on Patient Experience Improvement. A workshop was delivered in January 2020, with patients from across a range of cancer pathways, to understand our local patient experience **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, using the feedback from these sessions to develop an action plan for 2020/21, with some of the key themes including: o Improving the oncology environment o Improving written communications and health information o Improving access to clinical teams in a timely fashion o Improving signposting to support services and carers support o Improving communication across divisions o Improving engagement with seldom heard communities o Continue to provide opportunities for patients to be engaged in development of services o Advanced communication training around breaking bad news
5. To improve **outpatient experience** **How have we performed in 2019/20?** • Attain were appointed to complete a 12-week assessment of four specialties to support development of outpatient improvement programme • Four specialties involved in improvement work; Neurology, Dermatology, Rheumatology, Diabetes. Improvements achieved in these areas are included in report • Plans to extend this work to beyond the four original specialties **Plans for 2020/21:** • Continue as business as usual as part of our Outpatients Transformation Programme • Additional programme support has been allocated from Transformation

Priority quality indicator goals 2019/2020
and Service Improvement, and the latest plans for 2020/21 can be seen in report. Of particular note and focus is the introduction of a digital offer, the roll out of which has been accelerated during the management of Covid-19.
6. To improve **mental health care** for our patients coming to our acute hospital **How have we performed in 2019/20?** • The Lead for Mental Health Liaison and our Emergency Department Matron have been working on a Quality Improvement project (Silver GSQIA project) that uses a modified Manchester Triage Tool to identify Priority 1 & 2 patients for an early mental health review. • Trust has secured additional funding for Mental Health Nurses to deliver a mental health review response within 1 hour • The average length of stay for people with mental health issues who were seen by the Mental Health Liaison Team is on average 53.7% lower than those Mental Health patients who were *not* seen, which is a reduction of 2.2 days per patient on average • The re-admission rate is also lower for those patients who were seen by the Liaison Team (16.8% re-admission rate, compared with 18% for those who were not seen). Re-admission rates are steadily declining for all MH admissions. **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, to support the NHS Long Term Plan • A recruitment campaign will be our focus for 2020 so that the Mental Health Liaison Team can deliver first assessments to inpatients within 1 hour from the time of referral to all patients with a mental health issue or diagnosis of mental health problems. • There will be specific training given across the Trust to all nurses graded at Band 6's, 7's and junior doctors in the delivery of the modified risk assessment tool. • An evaluation of the use of Mental Health nurses at triage will be undertaken which will enable co-streaming and assist in delivering a 1 hour response.
7. To develop a **real time patient experience survey programme** **How have we performed in 2019/20?** • Recruited volunteers to deliver survey programme • Reviewed and refined process to get more reliable data, with new schedule providing coverage of surgical and medical wards each month • Data shows that our patients are responding with the same, or more positive, responses when benchmarked with our Inpatient Survey data **Plans for 2020/21:** • Continue to review and refine the approach, including volunteer recruitment and understanding patient numbers on wards to ensure responses are representative • Develop dashboards and reporting as business as usual, to be monitored through Quality Delivery Group and Quality and Performance Committee

Priority quality indicator goals 2019/2020
8. To enhance and improve our **safety culture** **How have we performed in 2019/20?** • In September 2019, the SCORE Survey was selected as the validated tool to measure the safety culture across pre-operative, operative and post-operative settings in Gloucestershire Royal Hospital, Cheltenham General Hospital & Cirencester Treatment Centre. • Focus groups beginning to analyse the data by work setting and staff group have begun across the theatres teams at all three sites. **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21 • Further focus groups to be held with anaesthetists and surgeons • Plans to develop a multi-disciplinary improvement collaborative using the data and feedback collected, supported by GSQIA team • The SCORE survey will be repeated in 2021 to determine the impact of the interventions undertaken.
9. To improve our patients beginning their **first treatment for cancer within 62 days** following an urgent GP referral for suspected cancer. **How have we performed in 2019/20?** • Nationally Trusts are continuing to struggle to meet the 62-day standard with latest national performance of 78.9% (March - latest data available). April un-validated position for the Trust is 81%. • COVID19 pandemic has impacted the delivery of cancer services. Cancer Services and specialties have had to adapt to new ways of working and pathways through March and April 2020. **Plans for 2020/21:** • To support improvement during 2020/21 specifically aimed at improvement of 62-day treatment we have a Delivery Plan for each speciality area • The main tumour site being supported in 2020/21 is Urology
10. To improve the issue of patients receiving delayed care **How have we performed in 2019/20?** • Focussed improvement work on Ophthalmology Outpatient Patient Services following issues with implementation of Trak Care • A number of actions have been taken, including clinical reviews, increase in staffing, increase of checks to improve data accuracy, close working with Central Booking Office, and increasing consultant capacity in Q4 • With additional consultant time, it is anticipated 800 patients could be seen, leaving an estimated deficit of 1000 appointments rolling over into next year **Plans for 2020/21:** • Work will continue into 2020/21in line with longer term plan, supported by regular review of data and progress on a monthly basis • Service line to develop options paper and plan that would see them be

Priority quality indicator goals 2019/2020
'best in class' by end of March 2021 and have no outstanding follow up's • Learning from Ophthalmology to be shared with other specialties
11. To improve the **prevention of our patients developing pressure ulcers** **How have we performed in 2019/20?** • Held Quality Summit in September 2019 to discuss pressure ulcer prevention improvement programme, with thirty-two staff attending • We have co-designed a quality improvement programme with staff from all areas and a mix of specialities. **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, with the delivery of the pressure ulcer prevention quality improvement plan which is led by the Tissue Viability team • Focus will be on how we use data, from a range of sources including the Electronic Patient Record (EPR) data, to see in real-time what staff are assessing and recording, and establishing measures to develop a single item quality report • This will include setting appropriate ward and specialty level targets, understanding where our high-risk wards are and providing all clinical staff with training and equipment to facilitate pressure ulcer prevention
12. To prevent **falls in hospital** **How have we performed in 2019/20?** • This has been one of our CQUINs for 2019/20, and the ambition was to have achieved 80% of older inpatients receiving key falls prevention actions. We do not meet the lowest threshold and so this is an area for continued focus. **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, with the delivery of a quality improvement plan which is led by the Lead Nurse for Falls Prevention • The implementation of the Electronic Patient Record has enabled us to have better oversight of falls risk assessments and prevention plans that are being put in place for our patients. • This data will be used to develop measures for ongoing monitoring and to undertake learning events to improve care
13. To improve the **learning from our investigations into our serious medication errors** **How have we performed in 2019/20?** • A pharmacist in Cheltenham ran a project look at facilitating self-administration of Insulin on Guiting Ward. Guiting Ward looks after patients needing vascular procedures, many of whom are diabetic patients who use insulin at home. • The aim of the project was to increase the number of patients appropriately self-administering insulin by 50% over 4 months. • The project showed a clear increase in the number of patients appropriately self-administering (12% at baseline to 73%). There is now

Priority quality indicator goals 2019/2020
the means to assess patients wishing to self-administer insulin on the ward, and patient-accessible safe storage is available. Location of insulin in use saw an improvement - from just 58% of it being stored securely to 82% by the end of the project. **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21 with the Medical Division and Specialist Diabetes Team leading this work. • The Trust will also be developing a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.

14. To improve our **care of patients whose condition deteriorates (NEWS2)**
 	
How have we performed in 2019/20?
• We audit the number of correctly calculated NEWS2 across various wards each month and these are reported on the Nursing Metrics.
• The current data highlights the need for education in this area with some wards only achieving 20% compliance and this is process is currently lead by the Resuscitation Lead for the Trust.
 	
Plans for 2020/21:
• This will continue as a Quality Indicator for 2020/21, with the following areas of focus:
  • Introducing an electronic recording system for observations (eObs) as part of our Electronic Patient Record roll out at the end of March 2020.
  • Early anticipatory planning and person-centred care
  • Structured review of the risk of deterioration
  • Reliable recognition of acute deterioration
  • Structured response to acute deterioration
  • Reliable communication and learning within and across multidisciplinary teams.

15. To improve our **learning into action systems** –learning from our own local investigations
 	
How have we performed in 2019/20?
• Testing of a new GSQIA Human Factors Faculty began with two half day sessions planned with colleagues across the Trust. The objectives of the Faculty are to improve:
  ○ the technical assessment of serious incidents
  ○ system redesign and testing with simulation
  ○ understanding of human factors across the Trust.
• In December, we were successful in a bid led by the GSQIA in collaboration with the wider Gloucestershire system for some Q-Exchange funding, the award was £30,000 to deliver a project to test collaborative approaches to facilitating 'wicked' system wide problems
 	
Plans for 2020/21:
• Continue as a Quality Indicator for 2020/21

Priority quality indicator goals 2019/2020

- Deliver a programme of improvement collaboratives
- Deliver an education programme of Human Factors

16. To improve our care for **patients with diabetes** in the perioperative period

How have we performed in 2019/20?

- In April 2019, we retrospectively reviewed the GRH PQIP database to identify patients with Type 1 or Type 2 diabetes. The team then audited the perioperative management of diabetes against the key indicators detailed above to identify areas for improvement.
- From reviewing the elective cases 14 patients were identified with diabetes out of a database of 86 cases (16%). Of the 14 cases, 5 were treated with insulin, 5 with non-insulin glucose lowering medication and 4 were diet controlled.
- Across all 14 patients, none of the audit standards were met 100%.

Plans for 2020/21:

- Continue as a Quality Indicator for 2020/21
- The Trust has developed a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.
- We have started pre-habilitation programme prior to major surgery which aims to improve pre-operative conditioning of patients to improve post-operative outcomes. This programme of work is aimed to assess the effect of pre-habilitation on post-operative outcome after major surgery and we hope to report on this work next year.

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

How have we performed in 2019/20?

- When we moved to a new Patient Administration System (Trakcare) reporting for this indicator declined which suggested to us that the new digital system had created issues for clinicians reporting because in previous years we had been able to demonstrate that FAIR clinical assessments were being carried out.
- When carrying out the digital diagnostics, as to why our performance had declined, we found that the answers to the FAIR questions had to be recorded in different areas within the new record. To test this theory, that clinicians were carrying out the assessments but were just not recording it in an area where the data could be extracted, an audit was carried out and all admission documentation was amended to include the dementia case finding question. Our audit demonstrated that our theory was correct and our performance improved from 0.3% (May 2019 digital extraction) to 67% (manual audit June 2019).
- This data captured is reported monthly in the Trusts Quality and Performance Report (QPR), showing our compliance with the FAIR assessment tool.

Plans for 2020/21:

- Early in 2020 NHS England and NHS Improvement held a consultation

Priority quality indicator goals 2019/2020
seeking views on the continuing suitability of the Dementia Assessment and Referral (DAR) data return. The consultation was open for eight weeks from Thursday 9th January until midnight 5th March 2020 but please note that due to the coronavirus illness (COVID-19) there will be a delay in the publication of the response to the consultation. • Our plan for 2020/21 will be to await national guidance and once published we will focus on improving the accuracy of our data.
18. To improve our **nursing care standards** through the Nursing Assessment and Accreditation Scheme (NAAS) **How have we performed in 2019/20?** • All 39 ward areas have been assessed twice using NAAS framework • In Round One, 33% of wards were red, 13% amber, and 54% green • In Round Two, 0% were red, 13% amber and 87% green • NAAS framework has been reviewed and refined to create NAAS2 framework, to support further improvements **Plans for 2020/21:** • Continue as a Quality Indicator for 2020/21, with improvement targets for NAAS2 scores of 0% Red wards, 30% Amber wards, 60% Green wards and 10% Blue wards • Rollout of NAAS2 accreditation schemes across the wards, supporting the introduction of shared governance and the American Nurse Credentialing Centre (ANNC) Pathway to Excellence® Programme • Develop Maternity equivalent to NAAS2, as well as a paediatric equivalent
19. To improve our **infection prevention and control standards** (reducing our Gram-negative blood stream infections by 50% by 2021) **How have we performed in 2019/20?** • All episodes of MSSA (Methicillin-sensitive Staphylococcus aureus) and Gram negative bacteraemia (*E.coli*, *Klebsiella* species and *Pseudomonas aeruginosa*) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements. • Data reported for MSSA and Gram negative bacteraemia can be seen in tables within section **Plans for 2020/21:** • To achieve 3-5% reduction in hospital acquisition of Gram negative blood stream infections, focussing on the following areas: o Hepatobiliary Tract o Urinary Tract Infections o Mouth Care Matters o Surgical Site Infections
20. Rolling out of **Getting It Right First Time** standards in targeted standards **How have we performed in 2019/20?** • Of the 39 + specialties monitored by GIRFT, 31+ relate to Gloucestershire Hospitals NHS Foundation Trust of which 26 services have been visited to date.

Priority quality indicator goals 2019/2020
• An annual review with the executive team for each specialty has now been set up. Eleven services have completed this process presenting their progress, achievements and concerns; updates are included in this report **Plans for 2020/21:** • Work will continue as business as usual to raise the profile of this work in the coming year. • There will be ongoing work for all services to complete the recommendations by GIRFT. • In addition, deep dive visits are arranged in the next few months for Cardiology and Rheumatology and dates for Respiratory, Neonatal medicine and Lung Cancer are imminent.
21. Delivering the 10 standards for **seven day services (7DS)** **How have we performed in 2019/20?** • We have prioritised the delivery of standards 2, 5, 8 and 6 • In June and November (to be validated by NHSI) 2019 our data confirmed that we are meeting standards 5 and 6, but not meeting standards 2 and 8 of the four priority standards. • For daily review at weekends (Standard 8), Service Directors have been asked to re-review consultant job plans to support this standard, and we have made clear processes for the identification and documentation of patients not requiring daily review at the weekend. • For consultant review < 14 hours of admission (Standard 2), we have undertaken the education of junior doctors about post take ward round documentation including documenting the time of review, as a lack of documented time accounted for 30% of our inability to meet this standard. **Plans for 2020/21:** • We are awaiting formal feedback on our November 2019 submission, and continuing with ongoing recruitment into vacant Consultant Posts which will help with 7DS delivery (2 possible recruitments to Acute Medicine, 3 new recruitments to Care of the Elderly). • Our 7DS delivery and our lack of compliance with priority standard 2 and 8 is in the process of being added to our Trust risk register as we are at risk of achieving these 2 standards. • The Trust will be required to submit its next 7DS self-assessment to NHSI in spring 2020 (date pending) and our improvement work will continue, based on feedback from NHSI
22. To deliver the programme of **Better Births** (maternity care) continuity of carer (CoC) improvement programme **How have we performed in 2019/20?** • For 2019/20, Local Maternity Services (LMS) have been set a target of 35% of women at booking being placed onto continuity of carer pathways and **receiving continuity of the person caring for them during pregnancy, birth, and postnatally**. • The overall percentage for Continuity of Care was 4.6%. • Two pilot models of continuity of carer were continued to achieve 10%

Priority quality indicator goals 2019/2020
of women on a Continuity of Carer pathway, one of which was successful; • Following the pilot, it was clear that to achieve the target a business case would be required. A business case was developed by the Multidisciplinary Team and was agreed by the Gloucestershire Clinical Commissioning Group (CCG) in March 2020. **Plans for 2020/21:** • Continue as business as usual, with a Continuity of Carer Improvement programme • This programme will have a particular focus on areas of highest deprivation and for our Black and Minority Ethnic (BAME) communities in Gloucester City and Cheltenham
23. To improve our care of children **transitioning** to adult care **How have we performed in 2019/20?** • Recognising the current gap in service provision around transition, one of the Adult Specialist Palliative Medicine consultants (ASPMC), who had a particular interest in this client group has over the years, provided care for several young people with life limiting/life threatening conditions (LL/LTC) into her caseload providing them with a 'helicopter' holistic medical service, undertaken as a **non-commissioned pilot**. • The pilot undertaken by the ASPMC and the PNNS has shown that this model of care provides the young people and carers of this client group with a service that 'spans the gap' to adult services. • A business case has been agreed to develop a transition pathway and identify an adequate resource to oversee the holistic transition of young people with LL/LTC that is not currently addressed using the Ready Steady Go Hello programme or current clinical services. **Plans for 2020/21:** • In 2020/21, we will be focussing on setting up the new service outlined in the business case, to ensure that young people with a LL/LTC and their families will have an identified transitional medical and care co-ordinator who will navigate this part of their journey with them ensuring they are embedded into adult primary and secondary services • Work on to improve transition will continue as a Quality Indicator for 2020/21, which will be informed by the scoping exercise commissioned to review all specialties of children transitioning from children to adult services to review what the process and care was given to young people through the transition pathway

1. Quality priority

To further enhance our quality improvement systems with support from the Quality Improvement by our Gloucestershire Safety and Quality Improvement Academy (GSQIA)

Background

We have a fully embedded systematic approach to quality improvement and now building on our successes in 2018/19 we chose to continue to intentionally design our quality improvement to be as inclusive and diverse as possible. We didn't want to just identify five or six big topics or areas for our improvement activity to focus on. We wanted everyone to feel that they could be part of this movement – '*the GSQIA way*', and so we have allowed a lot of scope for our silver projects to join the Academy. We valued our colleagues' involvement and interest above all else realising that if we achieved enough joy and energy in our first years this would become a real driving force for our future.

Across the Trust there is an increasing belief in the systematic approach of quality improvement. Our evidence base is growing and we are learning that we can solve our own issues by deeply involving those closest to the issue in a process of discovery (insight), design (involvement) and improvement.

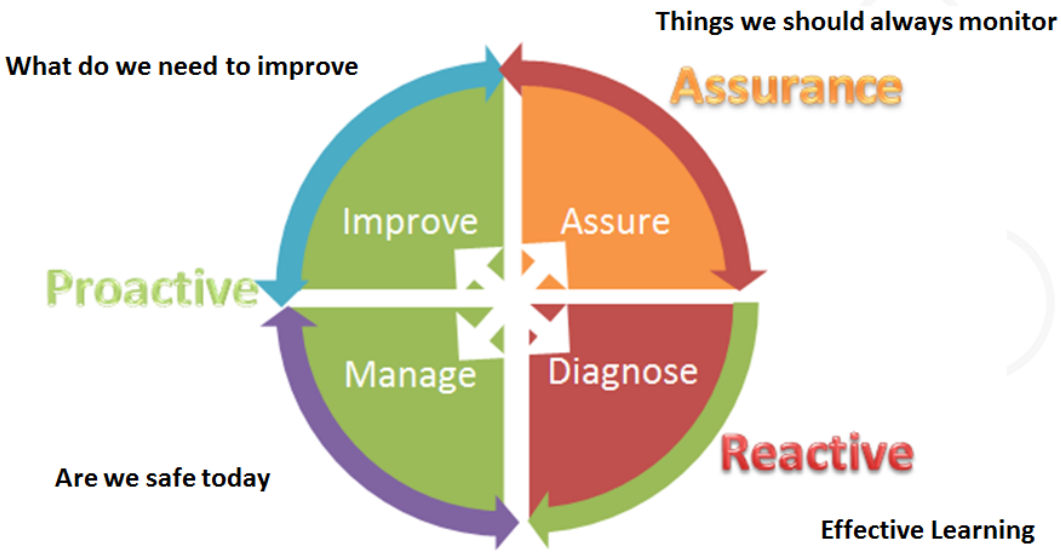
Now with the endorsement of our enabling Quality Strategy in December 2019 we are able to be explicit about what our strategic improvement priorities are, and we are going to form some light touch governance structures using the Quality Framework to ensure that Specialty Teams approve locally led projects to ensure that teams are tackling topics that are meaningful.

Quality Strategy

To continue to improve our approach to quality and learning we are establishing the Quality Framework at specialty and expert meeting level. The main focus in the coming year will be to establish the Quality Framework at Specialty level with key outcome objectives agreed in the Quality Strategy as follows:

50% of specialties and departments have:

a. An active improvement programme
b. Gold QI coach
c. Identified local quality assurance indicators



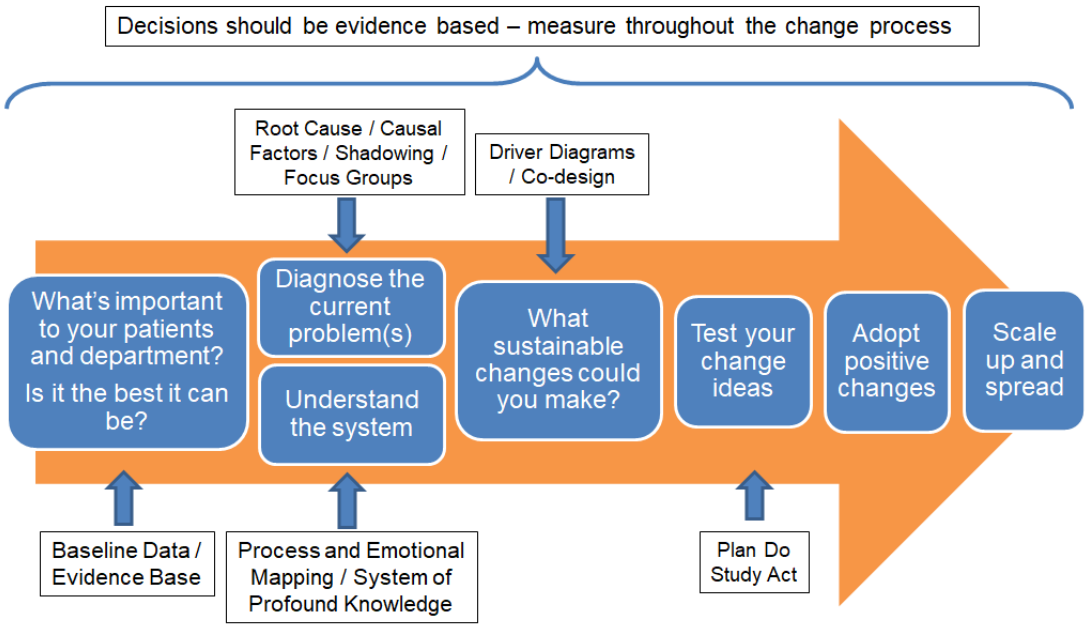
Gloucestershire Safety and Quality Improvement Academy (GSQIA) Training Update

The GSQIA continues to increase the Trust's capacity and capability to undertake structured and evaluated quality improvement projects.

During 2019, there were a total of 39 Bronze level improvement courses. These provide an overview of various QI methodologies in an interactive way designed to apply the theory of QI into practice. These courses resulted in 682 new Bronze improvers.

The Silver courses continue to be extremely popular. Participants come onto the course with a problem from their own areas of work that needs to be improved and the methodologies from the Bronze course (along with some additional teaching) are applied to this specific problem. 81 Silver projects were started during 2019. In addition, 5 Silver graduations events took place allowing the completion of 46 projects to be shared and celebrated. 78 staff members graduated as Silver QI practitioners.

The GSQIA Way



In 2019, the Gold QI coaching programme allowed 16 trainee Gold coaches to begin their journey and 11 new Gold coaches graduated and were recognised at the GHT staff awards. The next cohort of Gold coaches start their programme in March with 15 applicants.

The wider GSQIA team were also delighted to be recognised at the staff awards as winners of the 'Quality and Innovation Award'.

Picture: GSQIA Team winners of the Quality and Innovation Award at our Staff Awards (November 2019)

GSQIA Developments

Training Review

A review of training materials has resulted in the redevelopment of the course workbook provided to each Bronze and Silver trainee. This new format is more

sustainable than previous versions and has also resulted in a reduction in the time it takes to produce these materials.

Patient Experience Improvement Faculty

The Patient Experience faculty was launched on 2 March led by the Deputy Director of Quality and the Head of Quality (Patient Experience Improvement), to develop and facilitate one of the main drivers in the Quality Strategy.

"Building a culture of improvement with an expectation of co-design with patients and colleagues"

The Patient Experience team has produced a new module for both the Silver and Gold elements of the learning pathway. These modules provide training in methodologies that encourage involvement of patients, such as interviews, focus groups and questionnaire design. The most popular methodology has been the use of 'Emotional Mapping' for use in conjunction with 'Process Mapping' to show the emotional impact of each stage of the journey on patients, carers and staff, and use this to identify specific areas for improvement and co-design solutions.

Figure: Number of staff who have completed Bronze Quality Improvement training

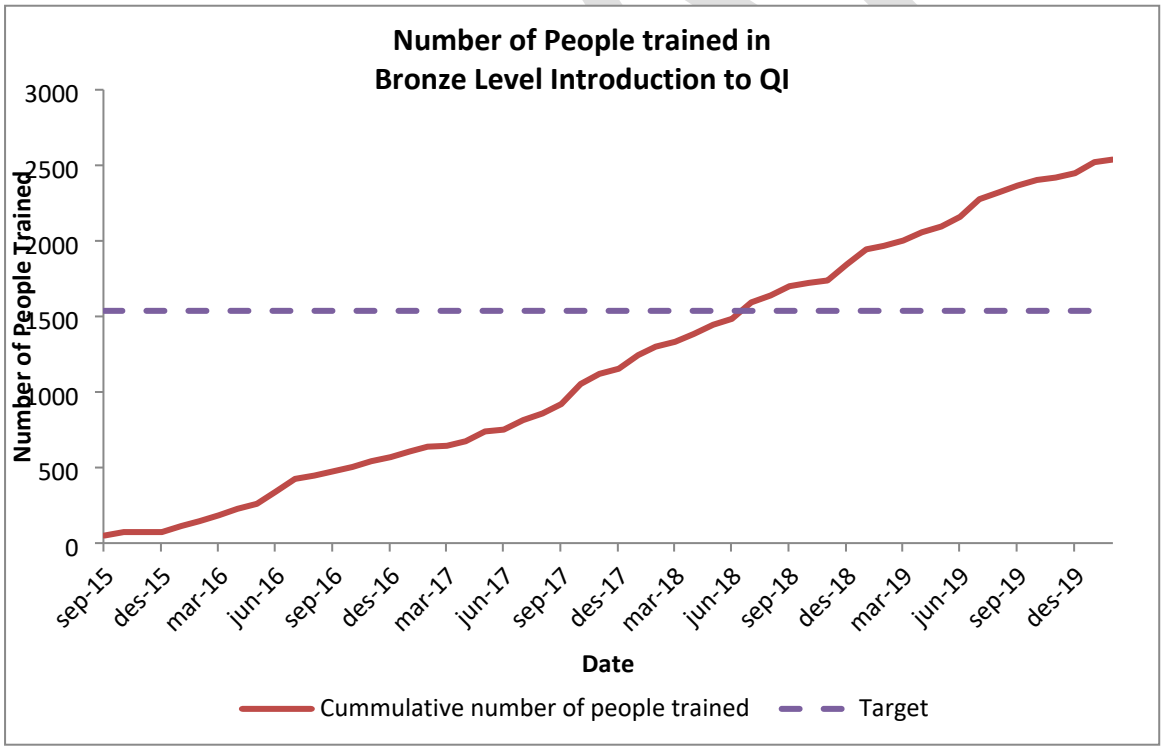
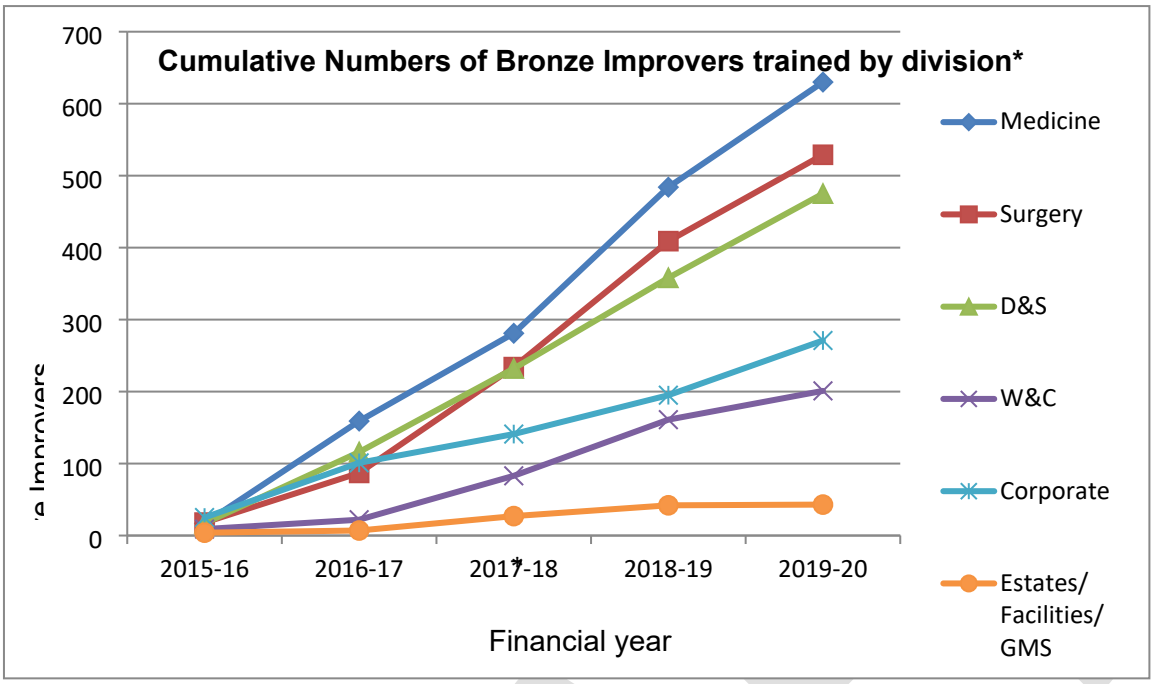


Figure: Number of staff who have completed Bronze Quality Improvement training by division



* As provided at point of booking (does not include preceptorship nurses, F1 or rotational doctors or bank staff)

Figure: Silver Quality Improvement training

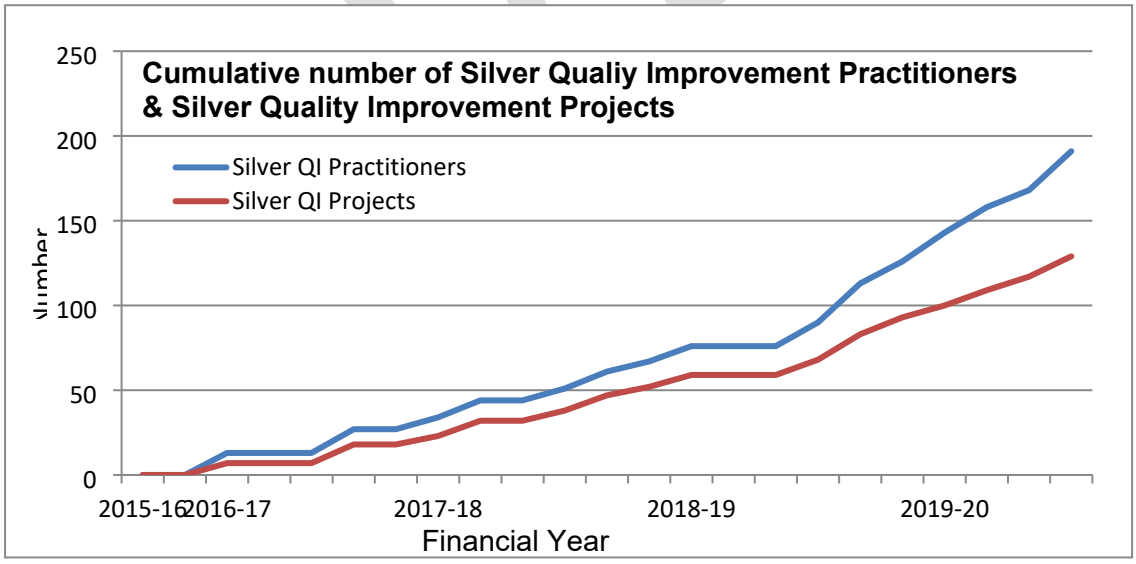
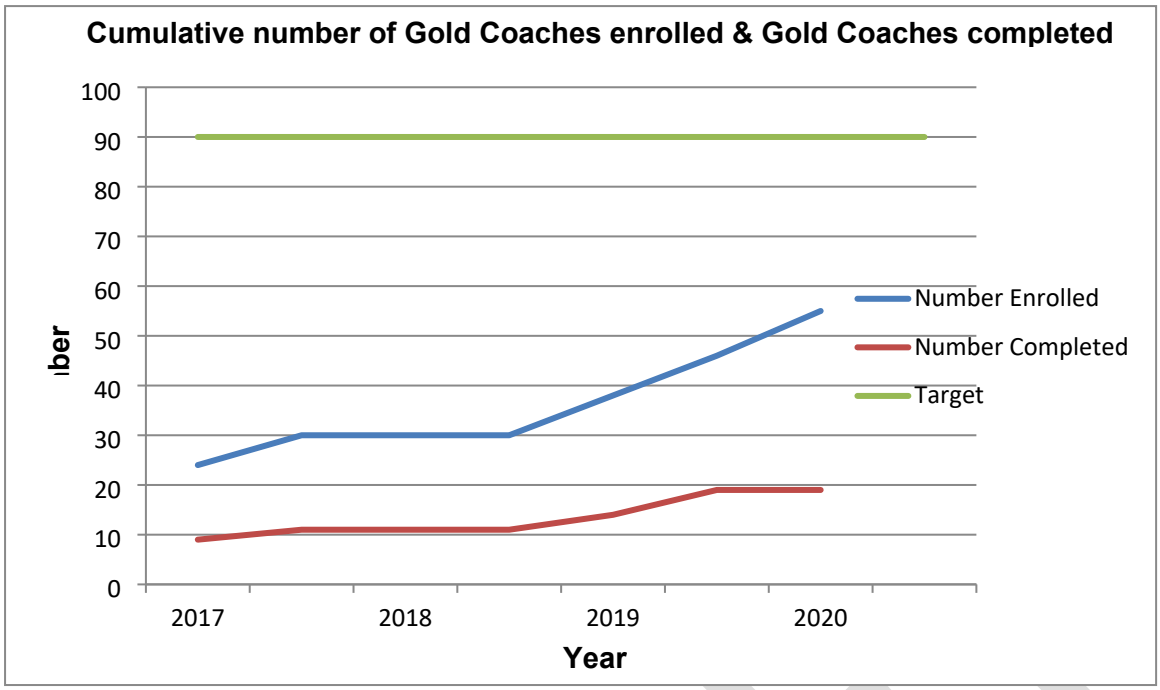


Figure: Gold Quality Improvement Coach training



Plans for improvement 2020/21

- The GSQIA team are looking at virtual training options, to continue to deliver Bronze, Silver and Gold training while we are social distancing due to Covid, which will continue for a number of months

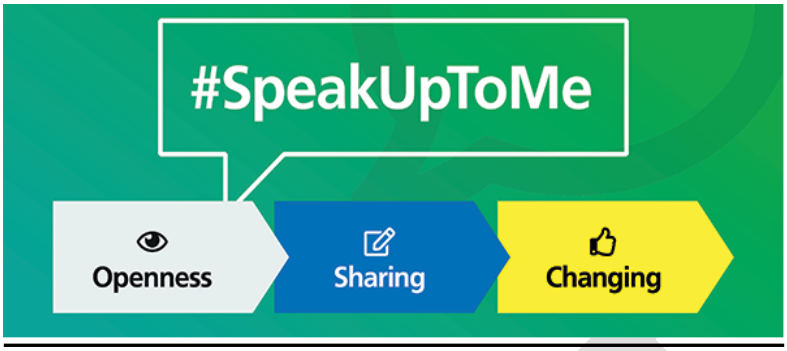
- The work of the GSQIA will continue and information can be reviewed on our Trust website, with regular communications about our work on Facebook, Instagram, LinkedIn and Twitter.

- GSQIA will support the delivery of the Quality Strategy across the Trust and measure our progress by monitoring our “Big Dot” metrics.

- After developing our Human Factors programme to the GSQIA portfolio of training we will begin work on introduce our Patient Experience Faculty and build in patient experience improvement into our Silver and Gold programme.

2. Quality priority

To continue to develop our speaking up systems and processes through Freedom to Speak Up



Background

Effective speaking up arrangements protects patients and improve the experience of our colleagues. Having a healthy speaking up culture is an indicator of a well-led Trust. We now have 4 Freedom to Speak up Guardians: -

- Suzie Cro, Deputy Director of Quality
- Katie Parker-Roberts, Head of Quality
- Sarah Brown, Voluntary Services Manager
- John Thompson, Lead Chaplain (Appointed March 2020)

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.

How we have performed 2019/20

Our data shows that there was a reduction in the number of concerns raised with the FTSUG from 26 in Q4 to 23 in Q1 and 2 but this has increased again in Q3.

Concerns	End of year 2017/18	End of Year 2018/19	April – June Q 1	July – Sept Q 2	Oct- Dec Q 3	Jan – March Q 4	End of Year 2019/20

Concerns	End of year 2017/18	End of Year 2018/19	April – June Q 1	July – Sept Q 2	Oct- Dec Q 3	Jan – March Q 4	End of Year 2019/20
Total number of people raised directly with the Freedom to Speak Up Guardian	31	**65**	14	9	18	15	**56**
Number of issues raised anonymously	4	15	3	4	7	5	19
Nature of issue							
- Patient quality issues	*17	*20	*3	*2	*2	*5	*12
- Staff experience - unacceptable behaviour (bullying / harassment)	*19	*47	*11	*8	*18	*5	*42
Action	Support and advice	All staff provided with support and advice	Yes	Yes	Yes	Yes	Yes
Outside referral	0	0	0	0	0	0	0
Number of case where people indicate detriment	1 case	0	None	None	None	None	1
Of the people asked in this quarter who would speak up again	The majority of individuals would speak up again.	Yes 100%	Yes 100%	90%	80% would	80%	87%

*One person may raise issues about quality and poor staff experience

<u>Individual/team changes</u>

The following lessons have been learned and improvements made for individuals/teams as a result of staff raising concerns over the last 12 months:

- Support and coaching provided by the Leadership and OD Team to individuals.
- Team development sessions have been organised
- Extra support provided to a new staff member with additional needs (reasonable adjustments).

Organisational change

The following organisational lessons have been learned and improvements made:

- Work has begun on a staff behavioural standards charter after engagement sessions with over 100 staff.
- We have been proactively implementing the Gosport Inquiry recommendations.
- The research on how rudeness impacts on how individuals and teams function has been shared with leaders within the organisation.
- The Dignity at Work (bullying and harassment) Policy has been reviewed and updated by the HR team.

We are on a cultural improvement journey and learning lessons will be key to developing the right Speaking Up culture. Freedom to Speak Up is now an integral part of the 'Well Led' domain of CQC inspections. Whilst this is a recent initiative, listening and responding to people who speak up and tackling the barriers to speaking up, is an ingredient of good leadership and an area where we want to excel.

Our Trust Freedom to Speak Up Index Score

Gloucestershire Hospitals NHS Foundation Trust is listed at 79%, which is above the national average (Acute Trust average is currently 75%). This was calculated as the mean average of responses to four questions from the NHS Annual Staff Survey.

Plans for improvement 2020/21

- Recruit more Freedom to Speak Up Guardians including two consultant posts, to improve links with the medical workforce.
- Review speaking up training requirements for all staff.
- Deliver our Freedom to Speak Up Improvement plan.
- Work with Leadership and Organisational Development team to support roll out of values and behaviours, including Civility Saves Lives campaign, and connect with Freedom to Speak Up agenda.

3. Quality priority

To improve patient experience of our discharge processes

Background

Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. Over 2019/20 we have continued our safe and proactive discharge programme which was a Commissioning for Quality Improvement programme (CQUIN 2019/20). Our Adult Inpatient Survey data identified this as an area of improvement which was endorsed by our Governors.

How we have performed 2019/20

Improving experience of patients on discharge is one of the quality priorities for the Trust in 2019/20, with the Inpatient Survey 2018 showing that we are performing below average on a number of areas relating to discharge, with three key areas requiring particular focus; patients knowing what would happen next with care after leaving the hospital, patients being given written or printed information about what they should or should not do after leaving hospital, and patients being told the purpose of medications. More details with the scores can be seen in the table below:

Table One: Discharge Indicators from Inpatient Survey 2018

		2014	2015	2016	2017	2018	Average	Organisation
Q48+	Discharge: felt involved in decisions about discharge from hospital	85%	84%	84%	82%	84%	84%	84%
Q49	Discharge: given enough notice about when discharge would be	87%	88%	87%	85%	84%	87%	84%
Q50	Discharge: was not delayed	63%	61%	63%	64%	62%	60%	62%
Q52	Discharge: delayed by no longer than 1 hour	14%	14%	20%	12%	10%	12%	10%
Q54+	Discharge: got enough support from health or social care	-	81%	76%	77%	78%	78%	78%

	professionals							
Q55+	Discharge: knew what would happen next with care after leaving hospital	-	63%	82%	82%	80%	84%	**80%**
Q56	Discharge: patients given written/printed information about what they should or should not do after leaving hospital	63%	60%	60%	62%	**54%**	63%	**54%**
Q57+	Discharge: told purpose of medications	89%	92%	90%	89%	87%	91%	**87%**
Q58+	Discharge: told side-effects of medications	56%	57%	48%	57%	54%	57%	54%

One particular area of the focus for the Trust this year has been about reducing Delayed Transfers of Care (DTOC), as this has a huge impact on patient outcomes and experience. Gloucestershire Hospitals NHS Foundation Trust have a target to keep Delayed Transfers of Care under 3.5% and this has not been achieved in recent months due to lack of flow across the system and ward closures due to infection control. December 2019 to February 2020 were particularly challenging months for the Trust.

Table Two – Delayed Transfers of Care at Gloucestershire Hospitals NHS Foundation Trust in 2019

Month	Bed Day Delays	DTOC %
Jan-19	838	2.94%
Feb-19	718	2.79%
Mar-19	899	3.15%
Apr-19	1,293	4.84%
May-19	1,067	3.87%
Jun-19	612	2.29%
Jul-19	933	3.42%
Aug-19	1,162	4.26%
Sep-19	1,192	4.51%
Oct-19	1,014	3.71%
Nov-19	852	3.28%
Dec-19	745	2.77%

NHS Benchmarking, however, shows our position more favourably nationally, as illustrated in the graph below:

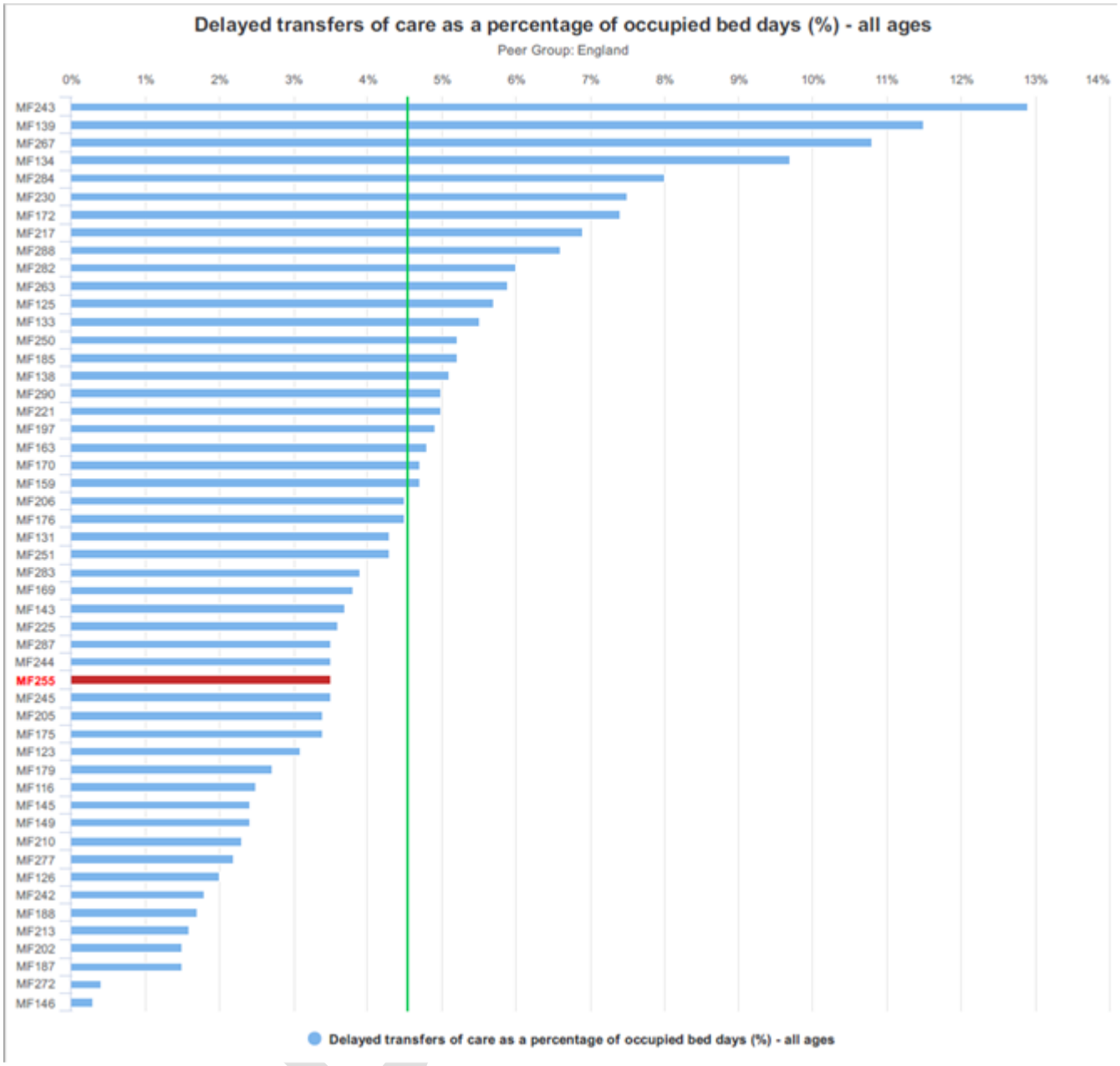


Fig One: national benchmarking for delayed transfers of care as a percentage of bed days

Plans for improvement 2020/21

Although national benchmarking has shown a more positive picture, our initial findings from the National Inpatient Survey 2019 results show that discharge is still an area of patient experience that we need to improve. There will be continued focus on reducing DTOC in 2020/21, in addition to the latest Inpatient Survey results

being used to coordinate an improvement plan across the Trust focussed on improving discharge experience, particularly around the information provided to patients.

4. Quality priority

To improve cancer patient experience

Background

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

How we have performed 2019/20

One of the challenges of the Cancer Patient Survey is the timeliness of the data, with the results being published a year after being collated. The latest Cancer Patient Experience Survey 2018 scores were published in September 2019; the Trust scored 'about the same' as other organisations for 41 of the questions. The tables below show where we performed outside of this range, either above or below:

Table One: Cancer Patient Survey 2018 scores above upper limit

Question no.	Question	Number of responses	2017 score	Lower limit	Upper limit	National average scores
Q20	Hospital staff gave information about support groups	1122	92%	83%	90%	86%
Q33	All staff asked patient what name they preferred to be called by	797	79%	60%	78%	69%

Table Two: Cancer Patient Survey 2018 scores below the lower limit

Question no.	Question	Number of responses	2017 score	Lower limit	Upper limit	National average scores

Question no.	Question	Number of responses	2017 score	Lower limit	Upper limit	National average scores
11	Patient given easy to understand written information about the type of cancer they had?	1140	68%	71%	77%	74%
15	Patient definitely told about side effects that could affect them in the future	1239	51%	53%	59%	56%
16	Patient definitely involved in decisions about care and treatment	1347	76%	76%	81%	79%
17	Patient given the name of the CNS who would support them through their treatment	1312	85%	89%	94%	91%
34	Always given enough privacy when discussing condition or treatment	798	83%	83%	88%	86%
38	Given clear written information about what should/should not do post discharge	726	84%	84%	90%	87%
55	Patient given a care plan	1058	29%	32%	39%	35%
57	Length of time for attending clinics and appointments was right	1354	62%	62%	76%	69%

Table Three: Cancer Patient Survey scores trends

	2015	2016	2017	2018	Trend
Number of scores better than national average	21	32	14	12	Down 2
Number of scores the same as	2	2	8	12	Up 4

national average					
Number of scores worse than national average	26	18	30	28	Down 2
No comparison	3	0	7	0	

A new Lead Cancer Nurse has been appointed whose focus is on Patient Experience Improvement. A major challenge has been around getting colleagues to recognize this data as the experience of our patients, as the data in the National Survey includes questions related to care provided from GPs and satellite clinics. A patient experience workshop was delivered in January 2020, with patients from across a range of cancer pathways, to understand our local patient experience, and start to shape an improvement plan.

The workshop was made up of patients who had used/ or were still using the cancer services within Gloucestershire Hospitals NHS Foundation Trust in the last two years (2017-2019), recruited through social media and local cancer charities.

Table Four: Patients who attended the workshop in January

Cancer site	Male	Female	Completed treatment	Still in treatment	Total Number of patients
Secondary Breast Cancer		5		5	5
Haematological Cancer	1	2	2	1	3
Breast Cancer		9	7	2	9
Upper GI	1		1		1
Lower GI	1	2	3		3
Gynaecological		3	2	1	3
Prostate	2		2		2

Plans for improvement 2020/21

Patients at the workshop reported a mostly positive experience. Largely they felt care they received from staff, particularly the oncology team, was compassionate, involved them as patients in decision-making, and generally provided them with good emotional support.

Patients were keen to celebrate where teams have exceeded expectations and provided compassionate care, but felt some changes being made would make 'good care' become 'outstanding', as well as celebrate and continue to deliver areas of care that were already outstanding.

The feedback from these sessions has been used to develop an action plan for 2020/21, with some of the key themes including:

- Improving the oncology environment
    - offering more healthy food choices in outpatients
    - improving dignity and confidentiality
- Improving written communications and health information
    - reviewing and improving the website as currently difficult to navigate
    - partnership working with the Trust Library and Knowledge services
    - reviewing patient information provided for use of health jargon and plain English
- Improving access to clinical teams in a timely fashion
- Improving signposting to support services and carers support
- Improving communication across divisions
- Improving engagement with seldom heard communities
- Continue to provide opportunities for patients to be engaged in development of services
- Advanced communication training around breaking bad news

This action plan will be monitored through Quality Delivery Group throughout the year.

5. Quality priority

To improve outpatient experience

Background

With the aim of improving outpatient experience across 'One Gloucestershire' Gloucestershire Clinical Commissioning Group secured funding to drive an improvement programme. An external company 'Attain' were appointed. Over a 12-week period Attain gathered available information, questioned patients, engaged with clinical and non-clinical staff and reviewed their findings against examples of best practice to co-produce a list of improvement options (relating to patient satisfaction, staff engagement and value for money) across four specialities.

Their assessment also identified a number of 'cross-cutting' themes (relating to booking pathways, workforce and communication) which if not addressed had potential to slow an improvement programme.

How we have performed 2019/20

The four specialities involved in the initial improvement work were

- Neurology
- Dermatology
- Rheumatology
- Diabetes

Feedback gained from the wide range of methodologies used by Attain e.g. staff engagement groups, patient questionnaires, patient emotional mapping questionnaires resulted in four action plans which the respective specialities within the Medical Division (with Transformation and Service Improvement Programme support) were responsible for delivering.

Key achievements in year include:

- Improved clinic outcome data
- Production of monthly clinic wait reports (by Consultant)
- Outstanding clinic change requests actioned by clinical systems team
- Commitment to the start of a physiotherapist led inflammatory arthritis clinic 2020
- Initiation of pilot non-face to face clinics e.g. telephone calls
- Redrafting of outpatient appointment letter, with launch September 2019.
- Redrafting of all other patient letters; to be circulated from 2020 after user training sessions completed
- Text reminders changed to 14 and 3 days (reminder) prior to appointment
- Referral Assessment Service started in Gastroenterology

- ‘One Gloucestershire’ introduction of Cinapsis software for GPs to forward photos as part of ‘Advice and Guidance’
- GP’s now able to order anti cyclic citrullinated peptide (CCP) test prior to referral for an Early Inflammatory Arthritis appointment
- Targeted GP training e.g. Rheumatology / rheumatic disease

The table below shows the attendance numbers and Did Not Attend (DNA) rates for outpatient services from August 2019-January 2020, including when different initiatives were introduced.

Table One: Attendance rates with initiative inputs

Attendances	*Thres hold*	Aug-19	New appt. letter format	Sep-19	Oct-19	Text reminder changes	Nov-19	Dec-19	Changes to all OP letters 16.01.20	Jan- 20
First Attendance	-	19,952		22,358	25,504		23,417	20,032		24,368
First DNA	-	1,666		1,932	2,048		1,806	1,740		1,999
Follow-up Attendance	-	38,045		39,937	44,441		42,337	37,716		44,481
Follow-up DNA	-	2,641		2,949	3,039		2,932	2,582		3,182
First DNA Rate	*5%*	7.71%		7.96%	7.44%		7.16%	7.99%		7.58%
Follow-Up DNA Rate	*8%*	6.49%		6.88%	6.40%		6.56%	6.41%		6.68%
First Attendance Discharged Rate	-	23.70%		22.12%	21.25%		21.59%	21.85%		25.72%

Plans for improvement 2020/21

It is recognised that outpatient departments are spread across and within all clinical divisions, and so the Trust steering group provides strategic lead to the optimisation and improvement of services. In November, the programme of work underwent a revision to focus improvements to specific activities, extending improvement implementation beyond the four initial specialties. Additional programme support has been allocated from Transformation and Service Improvement, and the latest plans for 2020/21 can be seen below. Of particular note and focus is the introduction of a digital offer, the roll out of which has been accelerated during the management of Covid-19.

Outpatient transformation programme 20/21

Work-streams

1. Improve clinic utilisation

Key tasks:

- Review of service level utilisation and plans to address
- Develop booking rules at specialty level
- Determine , capture and capitalise impact of Gastro RAS

2. Reduce F2F attendances

Key tasks:

- Patient advices lines/ services
- Increase Telephone clinics and capture existing activity
- Patient initiated FUP
- Variation – new: FUP ratio

3. Referral Assessment Service (RAS)

Key tasks:

- Develop Gynae RAS
- Develop Derm RAS
- Implement Prostate RAS
- Develop Cardiology RAS
- Develop Resp RAS
- Monitor Gastro RAS
- Evaluate options for future roll-out

4. Optimising workforce

Key tasks:

- OP nursing and associated staffing review

5. Booking and Utilisation

Key tasks:

- Review appointment types
- Improve missing outcomes
- Correct vetting errors
- Booking review – centralisation benefits realisation

6. Patient correspondence

Key tasks:

- New format for letters
- Improve text reminders
- Support access policy with correspondence
- Email correspondence

7. Increase Digital offer

Key tasks:

- Develop virtual clinics
- Remote monitoring
- Attend Anywhere video consultations
- Digital blood monitoring: DMARDS
- 2-way text (links to 6)

8. Efficiency & productivity

Key tasks:

- DNA reduction
- Improve clinic change process
- Advice and Guidance to GPs
- Increase use of Cynapsis
- DrDoctor

9. Division Activity

Key tasks:

- Quality Improvement: Radiology booking
- Enhanced Physio Ank S Service Rheumatology
- Pharmacist led pt education (Derm/ Rheum)
- Evaluate impact

Project contacts

- PMO support : Lucy Blandford / Debbie DeWit/ Jenny Yates
- Progress reports to OP service group. Chair: Alex Holland
- Exception reporting to OP Steering group. Chair::Judith Hernandez

6. Quality priority

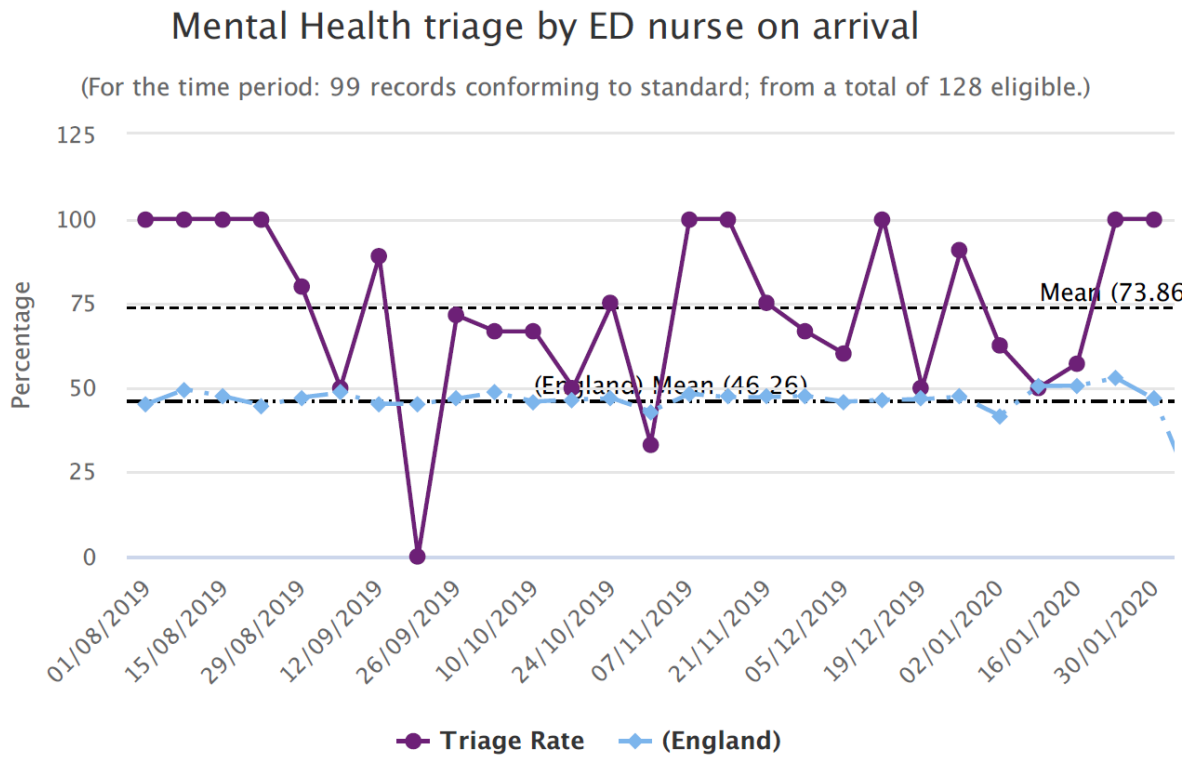
To improve mental health care for our patients coming to our acute hospital

Background

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

How have we performed 2019/2020

The Lead for Mental Health Liaison and our Emergency Department Matron have been working on a Quality Improvement project (Silver GSQIA project) that uses a modified Manchester Triage Tool to identify Priority 1 & 2 patients for an early mental health review. This is being run concurrently with the Royal College of Emergency Medicine who has also undertaken a Quality Improvement project but using a different tool. Below is the data for the numbers of patients who were triaged at Gloucestershire Royal Hospital by an Emergency Department (ED) nurse on arrival.



Training in the use of this Triage Tool has been given to all Band 6 nurses within Emergency Department.

The Trust now has secured £480,000 additional funding, on the Gloucestershire Royal Hospital site, and £345,000 at Cheltenham General Hospital site to recruit Mental Health nurses for the acute setting in order to deliver a mental health review response within 1 hour. The recruitment to these posts will help the Trust meet the national “CORE 24 standards” which is the initiative to provide a 24-hour service for mental health patients.

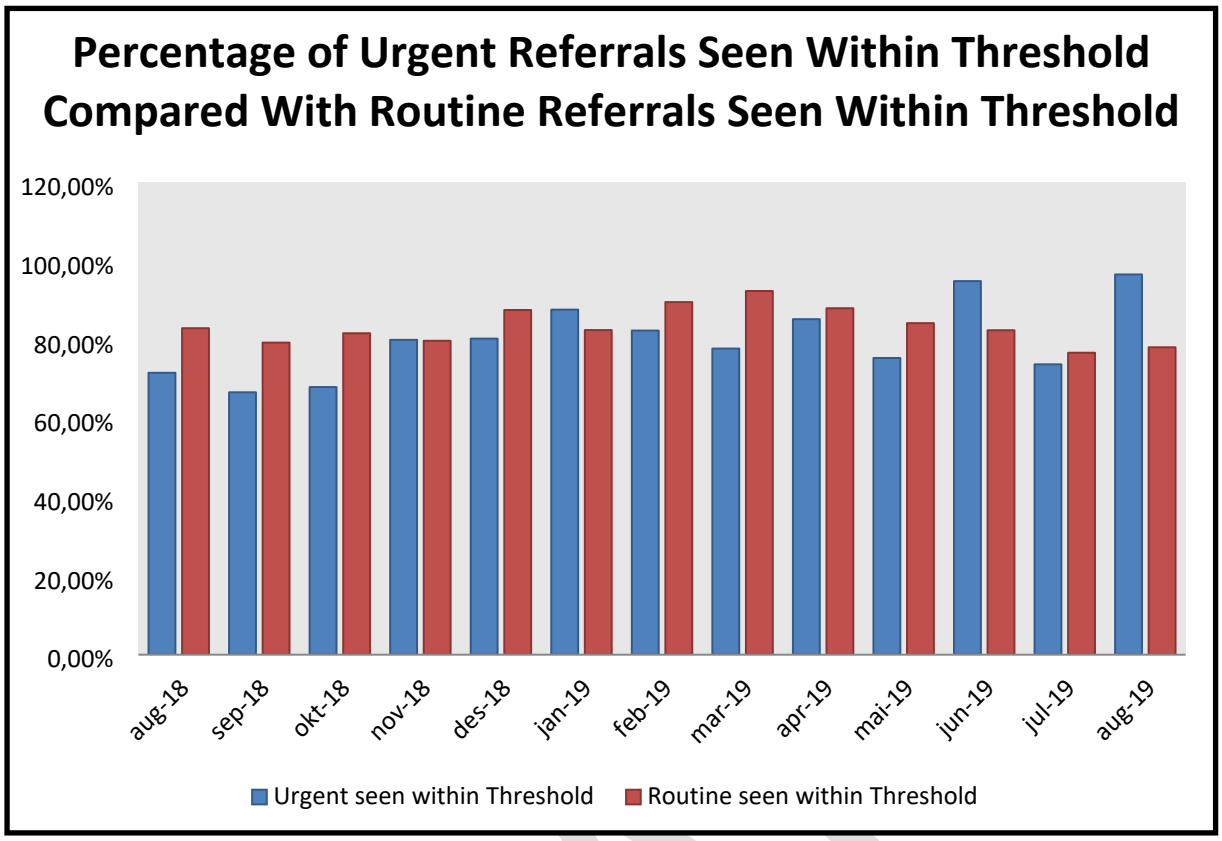
The average length of stay for people with mental health issues who were seen by the Mental Health Liaison Team is on average 53.7% lower than those Mental Health patients who were *not* seen, which is a reduction of 2.2 days per patient on average. This is more significant in that the average patient seen by the Liaison Team is ‘higher intensity’ and higher cost than the no contact cohort (average cost of Liaison contact spell = £557, average cost of non-contact MH patient=£428).

The re-admission rate is also lower for those patients who were seen by the Liaison Team (16.8% re-admission rate, compared with 18% for those who were not seen). Re-admission rates are steadily declining for all MH admissions.

There is still more work to be done on accurately recording data, such as developing the inpatient MH definition further to ensure that we are accurately capturing the correct cohort of patients. The switch to the new Emergency Care Data Set (ECDS) should enable an accurate baseline level of activity.

Current service improvements are seeking to improve patient flow, however, patients who require a medical admission for treatment still require that treatment irrespective of when a Mental Health Liaison Team assessment takes place. Current ED practice includes artificial barriers to referral which have been improved upon and could be further through upstreaming that assessment to impact on flow and length of stay. Improved triage, earlier senior review and adoption of the “medically fit for assessment” principle (rather than medically fit for discharge) are already having significant impact. Simultaneous streaming and robust mental health triage will result in drastically improved patient flow and experience, enabling time and cost saving potentials to demonstrate return on investment.

Data



Plans for improvement 2019/20

The NHS Long Term Plan includes the Mental Health Implementation Plan which runs over the next 5 years (2019/20 – 2023/24). By 2020/21 all acute hospitals will have Mental Health Liaison Services that can meet the specific needs of all ages and 50 % of liaison services will be meeting the CORE 24 Standards.

A recruitment campaign will be our focus for 2020 so that the Mental Health Liaison Team will deliver first assessments to inpatients within 1 hour from the time of referral to all patients with a mental health issue or diagnosis of mental health problems.

There will be specific training given across the Trust to all nurses graded at Band 6's, 7's and junior doctors in the delivery of the modified risk assessment tool. Also, an evaluation of the use of Mental Health nurses at triage will be undertaken which will enable co-streaming and assist in delivering a 1 hour response. The Mental Health Liaison Team will continue reducing unnecessary admissions where safe to do so.

7. Quality priority

To develop a real time patient experience survey programme

Background

Our National Adult Inpatient 2018 Survey scores tell us that patients would like more opportunities to provide us with feedback on how we can improve, and our staff survey data tells us that staff would like access to more real time patient experience data.
Real-time surveys were launched across the Trust in April 2019 in order to track real-time experience on key areas identified in Inpatient Survey as areas for improvement.

How we have performed 2019/20

The table below shows the real-time responses of patients, including the Inpatient Survey response in 2018 as a benchmark.

Real Time survey Question	Q1	Q2	Q3	Q4	2019/20 average score	Inpatient Survey 2018 scores
How much information about your condition has been given to you?	77%	81%	79%	81%	**80%**	**79%**
Are you involved as much as you want to be in decisions about your care and treatment?	93%	93%	90%	93%	**92%**	**89%**
Do you feel that you are treated with respect and dignity by all staff caring for you?	96%	99%	99%	99%	**98%**	**97%**
Do you feel well looked after by staff treating or caring for you?	98%	100%	98%	100%	**99%**	**98%**
Have you been asked to give your views on the quality of your care?	-	-	10%	9%	**9%**	**5%**
Do you know who you could talk to about any concerns or complaints you may have about your treatment?	91%	87%	75%	69%	**81%**	**-**
Do you get enough help from staff to wash or keep yourself clean?	97%	100%	90%	93%	**95%**	**87%**
Do you get enough help from staff to eat your meals?	90%	96%	83%	81%	**88%**	**74%**
In your opinion, how clean is the ward or area that you are in?	98%	99%	99%	99%	**99%**	**95%**
Are you bothered at night by noise from hospital staff?	-	76%	78%	74%	**76%**	**74%**
Are you bothered by noise at night from other patients	-	61%	59%	57%	**59%**	**55%**

Since launching in April 2019, there have been challenges with getting consistent and reliable data for real time surveys, due to issues with the tablets and also struggling to recruit volunteers to deliver the surveys, which makes analysing and understanding individual anomalies more difficult. Originally, the volunteers were completing surveys on one division per month, which gave an overall picture for each division, but did not provide enough detail at ward level to provide meaningful insights for improvement.

The Patient Experience Improvement Manager has been working with the volunteers to review this, and has a new plan for delivering real-time surveys for 2020. The

schedule for volunteers combines surgical and medical wards at each site every month.

This will move focus away from Women's and Children's (W&C) and Diagnostic and Specialties (D&S) wards. This should ease pressure on the volunteers conducting the surveys and give us more consistent month-on-month responses for the medical and surgical divisions.

Plans for improvement 2020/21

Due to Covid, we are unable to continue with the real-time survey programme temporarily as this is delivered by volunteers on the wards. We will continue working with the Business Intelligence team to estimate how many patients are on a particular ward at any time, to help guide our Real-Time survey delivery and gauge how representative it is. We hope this could give us an aim as to how many patients we should be speaking to each month, and in turn plan resource accordingly. The schedule above also gives us more consistent responses across a range of wards in both surgical and medical divisions each month, giving us data we can track over time more reliably.

We also plan to meet up more regularly with the volunteers on both sites, both to encourage and gratify them for their efforts. This will also give them the opportunity to feedback to us on how they find conducting the surveys. Volunteers get a regular schedule as above and reports showing the feedback that is received from patients, so they can see the impact they are having with the information they are collecting.

We have launched the Patient Experience Faculty, and the team are working closely with divisional leads to improve access to data, reporting and analysis, to support teams to use this feedback to drive improvement in their service areas.

8. Quality priority

To enhance and improve our safety culture (SCORE Survey)

Background

Safety culture refers to the way patient safety is thought about and implemented within an organisation and the structures and processes in place to support this. Measuring safety culture is important because the culture of an organisation and the attitudes of teams have been found to influence patient safety outcomes. Using validated tools, we are able to measure this culture, identify areas for improvement and monitor change over time.

How we have performed 2019/20

A variety of culture surveys were reviewed and the SCORE (Safety, Communication, Operational Reliability & Engagement Survey) survey by *Safe and Reliable Care* was selected. SCORE is an internationally recognised and scientifically validated way of measuring and understanding the culture that exists within organisations and teams. Through a number of specifically targeted questions it provides an assessment across a variety of domains including:

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

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

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

Focus groups beginning to analyse the data by work setting and staff group have begun across the theatres teams.

Plans for improvement 2020/21

Planning is currently under way for the outstanding surgical and anaesthetic focus groups. Once completed the next step of the process will be to develop a multi-disciplinary improvement collaborative using the data and feedback collected. This will utilise Quality Improvement methodologies and with the support of the Gloucestershire Safety & Quality Improvement Academy (GSQIA) involve the staff in developing and testing improvements in the identified areas.

The SCORE survey will be repeated in 2021 to determine the impact of the interventions undertaken.

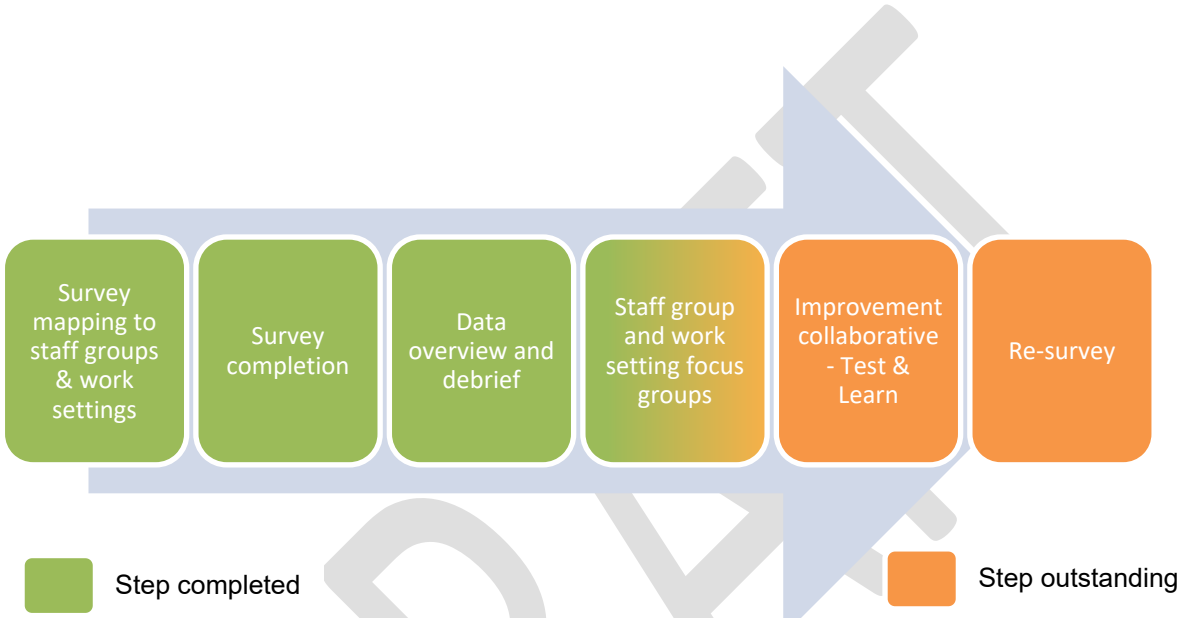


Figure 1: The Survey Process & Progress

9. Quality priority

To improve our patients beginning their first treatment for cancer within 62 days following an urgent GP referral for suspected cancer

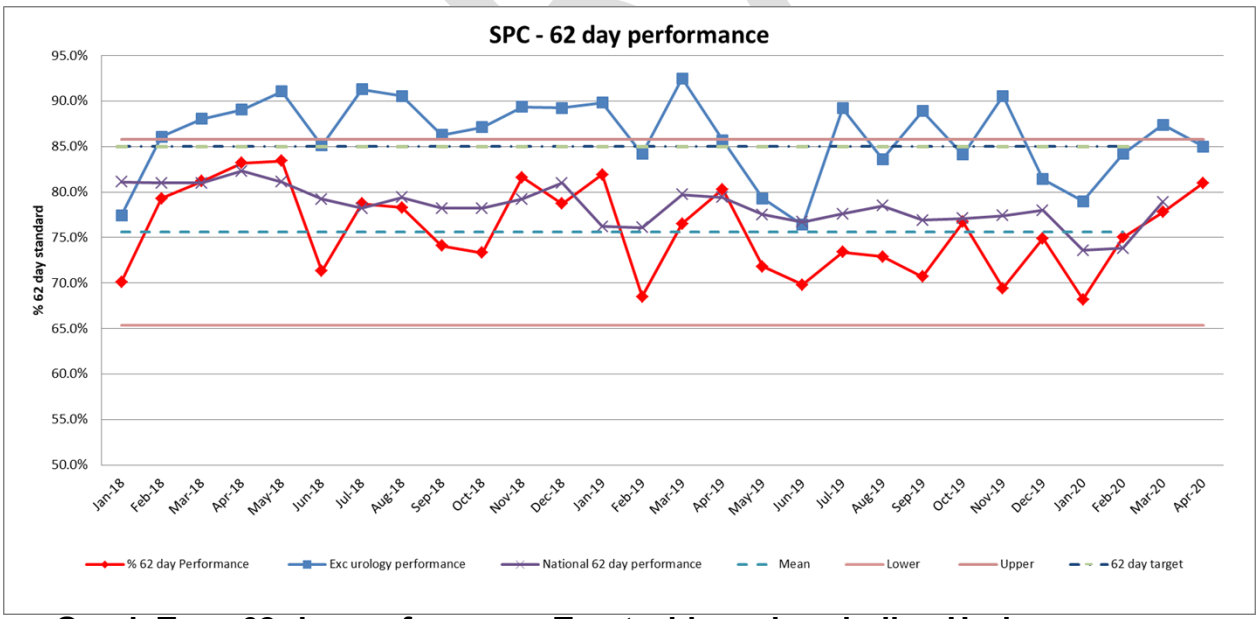
Background

The NHS Constitution sets out a number of pledges and commitments to the public about the access to services and people's rights. One of these pledges is "The NHS commits to provide convenient, easy access to services within the waiting times set out in the handbook to the NHS Constitution." This means that patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly. Organisations' performance is monitored across all waiting time pledges, including a national target for Trusts to ensure that 85% of patients to begin their first definitive cancer treatment following urgent GP referral within 62 days.

How we have we performed 2019/20

62-day performance

Nationally Trusts are continuing to struggle to meet the 62-day standard with latest national performance of 78.9% (March - latest data available). April un-validated position for the Trust is 81%. COVID19 pandemic has impacted the delivery of cancer services. Cancer Services and specialties have had to adapt to new ways of working and pathways through March and April 2020.



Graph Two: 62-day performance Trust wide and excluding Urology

Please see below the 62-day breach analysis for Quarter 4.

Cancer site	Treated	Breaches	Performance
Urology	137	80	41.6%
Lower GI	56.5	23	59.3%
Skin	139	14	89.9%
Head and Neck	30.5	10	67.2%
Lung	33.5	5.5	83.6%
Breast	92	2.5	97.3%
Gynae	31	7.5	75.8%
Haematology	23	3	87.0%
Upper GI	40.5	6.5	84.0%
Other	5.5	1.5	72.7%
Acute leukaemia	0	0	
Testicular	4	0	100%
Sarcoma	1.5	0	100%
Brain	1	0	100%
Trust wide (unvalidated)	**595**	**153.5**	74.2%
Trust wide (exc Urology)	**458**	**73.5**	84.0%
Trust wide performance with modelling of 65% performance for Urology	**458**	**121.5**	79.6%

Plans for improvement 2020/21

To support improvement during 2020/21 specifically aimed at improvement of 62-day treatment we have a Delivery Plan for each speciality area.

Corporate actions

- Radiology and Pathology Coordinators have been recruited and will now allow us clear support for escalation of patients who are not meeting timed targets on respective tumour site pathways.
- Videoconferencing equipment across all three rooms (Oncology seminar room, Sandford Education Centre and Redwood Education Centre). The first room has now been completed (Sandford Education Centre) the other two rooms are on course for completion before mid-March which will support effective use of clinical time between sites.

The main tumour site that we are supporting for 2020/21 is Urology.

Urology

- Executive led Task and Finish group established focusing on implementation of RAPID prostate pathway:-
    - Reduce timeframes and additional processes by:
        - Straight to Magnetic Resonance Imaging (MRI) pathway with reduced timeframes (request to report) – go live TBC – Revised prostate proforma and pathway submitted to Clinical Commissioning Group colleagues
        - Prostate cancer specific clinics
        - Consultant training for local anaesthetic template biopsies – completed
        - Improve pathology turnaround times – turnaround times monitored for technical and clinical approval
- Task and Finish group for Bladder and Renal to be initiated

Improvements we have made in the latter part of March 2020 also will support a sustainable improvement, namely:

Gynaecology

- Consultant led pathway review completed in September with plans to:-
    - Implement consultant triage to ensure patient is booked the most appropriate diagnostic in a timely fashion
    - Implement see and treat hysteroscopy service – now live
- Six hysteroscopes to support see and treat service funded through cancer transformation have now arrived and in operation

Head and Neck

- Review multi-disciplinary team (MDT) function in respect to operational delivery and implementation of MDT effectiveness interventions.
- Additional neck lump clinic trialled (1 in November and 2 in December)
- Additional Head and Neck Cancer Nurse Specialist (CNS) and Support Worker – Support Worker recruited, CNS out to advert again
- Bone Saw which was highlighted as major requirement for pathology following pathway session approved through Capital Control and to be delivered before Christmas

Haematology

- Demand and capacity review across routine and 2 week waits

- Utilise additional clinic space in Edward Jenner Unit (EJU) to create two additional consulting rooms
- Project focusing on inter specialty referral
- Currently out to recruitment for additional full time Consultant Haematologist
- Joint pilot Oncology and Haematology lymphoma clinic established with increased Nurse led bone marrow biopsy capacity

Pathology

- Access arranged for pathology colleagues to update patient records to reduce time between reported case and next action
- Additional capacity to support team

Radiology

- Improved escalation process and intelligence regarding patients waiting for event or report and by specialty. Data is now being collected to show longitudinal performance
- New Pathway Coordinator funded by Cancer Transformation now embedded and radiology huddle to be formed

10. Quality priority

To improve the issue of patients receiving delayed care

Background

Referral to treatment is a national target and is a term used to describe a standard for delivery of care in the NHS that no patient should wait longer than 18 weeks from to the start of their first **treatment**. Once a patient has started their treatment they usually attend follow up outpatient appointments so that we can monitor their condition and if necessary change or update treatment plans. To manage our Outpatient Follow Up appointments we use a Patient Tracking List (PTL) as this is an established, forward-looking, management tool so we know who needs follow up and can plan their appointments. Following the implementation of a new digital Patient Administration System, Trak Care, in December 2016, our operational teams had less visibility of people needing follow up appointments as we temporarily lost the ability to track patients on outpatient lists who were waiting for an appointment. Immediately we implemented a recovery plan to digitally 'find' our patients and what we found was that that there were patients who were delayed on both Referral to Treatment and follow up pathways. In this section, we will describe the improvements that we have been working on for our Ophthalmology Outpatient Patient Services.

Data

The table below sets out the national picture for the number of providers vs the number of patients on a glaucoma and medical retina pathway with a delayed follow up in the last 12 months. The inclusion of benchmarking information is being sourced for future reports to support further challenge to the service(s) where appropriate, but this remains difficult as approximately 30% of Trusts do not publish their individual reports, as illustrated below.

Table: Number of Providers vs number of patients on a glaucoma pathway with a delayed follow up in the last 12 months (GIRFT data)

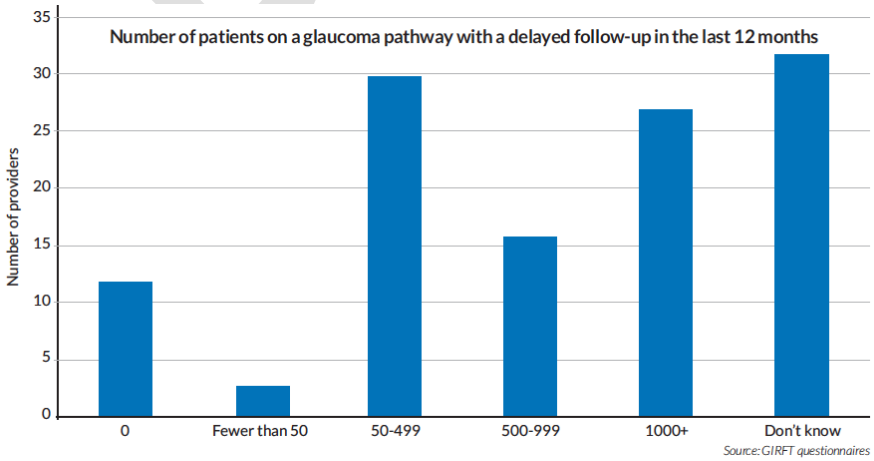
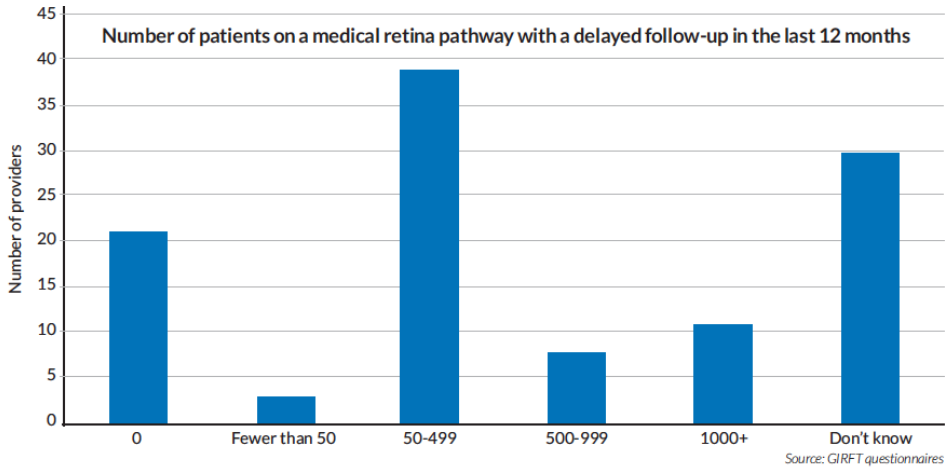


Table: Number of Providers vs number of patients on a medical retina pathway with a delayed follow up in the last 12 months (GIRFT data)



The table below sets out for Gloucestershire Hospitals NHS Foundation Trust Ophthalmology services the un-booked patients within each chronological cohort. Since January 2019 the service has eliminated all the 2017 cohort of patients and in addition has significantly reduced the 2018 cohort, from the start of last year.

[1]	2015 F/U	2016 F/U	2017 F/U	2018 F/U	2019 F/U	2020 F/U
October 2018				9,914	3,621	
January 2019	0	14	3,493			
April 2019	0	0	2,852			
September 2019	0	0	-	3,986		
December 2019	0	0	81	2,460	6,564	
January 2020	0	0	0	2,025	5,799	7,961

Our improvement plan was discussed with the Ophthalmology Service Team and an update on our progress is set out in the table below

Table: Actions taken to improve care for people having delayed care

Improving our capacity	Action	January 2020 Progress Update
We have increased our Medical Staffing for the Ophthalmology clinics	The team have recruited to two additional consultants. One individual commences before Christmas in 2019 and one individual (p/t) to commence February 2020.	In place

[1] Un-booked and excluding $appointment made issues

Improving our capacity	Action	January 2020 Progress Update
We have carried out clinical reviews for patients who have had delayed appointments to see if there has been any potential or actual harm caused by the delay	The Clinical Review for Harm Policy was approved was November 2019 and now being implemented in respect of delayed care for all services.	The review of Datix indicates, there were 23 safety incidents, of which 1 had serious harm; 8 had moderate harm; 2 had minor harm. All patients have been notified through our Duty of Candour processes
We have created additional support to check the accuracy of our data	Additional validation from Central team identified to support service line team.	Moved to 2019 as admin validation of 2018 less successful
We have been checking which patients need to be seen and when by carrying out additional clinical validation checks	Voluntary at present – significant validation undertaken for glaucoma patients and cataracts	In place At time of writing, 800 patients clinically validated
We have been working closely with our appointment booking Team in the Central Booking Office	Additional meeting to be set up before 30/12/19 given recent progress of clinical validation	In place Additional clinics being built and set up
We have improved our system for logging patients who could be discharged from the service	Support for clinical use of correct discharge process including eye casualty clinics (following review of these records may be over- inflating the position)	Advice given to junior colleagues Further work to be undertaken by service director to publish processes
We have considered the reduction of elective operating capacity to convert to clinic follow up slots and will review efficiency of theatre lists	Consideration of conversion of elective lists to mitigate the risk	Not required as yet
We have put in place a plan for additional Paid Sessions in January to March (Q4 19/20) to support having additional capacity	SD to email consultant colleagues for capacity in Q4	Service Director meeting with all consultants Clinics planned for April / May
We have produced a longer-term plan for 2020/21 to make sure that we continue to have	Service line to provide options paper /plan that would see them be 'best	D&C work underway.

Improving our capacity	Action	January 2020 Progress Update
enough appointments for people who need them	in class' by end of March 2021 to have no outstanding follow up's	
We are considering introducing a Navigator role to support people with chronic eye conditions	Based on the model in Head and Neck to support patients to be considered	Being investigated within the administrative function

Plans for improvement 2020/21

At the time of writing this, in December 2019, for our 2018 group of patients waiting for a follow up appointment, we need to find additional capacity to deliver a further 1,800 appointments. With the additional consultant time in December and February it is anticipated that 800 patients could be seen. This would then leave an estimated deficit of 1,000 appointments rolling over into the next year.

The Ophthalmology Team will continue to assess their data and progress monthly. They have challenged themselves to think further of ways they can mitigate both future and existing demand for appointments and will be developing an options appraisal with the aim of sorting the back log of appointments by the end of 2021. The service's main improvement priorities are: -

- To move forward is to work on the development and publication of protocols to prevent recurrent appointment issues and to support colleague training.
- To move to a more 'clinical risk-based' approach to follow up appointment management
- To review recurrent demand so that we have enough capacity.
    - To work with Business Intelligence team to see if there is a tool to support the identification of high risk patients
    - To include the 'rolling' clinical validation/virtual review of patients waiting.

These actions, alongside the learning the department is gaining, will ensure a more robust approach to any 'capacity shocks' in the future. Ultimately the department is currently working to ensure that the risk is mitigated that those patients who are high risk are known to the team, including those patients who are high risk because of they do not attend their appointment for any reason or non-compliance with treatment plans, so that they will not be delayed. The department is keen to support learning across specialties such as Neurology, as there is much learning to spread across the Trust.

11. Quality priority

To improve the prevention of our patients developing pressure ulcers

Background

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

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

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

How we have performed update

We are committed to reduce the number of pressure ulcers developing in patients in our care. On 22 September 2019, we held our first Quality Summit to discuss our pressure ulcers prevention improvement programme. Thirty-two staff joined us to review "where we are now" and "where we want to get to by when". The half day event gave staff time to think about our issues then learn a little about improvement methodologies also to spend time developing change ideas. The end result was that we developed a driver diagram which will be the basis of our improvement plan. At our Quality Summit we asked ourselves: "If most of hospital acquired pressure ulcers are preventable then how can we prevent them?"

We used our 3 Quality Strategy aims to as a framework for the event

1. Improve our understanding of quality by drawing insight from multiple sources (**Insight)**
2. Equip patients, staff and partners with the opportunity to co-design with us to improve (**Involvement**)
3. Design and support programmes that deliver effective and sustainable change (**Improvement**)

The summit helped the Tissue Viability team with the continued development of their education and audit. It also facilitated a structured learning from investigating in the form of the Preventing Harm Hub.

Data

Chart: our current data for category 2-4 and unstageable Hospital Acquired Pressure Ulcers/1000 bed days

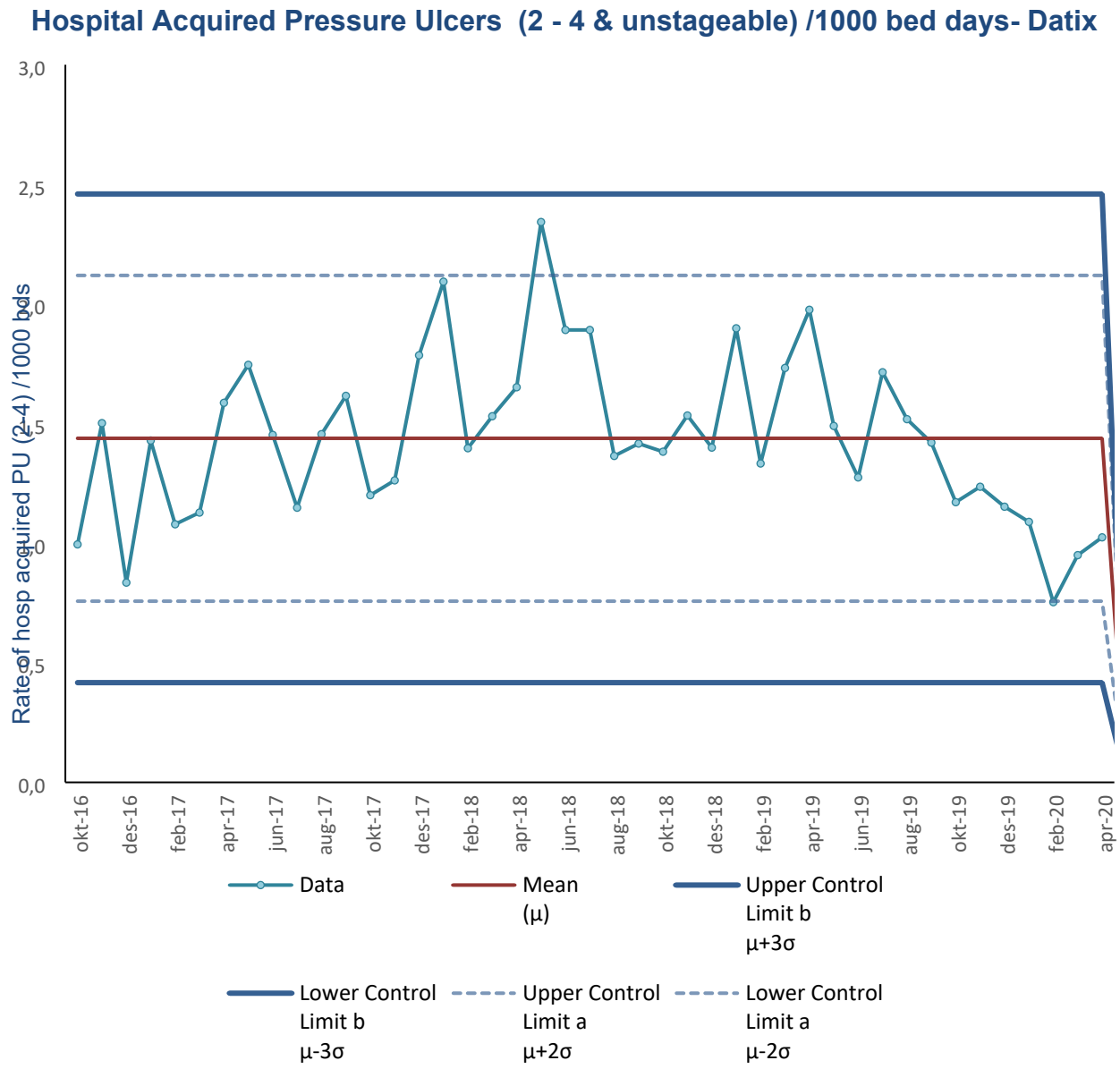
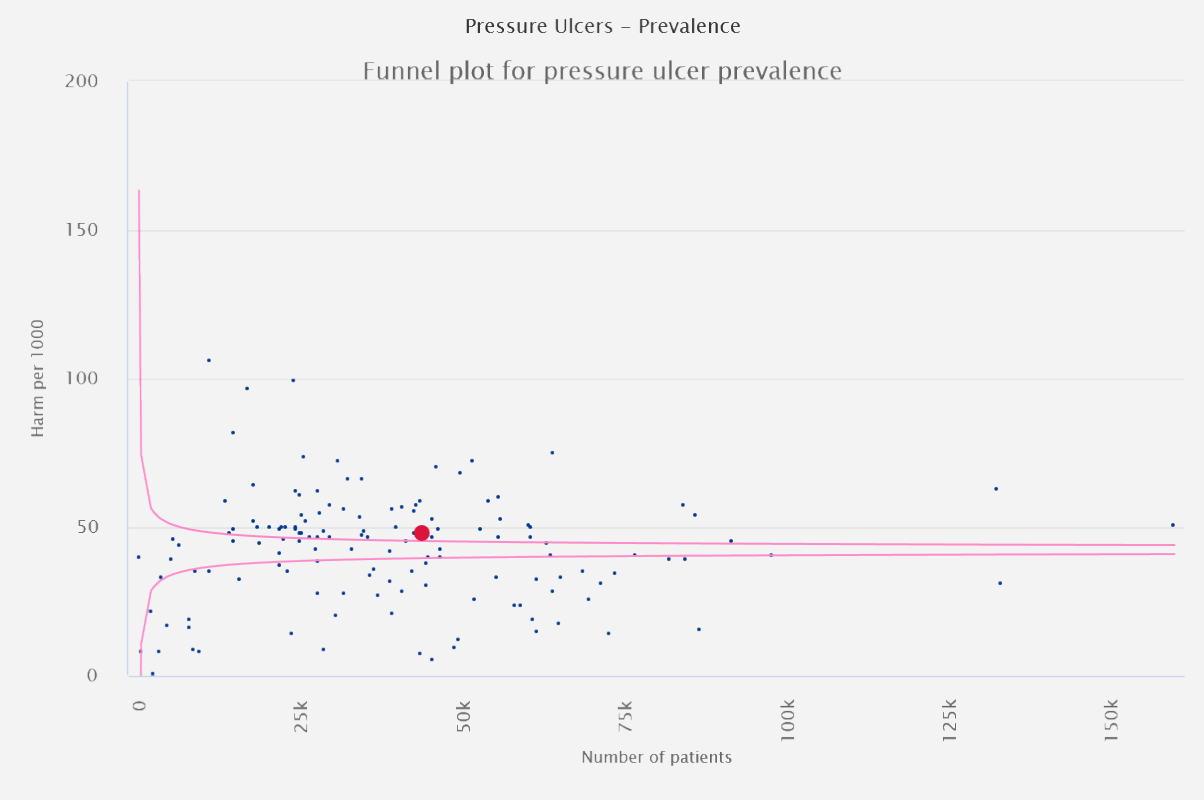


Diagram: Funnel plot diagram for pressure ulcer prevalence



Plans for improvement 2020/21

After our summit, we have developed a pressure ulcer prevention quality improvement plan which will be led by the Tissue Viability Team. Our first programme of work will be completing in depth diagnostic work of our data to turn this into insights so we can prioritise our improvement work. The implementation of the Electronic Patient Record has enabled us to have better oversight of pressure ulcer risk assessments and prevention plans that are being put in place for our patients.

Our work will focus on: -

- Review our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording.
- Establishing a programme of measurement from wards and relevant departments (connect this to preventing harm work streams).
- Map all our current data sources so that we can develop a single item quality report.
- Develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues.
- Regularly monitor data and undertake learning to improve care – develop quick feedback loops.

- Set ward level targets appropriate for their area.
- Develop speciality level data for pressure ulcers.
- Include pressure ulcers data at Divisional level reports in SPC charts.
- Map where the high-risk wards are and provide focused improvement work in these areas.
- Provide all clinical staff with educational resources for pressure ulcer prevention
- Ensure that all areas have access to equipment to facilitate pressure ulcer prevention
- Set up a network of tissue viability link nurses to support the trusts improvement plans.

12. Quality priority

To prevent falls in hospital

Background

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

Nationally

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

This CQUIN incentivised and encouraged us to focus our improvement efforts on the delivery of three high impact actions for falls prevention in hospital. These actions required nursing, pharmacy, medical and physiotherapy input. Each year almost 3,000 falls in hospital in England result in hip fracture or brain injury, typically subdural haematoma. Costs for patients are high in terms of distress, pain, injury, loss of confidence, loss of independence and mortality, and costly in terms of increased length of stay to assess, investigate or treat even modest injury.

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

The CQUIN applied to all patients aged 65 years and over who are admitted to an inpatient bed for more than 48 hours. The three key actions (Blood Pressure (BP), medications, mobility) were all audited: -

1. Lying and standing blood pressure to be recorded
2. No hypnotics or anxiolytics to be given during stay OR rationale documented
3. Mobility assessment and walking aid to be provided if required.

The ambition was to have achieved 80% of older inpatients receiving key falls prevention actions.

How we have performed

***Table: Overall CQUIN performance for high impact interventions – falls prevention*:**

Quarter	Number of patients audited	Percentage compliant (Min 25% maximum 80%)
1	100	27%
2	101	28%
3	100	29%
4	Quarter not completed due to Covid-19	Quarter not completed due to Covid-19

Table: CQUIN performance for individual actions

Actions	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Action 1: Patients who had lying and standing BP taken once during stay	50%	57%	61%	Quarter not completed due to Covid-19
Action 2: Patients given hypnotics during stay did not have rationale recorded in notes	14/16 (88%)	6/8 (75%)	9/14 (64%)	Quarter not completed due to Covid-19
Action 3: a) **Patients** had a mobility assessment within 24 hours of admission b) eligible patients received walking aids within 24 hours	a) 60% b) 42/48 (88%)	a) 61% b) 22/74 (29%)	a) 73% b) 35/62 (56%)	Quarter not completed due to Covid-19

Improvement actions taken

- Initial multidisciplinary team meeting to discuss improvement plan including medical staff and pharmacists
- Teaching for nurses to enable staff to assess for a mobility aid.
- Networking with other Trusts who are doing this well in the South West to see what they are putting in to place to make improvements.

- Education packages have continued around the reasons and the importance of recording a lying/standing BP (slight increase in recording or a rationale if not being recorded).
- Lead for Care of the Elderly (COTE) and Lead for Stroke having conversations with medical staff about documenting reasons for medication prescribing.
- Work continuing with the therapists providing a mobility assessment within 24 hours/providing walking aid - and recording this.
- Focused training on high risk wards (Cote, Stroke wards and 3a – Orthopaedics).
- There has been an increase in the number of procedures having been recorded.
- Introduction of Electronic Patient Record with the ability to now view risk assessments and falls data across the whole Trust.

Plans for improvement 2020/21

We have developed a quality improvement plan which will be led by the Lead Nurse for Falls Prevention. The start of our programme of work will be focus on completing in depth diagnostic work of our data to turn this into insights so we can prioritise our improvement work. The implementation of the Electronic Patient Record has enabled us to have better oversight of falls risk assessments and prevention plans that are being put in place for our patients.

Our work will focus on: -

- Review our Electronic Patient Record (EPR) data to see in real-time what staff are assessing and recording.
- Establish a programme of measurement from wards and relevant departments (connect this to preventing harm work streams).
- Map all our data sources.
- Develop our prevention measures (outcome and process) and additional data for wards and then provide to areas to share with colleagues.
- Regularly monitor data and turn this into insights
- Undertake learning events to improve care – develop quick feedback loops.
- Set ward level targets appropriate for their area – for e.g. number of days since last fall.
- Develop speciality level data for falls prevention.
- Include falls data in Divisional level reports in SPC charts.
- Map where the high-risk wards are and focus improvement work in these areas.

13. Quality priority

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

Background

As the incidence of diabetes increases both locally and nationally, insulin use can reasonably be expected to increase, and the mistakes will no doubt increase as well. Insulin is a very powerful medication, and some of these mistakes will require immediate urgent medical attention. Diabetes emergencies are mostly avoidable whilst an inpatient. The insulin omission, and other insulin errors can cause harm leading to further interventions and a longer length of stay in hospital. For the patient with diabetes, it can mean a poor patient experience and journey.

How we have performed 2019/20

A pharmacist in Cheltenham ran a project look at facilitating self-administration of Insulin on Guiting Ward. Guiting Ward looks after patients needing vascular procedures, many of whom are diabetic patients who use insulin at home.

When in hospital, these patients often want to continue self-administering their insulin and managing their condition as independently as possible. This should be encouraged, as self-administration of insulin is proven to result in better patient outcomes. However, patients should only be injecting themselves unsupervised if they are competent to do so. They should also be storing their insulin somewhere securely, in line with medication safety laws.

Previously there was no formal process for assessing the competence of patients, and patients could not access their bedside lockers, meaning they either had to ask a nurse to retrieve their insulin or leave it out at the bedside. Patients were unhappy with this arrangement and it was unsafe to have insulin lying about.

The aim of the project was to increase the number of patients appropriately self-administering insulin by 50% over 4 months. “Appropriately” here means there is documented assessment of self-administration if needed and the insulin in use is stored securely.

The team tested three different changes during this project:

- Change 1: Ward staff education and reminder cards stuck to bedside lockers.
- Change 2: Introduction of Trust documentation to assess patients as well as a separate prescription chart, designed to be filled in by patient (2 x PDSA cycles).

- Change 3: Provision of lockable boxes, accessible to patients and to be kept at bedside, to keep insulin and equipment in (2 x PDSA cycles).

The lockable bedside boxes were obtained from Bristol Maid, using a donation kindly gifted by Cheltenham and Gloucester Hospitals Charity. Huddles were held with the nursing staff to teach them about the new documentation and boxes.

Data was collected daily during pharmacist ward visit and recorded on a proforma. Data was gathered through examination of the prescription chart and observation of patient bed space. The location of insulin in use was also recorded.

From this initial project, there was a clear increase in the number of patients appropriately self-administering (12% at baseline to 73%). There is now the means to assess patients wishing to self-administer insulin on the ward, and patient-accessible safe storage is available. Location of insulin in use saw an improvement - from just 58% of it being stored securely to 82% by the end of the project. There was a positive response by both patients and staff.

The 50% target set within the aim was achieved, though it was difficult to sustain. The project ran over the 4 months originally intended. The team are now planning to work with other wards across the Trust to share some of the learning from this pilot.

Plans for improvement 2020/21

The Trust will examine the issue of self-administration further once the National Diabetes Audit data is published.

The Trust will also be developing a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.

14. Quality priority

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

Background

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

The National Early Warning Score

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

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

1 respiration rate

2 oxygen saturation

3 systolic blood pressure

4 pulse rate

5 level of consciousness or new confusion*

6 temperature

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

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

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

How we have performed 2019/2020

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

The current data highlights the need for education in this area with some wards only achieving 20% compliance and this is process is currently lead by the Resuscitation Lead for the Trust.

The basis for patient safety in relation to NEWS2 is around ‘5 R’s

Record	Have the vital signs be recorded in a timely fashion, is the data set complete (no missing variables) and have the totals been correctly added up to make the NEWS2 score
Recognise	Does the staff member know when to call for help and from whom
Report	Has the staff member reported appropriately every time it is required
Response	Has the response been timely and appropriate, does patient need transefer, if so was that in timely manner
Reassess	Have interventions made an appropriate difference to patient

Graph: Recording vital signs and recognising deterioration

The graphs below demonstrate that data sets became more complete with fewer variables missing. However there was little improvement in accuracy of calculation of total score.

It was difficult to make serious inroads into addressing these problems until electronic vital signs were introduced.

Plans for improvement 2020/2021

Further areas of focus throughout 2020/21 will be:

Introduction of Electronic Vital Signs was part of the role out Electronic Patient Record (EPR) and took place in March 2020 early in the Trust's response to the COVID-19 pandemic.

Recording

In relation to 'recording' the e-system addresses the completeness as it will not allow incomplete sets to generate a score, in addition the score is automatically calculated so is always present and correct. The system will also determine when the vital signs should be repeated with the frequency determined by the score.

This alerts staff to when vital signs are due and flags on the system when they are overdue. In time this data will used increasingly to ensure that observations are more likely to be completed with appropriate frequency.

This real time data will be visible on EPR and on the interactive whiteboard.

At present the e-system is not yet introduced to ED, DCC and theatres/recovery but in time there will be increased coverage across these areas.

Recognising

The electronic system, based on the score derived, alerts staff members to the potential actions required, these include alerting medical team or the acute care response team. In effect recognising what is required. This is a guide for staff and different patients will need different responses.

In time, as other systems are brought into EPR this will become more sophisticated – see below

Reporting

Staff members are required to report their concerns to appropriate personnel via the phone or bleep system.

However the system does generate lists for the Acute Care Response Team (ACRT) which will identify to them all patients in the Trust with a score of 7 or above, or 5-6, this in time will aid the management of deteriorating patients, but alerts via the bleep or phone remain necessary in an emergency

(Automated alerts may be possible in future but these are not possible at this present time.)

Response

The ACRT have been described as the canary in the coalmine as they cover every area of the Trust, across all specialities. In time they will become the first response to deteriorating patients and the team is being developed to ensure the service the team delivers can respond to all emergencies.

This year the ACRT will use the data that electronic vital signs provides to aim to improve the response to vulnerable and deteriorating patients.

Actions in 2020/21

- Work with ward teams to ensure that they are aware of how to determine frequency of vital signs for all their patients, how to effectively escalate and how to record that escalation has taken place
- Work with EPR team to tweak the information and reports derived from e-vital signs to optimise patient care. For example to ensure that all patients have the correct frequency set for their NEWS2 score and that all vital signs are recorded in appropriate timescale
- Work with EPR on layout, graphs etc to optimise presentation and maximise effectiveness of information generated
- Identify aspects of data collection that could be included that had not been considered at the planning stage
- Plan for EPR to include notes entries and patient records – after which time of response/interventions will be recorded electronically and will not reply on paper records being scrutinised
- Plan for Fluid Balance to become part of EPR. This important element of patient care will become more accurate, with data more accessible, than on paper. For example the patients weight will be on the system and will determine the patient's urine output if the two variables can be amalgamated
- Results of blood tests amalgamated with e-vital signs will add even greater accuracy and completeness to the patient picture. Sepsis for example relies on NEWS2 and blood results combined.

15. Quality priority

To improve our learning into action systems - learning from our own local investigations

Background

Most conceptualisations of the learning organisations seem to work on the assumption that '*learning is valuable, continuous, and most effective when shared and that every experience is an opportunity to learn'* (Kerka 1995). The following characteristics appear in some form in the more popular conceptions.

Learning organisations:

- Provide continuous learning opportunities
- Use learning to reach their goals
- Link individual performance with organisational performance
- Foster inquiry and dialogue, making it safe for people to share openly and take risks
- Embrace creative tension as a source of energy and renewal
- Are continuously aware of and interact with their environment (Kerka 1995).

How we have performed 2019/20

How we have improved the organisational learning capability

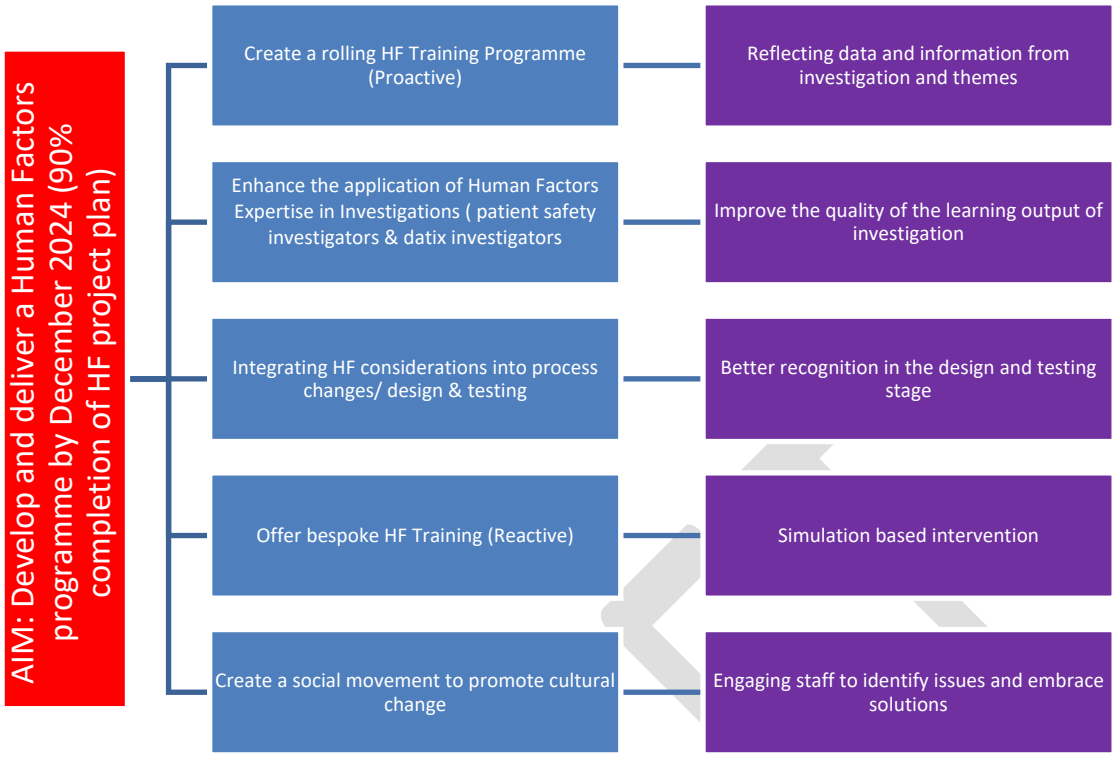
Investigation - Human Factors Faculty

2019 saw the start of the Gloucestershire Safety and Quality Improvement Academy (GSQIA) journey to introduce a Human Factors (HF) Faculty. Through funding provided by the Hospital's Charity and subsequent 'Expressions of Interest,' 15 Faculty members successfully underwent Human Factors 'Train the Trainer' Training from an external training provider. This was part of the Trust's Quality Strategy, which identified the following key objectives:

1. **Develop a Human Factors (HF) Faculty that improves:**
    a. **the technical assessment of serious incidents.**
    b. **system redesign and testing with simulation.**
    c. **human factors understanding across the Trust.**

As with the GSQIA philosophy, it is not intended that the offer is solely training and through collaboration with the Faculty a HF driver diagram has been created to map the overarching Trust approach.

Diagram: Our quality improvement driver diagram for human factors training



In order to utilise and embed the newly acquired skills of the HF Faculty and to start building a HF following, training is being tested through 4 half day sessions during March and April 2020. These have been advertised through the website, Twitter & 'This Week' and out of the 48 places on offer, only one place currently remains unfilled. Feedback from the training will be assessed and the HF offer will continue to be adapted and tested.

A full list of Faculty members and other information can be found on the website: https://intranet.gloshospitals.nhs.uk/departments/corporate-division/safety/Human-Factors/

Improvement Collaborative

Following the success of the Better Births collaborative, GSQIA have three new collaboratives programmed in for 2020 covering Patient Experience Improvement in Cancer Services and in CYPS (Children's and Young Peoples Services) as well as working with the Chief Registrars on a Deteriorating Patients Collaborative.

Additionally, the University of Gloucester approached us to work in collaboration with the 3rd year Student Nurses who for the first time this year will be joining a Silver project for part of the duration to gain an understanding of Quality Improvement in practice, and will be writing their dissertation on their experience and understanding of QI.

Network learning and sharing

The main function of GSQIA external work is to establish networks to share and learn quickly and effectively. One of the main networks is the Health Foundation Q network; we are currently one of the top 5 Acute Trust's in the country for membership.

GSQIA also promotes the sharing and development of all things QI. The GSQIA "Delivery Improvement Network' involves 30-40 different NHS organisation across the country involved in the network with meetings four times a year to share, learn and support QI practice.

There have been 5 #QIHour tweet chats hosted by GSQIA with four more planned this year. The chats are led by the GSQIA Coordinator and Trainer, and have had great engagement with a host of national leaders of improvement involved. The last network chat had over 6million impression on Twitter, and this work has been recognised as a "super-connector" in the QI community by Helen Bevan.

In December, we were successful in a bid led by the GSQIA in collaboration with the Clinical Commissioning Group and Gloucestershire Health and Care NHS Foundation Trust for some Q- Exchange funding, the award was £30,000 to deliver a project as follows:

To test collaborative approaches to facilitating 'wicked' system wide problems, from diagnosis through to improvement, whilst building QI capacity & capability through learning by doing.

The project stretches across the ICS and will use the End of Life team as the clinical platform for the project. The project was nationally reviewed and then selected through the Health Foundation Q network who voted for their preferred projects.

Plans for improvement 2020/21

1. Deliver an education programme of Human Factors
2. Through Human Factors approaches enhance the identification of causal factors for incidents, complaints and claims.
3. Create a programme of Quality Collaboratives for key quality initiatives

16. Quality priority

To improve our care for patients with diabetes in the perioperative period

Background

The Perioperative Quality Improvement Programme (PQIP) is a programme that aims to improve outcomes after surgery. One of our quality improvement programmes that was supported by our Gloucestershire Quality Improvement Academy (GSQIA) looked at the perioperative management of diabetic patients at the Gloucestershire Royal Hospital site (GRH).

Management of glycaemic levels in the perioperative setting is critical, especially in diabetic patients. The effects of surgical stress and anaesthesia have unique effects on blood glucose levels, which should be taken into consideration to maintain optimum glycaemic control. Each stage of surgery presents unique challenges in keeping glucose levels within target range. Additionally, there are special operative conditions that require distinctive glucose management protocols. It is known that careful glycaemic management in perioperative patients, reduces morbidity and mortality and also therefore improves surgical outcomes.

As a Trust, we have collected data on patients undergoing major surgery as part of PQIP since 2018 and diabetes management was identified as a key area for improvement.

The key indicators included: -

- measuring glycated haemoglobin (HbA1c) on all diabetic patients before major elective surgery so that consideration of postponing non-urgent surgery if HbA1c>8.5% (**HbA1c** is your average blood glucose (sugar) levels for the last two to three months. A high **HbA1c** means you have too much sugar in your blood. This means you're more likely to develop diabetes complications, like serious problems with your eyes and feet).

- measuring blood glucose regularly and aiming for blood glucose levels of 6-12 mmol/l throughout surgery.

How we have performed 2019/20

In April 2019, we retrospectively reviewed the GRH PQIP database to identify patients with Type 1 or Type 2 diabetes. The team then audited the perioperative management of diabetes against the key indicators detailed above to identify areas for improvement.

After reviewing our Trust diabetes guidelines and PQIP recommendations, the following standards were set:

- 100% of patients will have an HbA1c measured before major elective surgery
- Postponing non-urgent surgery will be considered if HbA1c>8.5% in 100% of cases
- 100% patients will have a capillary blood glucose (CBG) measured on admission
- 100% of patients will have CBG measured hourly in the perioperative period
- Blood glucose levels will be kept at 6-12 mmol/l throughout surgery in 100% cases
- Variable rate insulin infusions (VRII) will be used if blood glucose >12 mmol/l in 100% cases

From reviewing the elective cases 14 patients were identified with diabetes out of a database of 86 cases (16%). Of the 14 cases, 5 were treated with insulin, 5 with non-insulin glucose lowering medication and 4 were diet controlled.

Overview - across all 14 patients, none of the audit standards were met 100%.

Table: Audit results for perioperative care for diabetic patients

Audit standard measures	Results from audit
100% of patients will have an HbA1c measured before major elective surgery	Only 71% had an HbA1c measured, and in 29% the HbA1c was >8.5%.
Postponing non-urgent surgery will be considered if HbA1c>8.5% in 100% of cases	Out of the 4 cases with an HbA1c>8.5%, 3 were not delayed due to surgical urgency.
100% patients will have a capillary blood glucose (CBG) measured on admission	71% had a CBG measured on admission.
100% of patients will have CBG measured hourly in the perioperative period	None recorded hourly perioperative CBG's.
Blood glucose levels will be kept at 6-12 mmol/l throughout surgery in 100% cases	29% maintained CBG between 4-12 in the perioperative period
Variable rate insulin infusions (VRII) will be used if blood glucose >12 mmol/l in 100% cases	43% had a VRII appropriately commenced when CBG>12 mmol/L.

The case reviews showed:

The results have identified intraoperative measurement and documentation of CBG requires significant improvement. No cases recorded hourly perioperative glucose

measurement. Several cases had no documentation at all throughout surgery. We have also identified not all patients had an HbA1c measured. Comparing our data with the national PQIP data, GRH has a higher proportion of diabetic patients (16% vs 13%) and those with an elevated HbA1c (29% vs 20%).

In order to improve practice, we introduced pre-operative assessment nurse training sessions, are establishing a nurse champion to assist with diabetic queries pre-operatively, referring high risk cases for post-op diabetic nurse follow up and forming a joint working group with diabetic liaison nurses to review the current pathway and assess impact of new insulin regimes and pumps.

Plans for improvement 2020/21

The Trust has developed a business case for a dedicated Diabetes Inpatient Specialist Nurse team. This will provide education for wards as well as provide review and assessment of patients with diabetes, with the aim to reduce harm being caused to patients within our Trust and an improved patient experience.

We have started pre-habilitation programme prior to major surgery which aims to improve pre-operative conditioning of patients to improve post-operative outcomes. This programme of work is aimed to assess the effect of prehabilitation on post-operative outcome after major surgery and we hope to report on this work next year.

17. Quality priority

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

Background

Dementia is an umbrella term used to describe a range of progressive neurological disorders. Alzheimer's disease and vascular dementia are the most prevalent, accounting for 79% of all diagnoses. Other forms include frontotemporal, Lewy body, Parkinson's dementia, corticobasal degeneration, Creutzfeldt-Jakob–Jakob disease and young-onset dementia (Alzheimer's Society 2017, Dementia UK 2017). Symptoms include change of thinking speed, mental agility, language, understanding, judgement as well as memory loss (NHS Choices 2017), but each affected person will experience dementia differently.

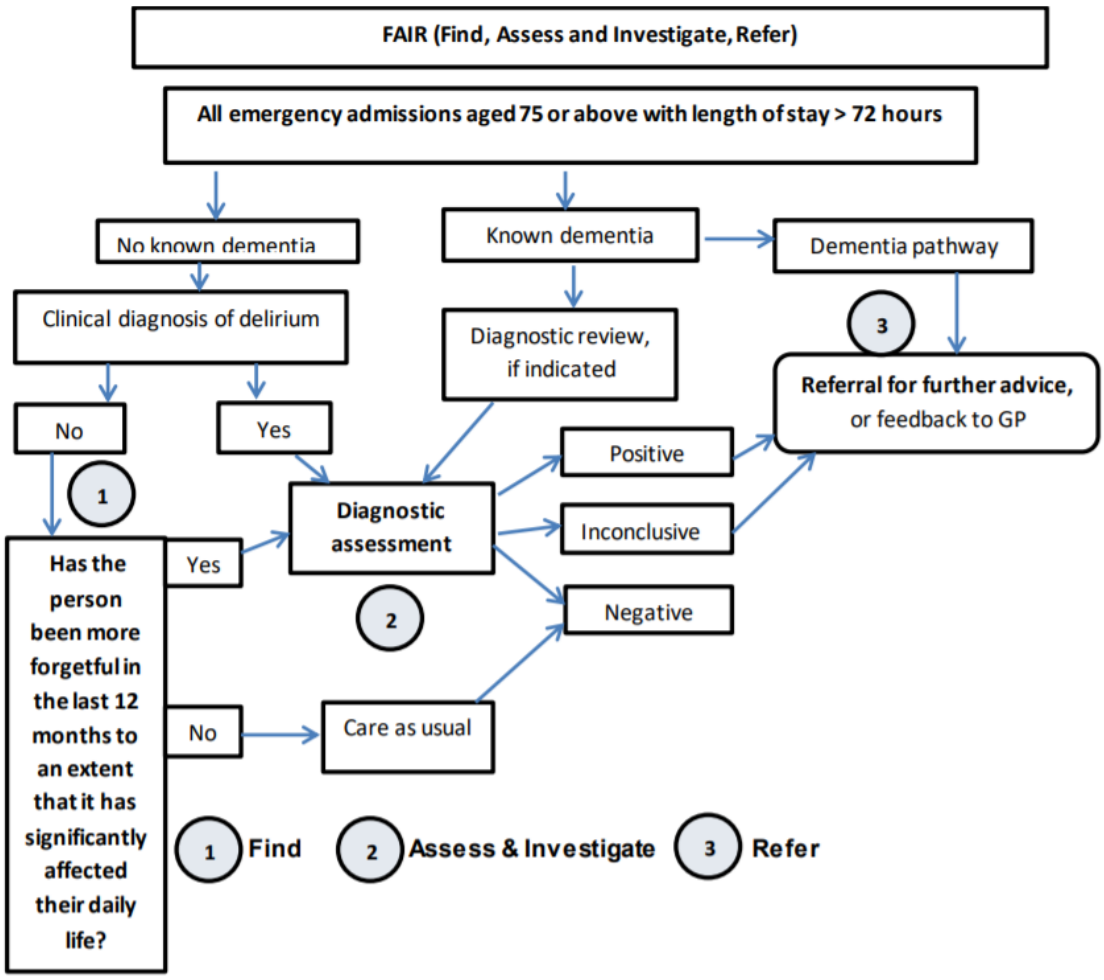
We report nationally on some quality indicators and dementia is one. This indicator reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been identified as potentially having dementia, who are appropriately assessed and who are referred on to specialist services. This is described with the acronym FAIR (Find, Assess/Investigate, Refer).

Table: Quality indicator data components

Indicator	Data description and targets
Find	The case finding of at least 90 per cent of all patients aged 75 and over following emergency admission to hospital, using the dementia case finding question and identifying all those with delirium (using a clinical assessment of delirium) and dementia (that is, with a known diagnosis of dementia). This has to be completed within 72 hours of admission.
Assess and investigate	The diagnostic assessment and investigation of at least 90 per cent of those patients who have been assessed as at risk of dementia from the dementia case finding question and/or presence of delirium. The provider should carry out a diagnostic assessment including investigations to determine whether the presence of dementia is possible.
Refer	The referral of at least 90 per cent of clinically appropriate cases for specialist diagnosis of dementia and appropriate follow up, in accordance with local pathways agreed with commissioners. This may include referral to an old age psychiatry liaison team, with the person assessed in hospital, or it could be referral to a memory

	clinic or to the GP to alert that an assessment had raised the possibility of the presence of dementia.

Fig 1: Dementia FAIR Flow chart



How we have performed 2019/2020

When we moved to a new Patient Administration System (Trakcare) reporting for this indicator declined which suggested to us that the new digital system had created issues for clinicians reporting because in previous years we had been able to demonstrate that FAIR clinical assessments were being carried out.

When carrying out the digital diagnostics, as to why our performance had declined, we found that the answers to the FAIR questions had to be recorded in different areas within the new record. The collection of the data was no longer simple and had become an additional burden to staff and therefore were not being completed. To test this theory, that clinicians were carrying out the assessments but were just not recording it in an area where the data could be extracted, an audit was carried out

and all admission documentation was amended to include the dementia case finding question. Our audit demonstrated that our theory was correct and our performance improved from 0.3% (May 2019 digital extraction) to 67% (manual audit June 2019).

This data captured is reported monthly in the Trusts Quality and Performance Report (QPR), showing our compliance with the FAIR assessment tool.

Figure 2: Quality and Performance Report Dementia FAIR test screening.

	18/19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Dementia Screening													
% of patients who have been screened for dementia (within 72 hours)	1.90%	1.90%	0.80%	0.60%	0.40%	0.30%	67.00%	66.00%	85.00%	63.00%	62.00%	50.00%	37.00%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	27.90%	40.00%	0.00%	33.30%	100%	50.00%	0.00%	0.00%	N/A	50.00%	0.00%	0.00%	18.00%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	2.80%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A	50.00%	N/A	N/A	0.00%

Plans for improvement 2020/2021

Early in 2020 NHS England and NHS Improvement held a consultation seeking views on the continuing suitability of the Dementia Assessment and Referral (DAR) data return. The consultation was open for eight weeks from Thursday 9th January until midnight 5th March 2020 but please note that due to the coronavirus illness (COVID-19) there will be a delay in the publication of the response to the consultation.

Our plan for 2020/21 will be to await national guidance and once published we will focus on improving the accuracy of our data.

18. Quality priority

To improve our nursing care standards through the Nursing Assessment and Accreditation System (NAAS)

Background

Evidence demonstrates that high quality nursing care is central to delivering the highest standards in our Trust and is essential to delivering the commitments made in our strategic objectives. We have developed standards against which quality and achievement of outcomes are measured to gain accreditation at ward and unit level. Accreditation brings together key measures of nursing and clinical care into one overarching framework to enable a comprehensive assessment of the quality of care at ward, unit or team level. When used effectively by the leaders of these areas, it drives continuous improvement in patient outcomes, and increases patient satisfaction and staff experience at ward/unit level. With a clear direction and a structured approach, it creates the collective sense of purpose necessary to help communication, encourage ownership and achieve high standards of care on a ward.

Our NAAS programme has been in place at the Trust since April 2018. The aim of the programme was to describe what "outstanding care" looked like and allowed individual areas to be measured against this. There are 13 quality standard (metrics) assessment areas within NAAS.

Table: Standards included within the NAAS assessment programme

Wards are organized and well managed		
Infection Control	Safety - Vital Signs	End of Life Care
Safeguarding	Safety - Environment	Medicines Management
Pain Management	Nutrition and Hydration	Person Centred Care
Pressure Ulcers	Elimination	Communication

How we have performed 2019/20

Our NAAS journey has recently been showcased as a "pop up presentation" at a national Ward Accreditation Masterclass. The key benefits of having implemented our assessment and accreditation programme are many and we have described these in the table below.

Table: Key benefits of a positive practice environment

Key benefits of a positive practice environment	
Quality	Reduces unwarranted variation by providing an evidence-based, standardised approach to supporting the delivery of care and improving quality.
Safety	Provides a platform for shared learning so that wards and units can learn from safety incidents and each other.
Leadership	Provides ward-to-board assurance on the quality of care and demonstrates compliance with fundamental standards which enables preparedness for external inspections.
Wellbeing	Increases staff engagement, encourages team working and improves staff morale.
Professional development	Creates a culture of pride and accomplishment and supports collective leadership, personal and professional development.
Shared decision making	Creates a platform for continuous improvement in patient safety and patient experience, and encourages staff engagement in local quality improvement projects.

Data

The NAAS team visits the ward or unit on the assessment day to carry out the assessments. This assessment team comprises two to three assessors. The assessors are given clear written guidance on carrying out the review and use our assessment tool. The assessment takes place in one working day. The assessment team meets mid- review to discuss progress, cross-check findings and discuss any issues identified up to that point. The ward or unit manager is the final person to be interviewed so that any questions arising from any of the assessments, observations or the assessment team can be asked and clarification sought. The assessment team then meets for a final time to discuss findings, cross-check the evidence and agree the final assessment outcomes.

The standards documentation includes the identified measures and examples of the evidence required for the assessment. Each standard is given a rating using a red – amber – green (RAG) rating system. A set of rules was developed to assess the overall achievement of the ward accreditation.

These are:

Assessment final outcomes	
Red	At least 5 red individual standards
Amber	3-4 red individual standards
Green	1-2 red individual standards
Blue - Area of Outstanding Care (AOC)	Assessed as green on 3 consecutive assessments and all standards met

There were 39 clinical areas that were included in the first NAAS programme of assessments. The first round of assessments was completed in January 2019 and the second round of assessments were completed in August 2019 with most areas showing an overall improvement.

A written accreditation report was prepared and distributed to the ward/unit manager, matron, and divisional director of quality and nursing within a few weeks of the assessment. Where required, the ward or unit manager, supported by the matron, prepared and then submitted an improvement plan within a few weeks of receiving the report and support was provided to the ward. The ward was then reassessed within a mutually agreed timescale.

Table: Final NAAS assessment outcomes for wards for round 1 and 2

Ward outcomes	Red	Amber	Green	Blue
Round 1	33%	13%	54%	0%
Round 2	0%	13%	87%	0%

Table: Results of Round 2 assessment outcomes by Division and site

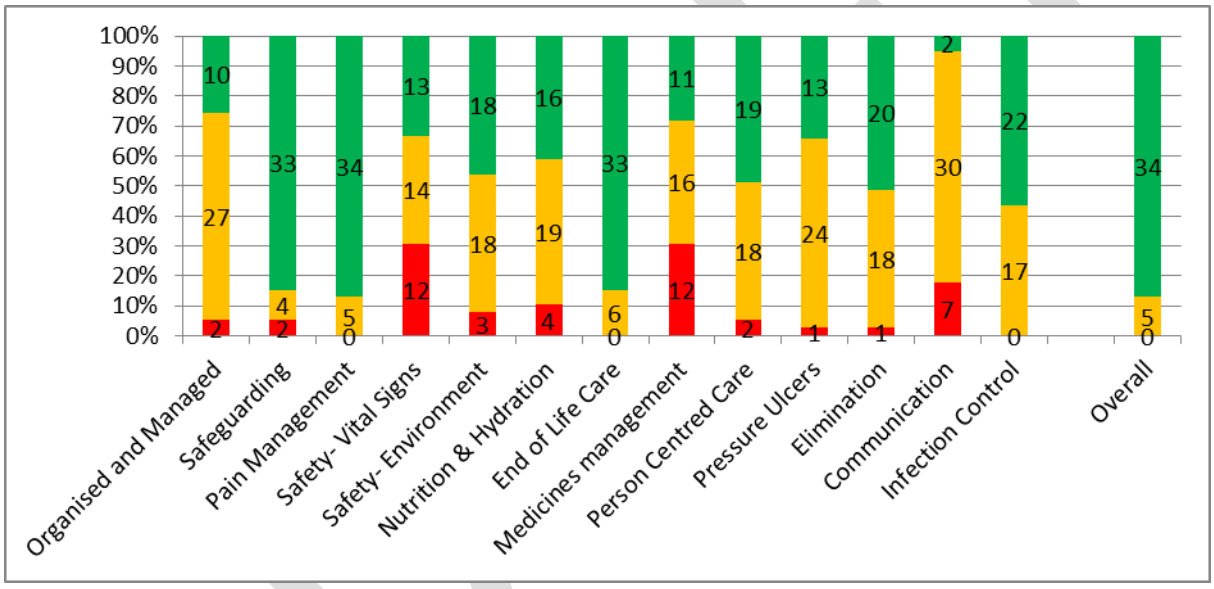
Medical Division			
GRH		**CGH**	
4A		ACUC	
4B		Avening	
6A		Cardiac	
6B		Emergency Dept.	
7A		Knightsbridge	
7B		Ryeworth	
8A		Snowshill	
8B		Woodmancote	
9B			
AMU			
Cardiology			
Emergency Dept.			

Diagnostic and Specialty Division			
GRH		**CGH**	
Gallery		Lilleybrook	
		Rendcombe	

Surgical Division			
GRH		CGH	
2A		Alstone	
2B		Bibury	
3A		Chedworth/Kemerton	
3B		Dept. Critical Care	
5A		Dixton	
5B		Guiting	
Dept. Critical Care		Prescott	
Mayhill			

Women and Children's Division (GRH)			
9A			

Table: Round 2 NAAS breakdown of outcomes by standard



Work on reformatting the assessment tool used has been ongoing throughout 2019/2020 as a response to conversations generated throughout the Trust as a result of the initial implementation phase. The new tool (now labelled as NAAS2) has considered our current position and describes the next milestone in our journey towards outstanding care in our ward areas. Our new "NAAS" tool has been trialled across 3 clinical areas. Areas within the current programme are currently completing a self-assessment and the first Round 3 assessments are booked to take place in 2020/21. There will be a drive across the Trust to have our first 'Blue' wards whilst achieving 60% 'Green' wards across both sites.

When a ward achieves Blue Assessment, this will mean that they have achieved accreditation and those wards will be awarded a certificate. Ward accreditation will be celebrated throughout the trust and certificates will be proudly displayed.

Plans for improvement 2020/2021

One of our key objectives in 2020/21 is introduce the American Nurse Credentialing Centre (ANNC) Pathway to Excellence® Programme. This programme provides a framework which we will use to create healthy workplaces for our nursing and midwifery staff. Pathway to Excellence® also supports the implementation of shared governance – the harnessing of collective nursing and midwifery leadership to influence and drive change. We see ward accreditation as a key enabler of the introduction of our new shared governance approaches.

Work on a Maternity equivalent to NAAS2 will begin April 2020 as well as discussions for developing a paediatric equivalent. There will be a case study written for the Chief Nursing Officer of England's "Shared Governance: Collective Leadership" Atlas of Shared Learning.

Table: Improvement targets for NAAS2 scores for 2020/21

	Red	Amber	Green	Blue
Ward outcomes	0%	30%	60%	10%

19. Quality priority

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

Background

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

How we have performed 2019/20

All episodes of Gram negative bacteraemia (*E.coli*, *Klebsiella* species and *Pseudomonas aeruginosa*) continue to be reported in line with Public Health England (PHE) mandatory reporting requirements. The Department of Health and Social Care (DHSC) has required Trusts to submit mandatory surveillance data on Escherichia coli bloodstream infections since June 2011.

Escherichia coli is part of the normal bacterial flora carried by all individuals. It is the commonest cause of clinically significant bloodstream infection. *E. coli* bacteraemia represents a heterogeneous group of infections. E.coli constitutes the most common Gram-negative bacterium detected from clinical microbiology samples; in Gloucestershire there are on average 22 E.coli bacteraemias each month. Most E. coli bacteraemia are not a reflection of Health Care Associated Infection (HCAI); most occur in patients due to underlying disease and are related to common infections such as urinary tract infection, intra-abdominal sepsis and biliary tract infection. Most of these infections commence in the community (but being detected when patients are admitted for investigation and treatment). A proportion of the E. coli bacteraemia are healthcare- associated and are related to recent previous hospitalisations and invasive interventions performed on patients, the most important of which is urinary catheterisation. A full break down on monthly E. coli bacteraemia cases can be seen in the below table. Monthly incidence of *E. coli* cases is seen in table 1. It is now necessary to report patient episodes where blood cultures have yielded *Klebsiella* species and *Pseudomonas aeruginosa* and these figures can be seen in tables 2 and 3.

Table 1: Monthly number of E. coli cases

Month	Time of E. coli bacteraemia acquisition	
	Day 0+1 CASE	After day 0+1
2019/20 Totals	**225**	**44**
April 2019	10	5
May 2019	21	4
June 2019	23	5
July 2019	13	1
August 2019	21	4
September 2019	9	3
October 2019	18	2
November 2019	13	5
December 2019	20	9
January 2020	8	3
February 2020	15	3
March 2020	14	2
Total 2019/20	185	46

Day 0 is taken as day of admission

Klebsiella

Monthly incidence of Klebsiella sp. cases to date are shown in table 2.

Table 2: Monthly number of Klebsiella sp. cases

Month	Time of Klebsiella bacteraemia acquisition	
	Day 0+1 CASE	After day 0+1
Totals 2019/20	**52**	**31**
April 2019	3	1
May 2019	5	3
June 2019	7	1
July 2019	3	1
August 2019	3	3
September 2019	4	2
October 2019	4	1
November 2019	4	1
December 2019	3	1
January 2020	2	1
February 2020	1	2
March 2020	2	1
Total 2019/20	41	18

Day 0 is taken as day of admission

Pseudomonas

Monthly incidence of Pseudomonas aeruginosa cases to date is shown in table 3.

Table: 3 Monthly number of Pseudomonas aeruginosa cases

Month	Time of Pseudomonas bacteraemia acquisition	
	Day 0+1 CASE	After day 0+1
Totals 2019/20	**19**	**12**
April 2019	1	1
May 2019	0	0
June 2019	0	0
July 2019	2	2
August 2019	0	1
September 2019	0	0
October 2019	2	1
November 2019	2	0
December 2019	1	0
January 2020	2	3
February 2020	2	0
March 2020	0	1
Total 2019/20	12	9

Day 0 is taken as day of admission

Plans for improvement 2020/21

To achieve 3-5% reduction in hospital acquisition of Gram negative blood stream infections, a focus of our 2020/21 infection prevention and control strategy will be to address key areas for improvement using our insights/data. The following projects have been identified:

- Hepatobiliary Tract
  The Gram-negative blood stream infections associated with a hepatobiliary tract source; a source not addressed in previous plans at Gloucestershire Hospitals NHS Foundation Trust. Reviews of cases of Gram negative blood stream infections with a hepatobiliary source during 2019/20 will be undertaken to identify whether Cholecystectomy on first presentation of Cholecystitis could have prevented a Gram-negative blood stream infections. This will be used to explore consideration for a 'hot gallbladder' pathway to support appropriate and prompt cholecystectomy in line with NICE guidance.

- Urinary Tract Infections
  The plan will also continue to address Gram negative blood stream infections related to urinary tract infections and catheter associated urinary tract

infections with the Trust wide launch of ‘Alert before you insert’, which is a process to guide staff on appropriate catheter insertion. This will also be supported by education and training for Nurses and Medical staff to competently insert catheters using an aseptic technique. A pilot across the Trust is also planned in which Chlorhexidine 1% sterile wipes will be used for meatal cleaning on catheter insertion, which has been evidenced to reduce catheter associated urinary tract infections. Engagement of the Trust will continue in the countywide urinary tract infection group which delivers system wide actions to prevent and manage urinary tract infections and catheter associated urinary tract infections effectively.

- Mouth Care Matters
  The mouth care matters programme will be enhanced so it can be delivered across the system to support reductions in Pneumonia and associated Gram negative blood stream infections.

- Surgical Site Infections
  The Trust will also continue to participate in the ‘PreciSSIon’ West of England Academic Health Science Network collaborative; which delivers an evidence-based bundle to reduce colorectal surgical site infection and is supported by an enhanced Surgical Site Infection surveillance programme.

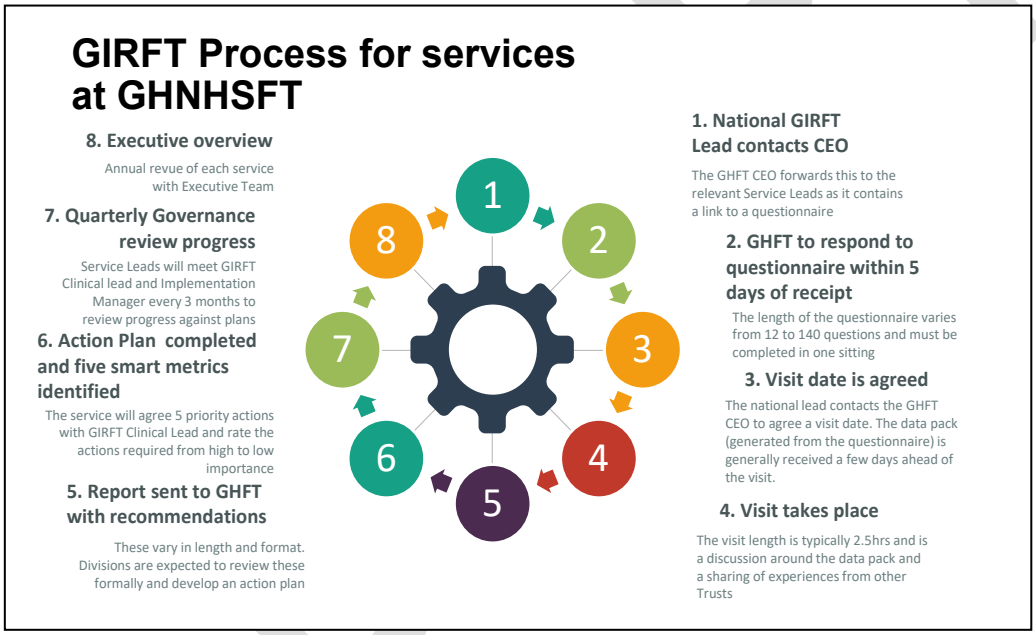
20. Quality priority

Rolling out of Getting It Right First Time standards in targeted standards

Background

Getting It Right First Time is a national programme founded by Professor Tim Briggs, GIRFT Chair & National Director of Clinical Improvement at NHSI, and is 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.

A process for the implementation of the GIRFT actions has been set up within the Trust. There is a clinical lead and manager who work with the specialties to support the completion of the actions and who organise the initial deep dive meetings and have now started the executive report. The GIRFT implementation team report progress in to our Trust Quality Delivery Group.



How we have performed 2019/2020

Of the 39 + specialties monitored by GIRFT, 31 + relate to Gloucestershire Hospitals NHS Foundation Trust of which 26 services have been visited to date.

An annual review with the executive team for each specialty has now been set up as some of the actions required are not only within the gift of each service but have implications to service redesign and sometimes countywide input. Eleven services have completed this process presenting their progress, achievements and concerns.

Key progress to note:

- A litigation report has been prepared for the Trust, which is currently being validated by the legal department; all specialties are keen to have regular feedback of litigation as the majority were unaware of a number of claims against them.
- The Ophthalmology service has been an identified as an exemplar of good practice in pioneering non-medical injectors for age-related macular degeneration and diabetic retinopathy in Gloucestershire. This has been adopted by the Royal College of Ophthalmology.
- The Trauma and Orthopaedic service has been used as an example of good practice in enacting a “Hot/Cold” site split for elective and trauma work. Other Trusts have been directed to Gloucestershire to observe how this has been done.
- The quality of coding has been identified as an area across all specialties with significant opportunities to improve both data quality and income. A standardised approach for review of opportunities for improvement, using a PDSA approach has begun.
- Specialties have all engaged with the process and are identifying QI opportunities. Specialties are also identifying their own areas of priority for improvement/action, based on data not reviewed, or more contemporaneous than that used by GIRFT.
- A Medical Forum for review of shared learning is being established for medical specialties that have embarked on the GIRFT process. The aim of this will be to use the diversity of approaches taken by the national specialty teams to enrich our own understanding of patient quality and safety issues, and identify common opportunities for improvement.
- The Paediatric Surgery specialty is the first to complete all the GIRFT recommendations.
- There has been a surgical site infection audit organised by the GIRFT team, and the Trust has contributed for Breast and Orthopaedic Surgery.
- 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. GIRFT Veteran’s Covenant Hospital Alliance accreditation was achieved in April 2019.
- The Trust have been working to raise the profile of GIRFT with staff, and an intranet page specifically relating to GIRFT is now displayed as part to the Trust intranet site.

Data

The following services have had GIRFT reviews and have started working on the recommendations:

Speciality	Date of Deep Dive Visit	No. of GIRFT recommendations /actions	No. of National recommendations /actions	No. GIRFT recommendations completed	No. GIRFT Actions Making progress/ on track	No. GIRFT Actions that will be delivered late	No. Off track no plan to recover	No. of local actions
Acute and General Medicine	18.11.2019	27	0	0	0	0	0	0
Anaesthetics & Perioperative Medicine	23.11.2018	8	2	2	6	0	0	2
Breast Surgery	28.05.2019	13	0	0	13	0	0	0
Dermatology	19.12.2018	18	0	0	18	0	0	0
Diabetic Medicine	22.01.2019	15	0	1	14	0	0	0
Emergency Medicine	11/10/2018	7	0	2	5	0	0	0
Endocrinology	02/11/2018	6	0	0	6	0	0	0
Ear Nose & Throat Surgery	21/04/2017	10	0	4	6	0	0	0
Gastroenterology	16.08.2019	18	0	0	0	0	0	0
General Surgery	13/03/2018	5	23	16	11	1	0	2
Geriatric Medicine	05.11.2019	17	0	1	16	0	0	0
Hospital Dentistry	20.09.2019	13	0	0	0	0	0	0
Imaging & Radiology	09.12.2019	28	0	0	28	0	0	0
Litigation	N/A	0	4	3	1	0	0	0
Neurology	24.06.2019	8	0	0	8	0	0	0
Obstetrics & Gynaecology	29/11/2017	13	0	11	1	1	0	1
Oral and Facial	21/04/2017	7	18	8	17	0	0	1
Ophthalmology	30/08/2017	7		3	1	3	0	0
Orthopaedics	10/01/2017	28	25	49	3	1	0	4
Paediatric Surgery	11/08/2017.	9	0	9	0	0	0	2
Renal Medicine	11.01 2019	9	0	1	8	0	0	0
Spinal Surgery	23/11/2016	7	20	13	13	1	0	0
Stroke Medicine	06/06/2019	16	0	3	13	0	0	0
Trauma Surgery	10/01/2018	28	15	39	2	2	0	3
Urology Surgery	21/06/2017	12	18	10	2	0	0	0
Vascular Surgery	10/02/2017 revisit 13.12.2019	17	34	28	21	2	0	0

Plans for improvement 2020/21

Work will continue to raise the profile of this work in the coming year. There will be ongoing work for all services to complete the recommendation by GIRFT. In addition, deep dive visits are arranged in the next few months for Cardiology and Rheumatology and dates for Respiratory, Neonatal medicine and Lung Cancer are imminent.

There are a number of actions that are very challenging and will require multiple agency working. Reconfiguration of General Surgery continues with public engagement.

The GIRFT national teams are also publishing national reports with generalised recommendations for all Trusts. So far reports for Orthopaedics, General Surgery, Vascular Surgery, Oral and Maxillofacial Surgery, Spinal Surgery, Ear Nose and Throat Surgery, Ophthalmology and Urology have been received. Work will continue to check that we are compliant with these recommendations.

The early reports were within the surgical division and many of the actions were within the gift of the specialty. Over the past year many of the deep dive presentations have involved the medical specialties. Many recommendations for medical specialties involve multidepartment collaboration and a Medical Forum for review of shared learning is being established for medical specialties that have embarked on the GIRFT process. The aim of this will be to use the diversity of approaches taken by the national specialty teams to enrich our own understanding of patient quality and safety issues, and identify common opportunities for improvement.

21. Quality priority

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

Background

There is a national driver to deliver hospital services seven days a week and this improvement programme is called Seven Day Services (7DS). 7DS provision is about equitable access, care and treatment, regardless of the day of the week. The level of service provided should ensure that the patient has a seamless pathway of care when accessing services, no matter what day of the week.

Ten clinical standards for **seven day services** in hospitals were developed in 2013 through the **Seven Day Services** Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care.

Table: The Ten 7DS Standards with descriptions

No.	7DS Standard	Description
1	Patient experience	Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on- going care that reflect what is important to them. This should happen consistently, seven days a week.
2	**Time to first consultant review - priority**	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.
3	Multidisciplinary team Review	All emergency inpatients must have prompt assessment by a multi-professional team to identify complex or on-going needs, unless deemed unnecessary by the responsible consultant. The multi-disciplinary assessment should be overseen by a competent decision-maker, be undertaken within 14 hours and an integrated management plan with estimated discharge date to be in place along with completed medicines reconciliation within 24 hours.
4	Shift handovers	Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in- coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.
5	**Access to diagnostic tests - priority**	Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy

No.	7DS Standard	Description
		and pathology. Consultant-directed diagnostic tests and their reporting will be available seven days a week: • within 1 hour for critical patients; • within 12 hours for urgent patients; and • within 24 hours for non-urgent patients
6	**Access to consultant directed interventions- priority**	Hospital inpatients must have timely 24 hour access, seven days a week, to consultant- directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as: • critical care; • interventional radiology; • interventional endoscopy; and • emergency general surgery.
7	Mental health	Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: • Within 1 hour for emergency* care needs • Within 14 hours for urgent** care needs
8	**Ongoing review by consultants twice daily if high dependency patients daily for others - priority**	All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.
9	Transfer to community, primary and social care	Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.
10	Quality improvement	All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high- quality, safe patient care, seven days a week.

7DS four priority standards (2, 5, 6 & 8)
With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

Standard 2 – Time to first consultant review
Standard 5 – Access to diagnostic tests
Standard 6 – Access to consultant-directed interventions
Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others.

7DS standards for continuous improvement (1, 3, 4, 7, 9 & 10)
The remaining six clinical standards are collectively referred to as the 7DS Standards for Continuous Improvement, and taken as a whole, impact positively on the quality of care and patient experience.

Monitoring improvement
Our Trust is required to provide an update to NHS Improvement about how we are progressing. We have previously completed a bi-annual self-assessment survey and this process changed to a self-assessment called a board assurance framework. The new tool was launched in November 2018. The new measurement system consists of a standard template that all trusts complete with self- assessments of their performance against the 7DS clinical standards, supported by local evidence. This self-assessment was then formally assured by our Board. Our Board then decided on appropriate improvement processes, trajectories, details and timetables.

How we have we performed 2019/20 and data

This section shows how we are performing and our self-assessment, identifies the gaps we have in 7DS provision and shows where we are going to focus for improvements. The board assessment template provides an assessment of the priority clinical standards and a narrative of the clinical standards for continuous improvement (1, 3, 4, 7, 9, 10).

We have submitted data in the new format to NHSI: -

- Trial run Jan - Feb 2019
- Spring June 2019
- Autumn November 2019

Four priority standards

In June and November (to be validated by NHSI) 2019 our data confirmed, of the 4 priority standards,

- We are meeting standards 5 and 6.
- We are not meeting standards 2 and 8.

7DS Clinical Standards for Continuous Improvement

The remaining six clinical standards are collectively referred to as the 7DS Standards for Continuous Improvement, and taken as a whole, impact positively on the quality of care and patient experience. The Trust is required to provide narrative against each standard to explain work being undertaken in relation to their delivery and overall improvement. There is no requirement for evidence or assessment of meeting the standards.

Table: Summary of results

No.	7DS Standard	June 2019	July audit for Nov 2019
1	Patient experience	Narrative provided	
2	**Time to first consultant review (priority)**	**Not met**	**Not met**
3	Multidisciplinary team Review	Narrative provided	
4	Shift handovers	Narrative provided	
5	**Access to diagnostic tests (priority)**	**Met**	**Met**
6	**Access to consultant directed interventions (priority)**	**Met**	**Met**
7	Mental health	Narrative provided	
8	**Review by consultants** twice daily if high dependency patients daily for others **(priority)**	**Not met**	**Not Met**
9	Transfer to community, primary and social care	Narrative provided	
10	Quality improvement	Narrative provided	

A summary of our improvement work

- **Daily review at weekends**
  - Service Directors have been sent the assessment findings and have been asked to re-review consultant job plans to ensure their provision is adequate in order to reliably and consistently meet this clinical standard including the need for additional staff if necessary
  - We have made clear processes for the identification and documentation of patients not requiring daily review at the weekend.
- **Consultant review < 14 hours of admission**

- Ward round practice is being reviewed to ensure that new patients are seen earlier
- Focused work with particular specialities with poorer performance including reviewing the need for additional staff
- We have undertaken the education of junior doctors about post take ward round documentation including documenting the time of review – a lack of documented time accounted for 30% of our inability to meet this standard.

Plans for improvement 2020/2021

The Medical Director met with a member of the NHSI South West team in November 2019 and discussed current position and plans for improvement. We are awaiting formal feedback on our November 2019 submission. We are continuing with ongoing recruitment into vacant Consultant Posts which will help with 7DS delivery (2 possible recruitments to Acute Medicine, 3 new recruitments to Care of the Elderly).

Our 7DS delivery and our lack of compliance with priority standard 2 and 8 is in the process of being added to our Trust risk register as we are at risk of achieving these 2 standards.

The Trust will be required to submit its next 7DS self-assessment to NHSI in spring 2020 (date pending) and our improvement work will continue.

Areas we will be reviewing and focusing on, as suggested by NHSI include:

- patient Length of Stay (LOS) for admitted at weekend vs weekday,
- updated Hospital Standardised Mortality Ratio (HSMR) weekend versus weekday,
- updated patient feedback & complaints directly related to the weekend, and
- an overview of ongoing projects which relate to 7DS (e.g. patient flow board round project and our criteria led discharge project).

22. Quality priority

To deliver the programme of Better Births (maternity care) continuity of carer (CoC) improvement programme

Background

On 22 December 2017, the Maternity Transformation Programme published Implementing Better Births: Continuity of Carer, to help our Local Maternity Systems (LMS) plan and deploy continuity of carer models in our services. The evidence shows that women want and benefit from continuity of carer. The Cochrane research review (2016) found that women who received midwife-led continuity of care were less likely to experience preterm births or lose their baby in pregnancy or in the first month following birth. The research evidence showed that women were: -

- 16% less likely to lose their baby
- 19% less likely to lose their baby before 24 weeks
- 24% less likely to experience pre-term birth.

Equally, safety is not just about whether their baby lives or dies; safety for childbearing women and their partners and families also means emotional, psychological, and social safety. This holistic sense of safety is what they receive through continuity models of care.

Being a recipient of continuity of care from the same one or two midwives is very different to experiencing the care delivered through more traditional models of midwifery which in some areas can mean meeting a different midwife at every appointment. Becoming comfortable with someone, building a relationship with them which grows and deepens over time, enables trust to develop and women begin to share their deeper anxieties and insecurities as well as enjoying the more positive aspects of growing knowledge and confidence through a supported journey of discovery.

Midwives benefit too. For a midwife, getting to know the woman, and developing a trusting relationship with her during her pregnancy, is the best way to help her have a safe, positive and empowering experience of pregnancy birth and parenthood, whilst maintaining and strengthening clinical expertise across all areas of maternity care.

In a continuity model, in close collaboration with her colleagues from across the multidisciplinary team, midwives have a critical role to play in ensuring that women are physically and psychologically well, so that they can develop a responsive and nurturing relationship with their children.

How we have performed 2019/20

To help generate momentum and ensure that the NHS is on track to deliver the ask that most women receive continuity of carer by March 2021, *Refreshing NHS Plans for 2018/19* requires LMS to ensure that from March 2019, 20% of women at booking are placed onto continuity of carer pathways and **receive continuity of the person caring for them during pregnancy, birth, and postnatally**.

Table: Percentage of women booked on Continuity of Carer pathways April – March 2019/20

Target	Q1	Q2	Q3	Q4	YTD Total
> 35%	7.8%	8.2%	11.7%	*4.6%	8.0%

* Stroud no longer included in CoC from January 2020 onwards

Table: Annual summary of continuity of Carer pathways actuals and targets

Year	National Target %	Trust Projected Trajectory %	Actual figures achieved %
2018/2019	20	10.29	10.3%
2019/2020	35	10.54	8.0%
2020/2021	50	30.00	
2021/2022	50	35.00	
2022/2023	50	40.00	
2023/2024	50	51.07	

During 2019/20, the Better Births clinical team has engaged with staff in a number of ways regarding Continuity of Carer and the requirement to meet the national target of 50% of women to be on a continuity of carer pathway.

Two pilot models of continuity of carer were continued to achieve 10% of women on a Continuity of Carer pathway; unfortunately, one of the models was not sustained while one model continues. Following the pilot, it was clear that to achieve the target a business case would be required. A business case was developed by the Multidisciplinary Team and was agreed by the Gloucestershire Clinical Commissioning Group (CCG) in March 2020.

Plans for improvement 2020/21

In addition to focussing on increasing the number of women who are on a Continuity of Carer pathway in 2020/21, the implementation of Continuity of Carer Improvement programme will be focused in areas of highest deprivation and for our Black and Minority Ethnic (BAME) communities in Gloucester City and Cheltenham.

23. Quality priority

To improve our care of children transitioning to adult care

Background

Following some work around the Transition CQUIN in 2015-2017, a significant gap in service provision was identified, particularly in relation to young people with Life Limiting (LL) and Life Threatening Conditions (LTC). With the advances in medical knowledge and intervention these young people are now surviving into adulthood presenting with complex medical, social and educational needs. Transitioning to adulthood for any young person presents its challenges but for this group it was identified that there were many additional hurdles to face.

In order to meet national guidelines and recommendations during transition, all aspects of the young person's care need to be considered and co-ordinated. This is called the pentagon of support and includes healthcare, social care, education, housing and work/life balance. With current data, we are estimating that there will be 10-15 young people that will fall within this group per year, however it is recognized nationally that this number will be increasing year on year. Currently the following areas have been identified as risks or issues:

- This group of patients present with life-limiting, multi-systemic medical problems and, although not exclusively, a profound learning disability. The complex nature of these young people makes their care in adult services difficult due to the multiple clinicians that need to be involved and a lack of a 'helicopter' clinician who can provide holistic, symptomatic care.
- Due to this complexity, these young people require a different skill set and additional layers of support that is not currently available from an adult clinician or their team. As many of these young people have potentially life-limiting conditions which fall into a broader range than traditionally seen in Adult Specialist Palliative Medicine, the skill base of these clinicians can easily be transferred to managing this caseload providing the holistic 'helicopter' service that is required.
- As these young people transition to adult services they will need to access various teams/services. Each service has a different age at which they will engage with the young person. For example, the adult learning disability team will not accept a referral until the young person is 17.5 years old and their service is commissioned from 18 years. The transitional process cannot therefore take place and the young person is transferred to adult care.
- Equipment – the provision, supply and adaptation of equipment is different in adult services, and equipment also 'gets lost' during transition. There are also the challenges of available equipment in acute adult services e.g. hoists, communication aids

- Training needs for adult colleagues, particularly around medication such as paraldehyde and clinical interventions such as the use of Porta Catheters.

How we have performed

Recognising the gap in service, one of the Adult Specialist Palliative Medicine consultants (ASPMC), who had a particular interest in this client group has over the years, provided care for several young people with LL/LTC into her caseload providing them with a 'helicopter' holistic medical service, undertaken as a **non-commissioned pilot**. The Trust also appointed a new and innovative role of a Paediatric Neurodisability Nurse Specialist (PNNS). They have worked closely with the ASPMC on individual cases resulting in the provision of high quality transitional care for this client group.

The pilot undertaken by the ASPMC and the PNNS has shown that this model of care provides the young people and carers of this client group with a service that 'spans the gap' to adult services.

A business case has been agreed to develop a transition pathway and identify an adequate resource to oversee the holistic transition of young people with LL/LTC that is not currently addressed using the Ready Steady Go Hello programme or current clinical services.

Our proposal is for a commissioned service consisting of 2 posts: -

1. Medical co-ordinator who will work with consultant paediatricians and adult specialties providing a holistic medical overview of health care needs during the transitional period ensuring that robust primary and secondary teams are in place
2. Transitional care co-ordinator who will work closely with the medical co-ordinator ensuring that all aspects of transition for these young people are identified and addressed

The aim of the new service would be that all young people between the ages of 14 – 25 years with a LL/LTC with complex medical, social and educational needs will have: -

- An identified transition care coordinator
- A medical professional to co-ordinate medical care across specialities, primary and secondary care
- A personalised transition plan in place
- A treatment escalation plan /ReSPECT form in place
- Improved experience of transition for themselves and their families
- Confidence in their new teams

Plan for improvement 2020/21

In 2020/21, we will be focussing on setting up the new service, the benefits of which include:

- Young people with a LL/LTC and their families will have an identified transitional medical and care co-ordinator who will navigate this part of their journey with them ensuring they are embedded into adult primary and secondary services
- Increased competence and confidence of adult services to manage the medical, social and educational complexity of these young people
- Using a new and innovative approach to address a nationally recognised need
- Commissioner will have a better understanding of the numbers and needs of this group of young people transitioning to adult services

This will be done in partnership with Trust Paediatric and Adult leads, as well as the Clinical Commissioning Group Lead for Transition, to develop the transition work within the Trust further whilst maintaining the progress achieved following the CQUIN implementation of the Ready Steady Go Hello pathway.

In addition to the business case, a scoping exercise was commissioned to look at all specialties of children transitioning from children to adult services to review what the process and care was given to young people through the transition pathway. The specialty review against the NICE Standard's 5 statements can be seen below. This review will form the baseline that shows the number of services currently starting transition at year 9, which will form the basis for our improvement programme in 2020/21.

Table: Results of speciality review against NICE Standard's 5 Statements

Specialty	**Statement 1 Ready, Steady Go started at 14?**	**Statement 2 Documented annual review (or transition clinic?)**	**Statement 3 Keyworker ?**	**Statement 4 Meet adult consultant/ team?**	**Statement 5 Chased if DNA?**
Asthma	Specific few patients	No unless at GP's	CNS	Consultant/ CNS Majority GP care	yes
Allergy	No	3yrly OPA's	CNS	N/A: GP care	N/A: GP care
Bladder & Bowel	No	yes	CNS	CNS to CNS	yes

Children's Community Nursing/Complex Care (GHC)	No	May be documented as part of TAC/EHCP review	CNS of co-morbidity e.g. Neuro-disability takes lead	CCN to Integrated Care Team (Adult District Nurses)	No
Congenital Cardiology	Yes, if seen at BCH, no at GRH	Yes, at BCH otherwise Informal	CNS at BCH	At BCH GRH: Consultant letter only	No
Cystic Fibrosis	yes	yes	CNS	Yes, MDT in Bristol	Yes, by Bristol
Dermatology	No (but willing to start)	informal	CNS	Yes	Yes
Diabetes	Yes	Yes	CNS/Dietician	Yes MDT: Young Person's Clinic	Yes
Endocrine	No	Informal	CNS	Some sub-specialities only	No
Epilepsy	Yes	Yes	CNS	Yes	Yes
ENT	?	n/a	n/a	Same team	No
Enteral Feeding Team	No	informal	CNS/Dietician	CNS/Dietician	Yes

Part 2.2: Statements of assurance from the board

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

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

Health services

During 2019/20 Gloucestershire Hospitals NHS Foundation Trust provided and/or subcontracted 111 NHS Services.

Gloucestershire Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 111 of these relevant health services.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust can confirm compliance with this requirement for the 2019/20 financial year.

Information on participation in clinical audit

From 1 April 2019 to 31 March 2020, 44 national clinical audits and 4 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 98% 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 2019/20 are as follows:

	Eligible	**Participated**	**Status**
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes	Yes	Complete
BAUS Urology Audits: Cystectomy	Yes	Yes	Underway

BAUS Urology Audits: Nephrectomy	Yes	Yes	Underway
BAUS Urology Audits: Percutaneous nephrolithotomy	Yes	Yes	Complete
BAUS Urology Audits: Radical prostatectomy	Yes	Yes	Underway
Care of Children in Emergency Departments	Yes	Yes	Complete
Case Mix Programme (CMP)	Yes	Yes	Ongoing
Elective Surgery (National PROMs Programme)	Yes	Yes	Ongoing
Endocrine and Thyroid National Audit	Yes	Yes	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	Yes	Complete
Inflammatory Bowel Disease (IBD) programme	Yes	No	n/a
Major Trauma Audit The Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing
Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection	Yes	Yes	Ongoing
Maternal, Newborn and Infant Review Programme Clinical Outcome	Yes	Yes	Ongoing
Mental Health - Care in Emergency Departme	Yes	Yes	Completed
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	Ongoing

National Audit of Care at the End of Life (NACEL)	Yes	Yes	Underway
National Audit of Dementia	Yes	Yes	Complete
National Audit of Seizure Management in Hospitals (NASH3)	Yes	Yes	Ongoing
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	Ongoing
National Bariatric Surgery Registry (NBSR)	Yes	Yes	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Ongoing
National Diabetes Audit – Adults	Yes	Yes	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Ongoing
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Underway
National Gastro-intestinal Cancer Programme	Yes	Yes	Ongoing
National Joint Registry (NJR)	Yes	Yes	Ongoing
National Lung Cancer Audit (NLCA)	Yes	Yes	NYR
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Ongoing
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Yes	Yes	Ongoing
National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	Ongoing
National Ophthalmology Audit (NOD)	Yes	Yes	Ongoing
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Ongoing

National Prostate Cancer Audit	Yes	Yes	Ongoing
National Smoking Cessation Audit	Yes	Yes	Underway
National Vascular Registry	Yes	Yes	Ongoing
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	DTF
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	Ongoing
Surgical Site Infection Surveillance Service	Yes	Yes	Ongoing
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	Underway
UK Cystic Fibrosis Registry	Yes	Yes	Ongoing
UK Parkinson’s Audit	Yes	Partially	Underway
NCEPODs			
Long Term Ventilation	Yes	Yes	Completed
Acute Bowel Obstruction	Yes	Yes	Completed
In Hospital Management of Out of Hospital Cardiac Arrests	Yes	Yes	Completed
Dysphagia in Parkinson’s Disease	Yes	Yes	Completed

Key
Underway – Data collection has started but the deadline has not yet passed, or collection has been suspended due to Covid 19

Ongoing – relates to continuous data collection, please note some audits have suspended data collection due to Covid 19
NYR – data collection has not yet started
DTF – Details to Follow

Participation in clinical research

The number of patients receiving relevant health services provided by Gloucestershire Hospitals NHS Foundation Trust in 209/20 that were recruited during that period to participate in research approved by a research ethics committee was 1834.

Commissioning for Quality and Innovation (CQUINS)

There are 7 CQUINS in total this year;

- 5 CCG commissioned schemes,
- 1 Specialised Commissioning and
- 1 commissioned by the Armed Forces arm of specialised commissioning.

The overall 19/20 CQUIN value is £4,849m:

- GCCG is a block contract (1.5% contract value) of £4,046m
- Specialised commissioning (0.75% contract value), NCA and PH contributions: £641,184k
- Armed Forces: 4,451k
- South Worcester and associates: £157k

Table: Breakdown of potential income if all CQUIN requirements met to the highest levels

CQUIN	**Description**	Value (£) if requirements met
CCG1 AMR:		
a) Lower UTI older people	Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.	420,332
b) Antibiotic prophylaxis in elective colorectal surgery	Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	420,332
CCG2 Staff Flu jab	Achieving an 80% uptake of flu vaccinations by frontline clinical staff.	840,663
CCG3 Screening and advice for alcohol & tobacco in inpatient setting		
a) Alcohol & Tobacco	Achieving 80% of inpatients admitted	280,221

screening	to an inpatient ward for at least one night that are screened for both smoking and alcohol use.	
b) tobacco – brief advice	Achieving 90% of identified smokers given brief advice.	280,221
c) Alcohol – brief advice	Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	280,221
CCG7 3 high impact interventions – falls prevention	Achieving 80% of older inpatients receiving 3 key falls prevention actions	840,663
CCG 11 Same Day Emergency Care:		
a) Pulmonary Embolus (PE)	Achieving 75% of patients with confirmed PE being managed in a same day setting where clinically appropriate.	280,221
b) Tachycardia with AF	Achieving 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate.	280,221
c) Community Acquired Pneumonia	75% Patients with confirmed CAP should be managed in a same day setting where clinically appropriate.	280,221
PSS1 Medicines Optimisation:		
Trigger 1: Chemotherapy Waste	Improve efficiency in IV chemo pathway – reducing waste	192,355
Trigger 3: Auditing prior approvals of NHSE commissioned drugs	Accurate prior approval (Bluteq) completion – reducing clinical variation	128,237
Trigger 4: Faster adoption best value medicines	Improving adoption rates of prioritised medicines at local level	192,355
Trigger 5: Anti-fungal stewardship	Reduce inappropriate use AF's and prevent resistance through development of AF stewardship teams	128,237
PSS-AF: Armed Forces Scheme	Continue to embed AF covenant	4,451
	Total Value:	**4,848,950**

End of year performance

As we were not required nationally to submit data for Q4 because of the Covid-19 Pandemic our final performance will be agreed with the CCG and will be based on Q3 performance where appropriate based on the national advice.

Performance and payment calculations:

Payment calculation is usually based on accumulative value of achievement across the quarters. If the upper threshold is reached accumulatively at year end 100% of payment will be earned; where it drops below the lower threshold, 0% would be earned. Payment is graduated between the two thresholds**.**

Q3 performance:
PSS1 Medicines Optimisation:
All indicators achieved 100% to Q3 – securing £480,888 with no losses. The concerted pharmacy team, and individual effort, to achieving this result should be recognised and acknowledged as a significant result.
Trigger 1: Implementation of chemo waste Calculator tool
Trigger 3: Audit of Bluteq prior approval forms (Q3 - Pembrolizumab and Dimethyl Fumerate)
Trigger 4: Adoption best value drugs in new and existing patients for identified Q3 drugs.
Trigger 5, Antifungal Stewardship – Gap analysis completed. There have been resource concerns around auditing requirements, however the first audit is not required until Q4; Q1-Q3 focus is on implementation of an AF Stewardship team that will meet NHSE guidelines, and it is anticipated that this team will be in a better position to co-ordinate the required Q4 baseline audit.

CCG1a Lower Urinary Tract Infection (UTI) older people:
40% compliance therefore did not achieve the minimum target of 60% (max 90%) - unlikely to attract any performance pay for 19/20. As for each of the schemes this year audits require a minimum of 100 patients sample which has continued to be extremely challenging. Clinical signs and symptoms need to be recorded in the patient notes and coded appropriately, hence the recommendations from NHSE is that audits should be retrospective - this has proved very time consuming and a prospective approach was planned for Q2/3 – however due to pressures on the wards for pharmacists this was not successful. Discussions have begun with EPR team to help data capture for 20/21 as UTI will continue in some form next year. A working team is also a requirement to include support for audits which will see this CQUIN under achieving 20/21 if that is not available.

CCG b) Antibiotic prophylaxis in elective colorectal surgery:
100 patient audit produced a performance total of 90% against a maximum target of 90% – therefore we were on target for maximum achievement 19/20.

CCG3 Screening and advice for alcohol & tobacco in inpatient setting:
a) **Alcohol & Tobacco screening** – Q3 84% compliant against a maximum target of 80% (minimum 40%) bringing cumulative performance Q1-Q3 to 82%. On target to achieve maximum for this element.
b) Tobacco – brief advice – 78**%** compliant against a maximum target of 90% (minimum 50%) bringing cumulative performance Q1-Q3 to 75%. Currently on target to achieve 63% of this element.
c) Alcohol – brief advice – 72% compliant against a maximum target of 90% (minimum 50%) bringing cumulative performance Q1-Q3 to 77%. Currently on target to achieve 67% of this element.
As part of the healthy living message and improvement plan a smoking quality improvement group led by Dr Charles Sharpe are now meeting; this is collaboration

across surgical and medical services, including Healthy lifestyles and GCCG. Alcohol and tobacco questions have been approved for EPR and will improve data capture.

CCG7 3 high impact interventions – falls prevention (see section in quality account for update):
Q3 100 patient audit - 29% compliant for all 3 falls preventative actions against a minimum target of 25% (maximum 80%), the remainder failing to fulfil one or more of the actions:

CCG 11 Same Day Emergency Care:
100 patient audits, or all patients meeting diagnosis, were completed for each of these elements, however not all who met the eligibility criteria for SDEC were fit to discharge – that made this a challenging CQUIN as this was not considered.

11a) Pulmonary Embolus (PE) – report not received by time reporting portal closed – working to make
the appeal deadline date in May.
11b) Tachycardia with AF – 91% achieved against minimum target of 50% (maximum 75%)
11c) Community Acquired Pneumonia – 63% achieved against maximum target of 75% (maximum 75%).

The clinicians report that they feel the CAP indicator also presented challenges. The NICE guidance on which it was based specifically says: "Use clinical judgement in conjunction with the CURB65 score to guide management of CAP
The CQuIN criterion doesn't include bloods or clinical judgement – although these are taken into consideration for SDEC.

It is possible to have a NEWS of 6 (and therefore be clinically septic) and not trigger any of the criteria so have a score of 0-1. It is possible there were some more patients that could have pulled through SDEC but at the same time most of them were unsuitable for SEC for any number of reasons. The team will continue to review.

	Min	**Max**	**Q1**	**Q2**	**Q3**
Med Ops:					
Trigger 1			achieved	achieved	achieved
Trigger 3			achieved	achieved	Achieved
Trigger 4			achieved	achieved	Achieved
Trigger 5			achieved	achieved	Achieved

AMR:					
UTI	60%	90 %	45.0	35	40
Colorectal	60%	90 %	88.0	90	94
Flu	60%	80 %	Q4 only		
Alcohol/Tobacco					
a) Screen for both	40%	80 %	84.2	78.2	83.9
b) Tobacco brief advice	50%	90 %	77.1	70.7	78.2
c) Alcohol brief advice	50%	90 %	89.7	69.2	72.1
Falls	25%	80 %	27.0	28.0	29
SEC:					
a) PE	50%	75 %	76.0	69.0	Late report
b) Tachycardia with AF	50%	75 %	67.0	73.0	91
c) CAP	50%	75 %	27.0	38.0	63

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 2019/20 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:

99.3% for admitted patient care

100% for outpatient care and

100% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

99.4% for admitted patient care;

99.8% for outpatient care; and

99.8% for accident and emergency care.

Information Governance Statement

Information governance incidents are reviewed and investigated throughout the year and reported internally through the Committees. 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.
Fourteen incidents have been reported to the ICO during the 2019/20 reporting period. This compares to three reported in the previous period. This largely reflects the fact that reporting criteria under the GDPR have a lower threshold than under the previous Data Protection Act.

Table: Summary of incidents reported to the Information Commissioner

Summary of incidents reported to the ICO under Article 33 GDPR				
Month of Incident	**Nature of Incident**	**Number Affected**	**How Patients informed**	**Lessons Learnt**
June 2019	A letter addressed to the natural mother of a child was sent and included the address of the foster parents.	3	Social worker	Review of practice for cc letters for children in care. Improved visibility of children in care status on trust clinical information and administration systems. Ensure there

				are appropriate checking and verification measures in place
July 2019	Package containing copy patient records being sent to patient by post broken in transit	1	Correspondence following patient enquiry	Improvement made to packaging used to send copies of records in the post
August 2019	Spreadsheet containing staff information saved in a shared drive was moved / copied in error to a shared drive with insufficient access control	75	Face to face (for those of the 75 where sensitive data involved)	Improved project governance for new data processing initiatives. Restricted access to shared drives. Reduction in amount of data held. Sensitive data to be password protected
August 2019	A letter, intended to inform a patient of the outcome of tests, included in a collection of documents sent to another patient.	1	Letter from service	Element of human error. Ensure there are appropriate checking and verification measures in place
September 2019	A copy of a ward nursing handover sheet was accidently included in paperwork given to a	14	Not informed	Element of human error. Ensure there are appropriate checking and verification measures in

	patient to take home on discharge.			place
October 2019	Several emails relating to other patients were included in a Pregnancy Pack given to a patient. Emails related to safeguarding issues.	5	Not informed	Review of management of safeguarding information prepared for safeguarding reviews.
October 2019	Paediatric Safeguarding Notification forms being emailed to internal and external recipients accidentally copied to a member of public – wrong email address selected.	7	Not informed	Review of email safeguards in place where external recipients are involved and outside of organisation warning present
November 2019	Care Plans were printed to be sent to patients. Plans for patients' A and B were accidentally picked up together and posted to patient A in the same envelope.	1	Letter from service	Human error rather than systemic failure. Example to be used in IG training
November 2019	Member of staff inappropriate access to patient record	2	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February	Member of staff	1	Correspondence	Personal

2020	inappropriate access to patient record (2)		following patient enquiry / complaint	reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Member of staff inappropriate access to patient record (3)	1	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Report relating to a nine-year-old child inadvertently disclosed to the ex-wife of the child's father who was not the child's mother and had no parental rights.	2	Correspondence following patient enquiry / complaint	Improved visibility of parental responsibility required within trust clinical information and administration systems. Ensure there are appropriate checking and verification measures in place
February 2020	Member of staff inappropriate access to patient record (4)	2	Correspondence following patient enquiry / complaint	Personal reasons motivated access. Additional communications reminding staff of responsibilities
February 2020	Medical report sent to patient's employer without consent	1	Correspondence following patient enquiry	Human error rather than systemic failure. Consent thought to have been obtained.

The majority of the incidents have been now been closed by the ICO with the ICO expressing satisfaction with the steps taken by the Trust to mitigate the effects and minimise the risk of recurrence. With respect to the number of incidents of inappropriate access by staff there has been a communications exercise to remind staff of the requirements of the Code of Confidentiality.

A large number of the near miss reported incidents (189) relate to lost SmartCards which are disabled when reported as missing.

Summary of confidentiality incidents internally reported 2019/20	
Reportable breaches	(detailed above) 14
Number of confirmed Non-reportable breaches	153
Number of no breach / Near miss incidents.	266
Total number of confidentiality incidents internally reported	433

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

Clinical coding

Gloucestershire Hospitals NHS Foundation Trust was not subject to the “Payment by Results clinical coding audit” during 2019/20.

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

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

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

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

- Identification, review and resolution of potential duplication of patient records
- Monitoring of day case activity and regular attenders
- Gathering of user feedback
- All existing reports have been reviewed and revised
- Routine DQ reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'Insight'
- The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.
- Gloucestershire Hospitals NHS Foundation Trust regularly send data submissions to SUS and via these submissions we receive DQ reports back from SUS. Based on SUS DQ reports we action all red and amber items highlighted in report to improve Data Quality.
- In data published for the period April 2019 to March 2020, the percentage of records which included a valid patient NHS number was:
    - 99.8% for admitted patient care (national average: 99.4%)
    - 100% for outpatient care (national average: 99.7%)
    - 99.1% for accident and emergency care (national average: 97.7%)
- The percentage of published data which included the patient's valid GP practice code was:
    - 99.9% for admitted patient care (national average: 99.7%)
    - 99.8% for outpatient care (national average: 99.6%)
    - 99.9% for accident and emergency care (national average: 97.9%)
- A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly
- These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as: -
    - Outpatients including attendances,
    - Outcomes, invalid procedures
    - Inpatients including missing data such as

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

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

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

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

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

Learning from deaths

Statement NHS doctors in training rota gaps

Doctors in Training rota gaps

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receives, and patient feedback about the care provided. As part of our Quality Account 2019/20 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 (2019/20)

Through analysis of our data and knowing what our issues are in 2019/20 we took the following steps to make improvements

1. Looking at data to support hard to fill areas where there are pressures on certain rotas due to national supply and reviewing the demand requirements within departments to ensure that there is a transparency about safe staffing levels.
2. Setting up regular meetings with the Medicine Division Rota leads to discuss known issues and discussing ways of reducing gaps.
3. Guardian of Safe Working proactively involved with rotas to ensure these maintain safe working hours along with good training/education opportunities, encouraging future applicants.

Next Steps (2020/21)

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

Part 2.3 Reporting against core indicators

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

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

Figure: Reporting against core indicators

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	*GHT considers that this data is as described for the following reasons.*	*GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.*
a) The value and banding of the Summary Hospital level Indicator SHMI for trust for the reporting period	2015/16	1.13	1	1.178	0.68	2019/20 data period: Dec18 - Nov19 (latest published data as at 11/05/20)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17	1.12	1	1.23	0.73		
	2017/18	1.09	1	1.11	0.89		
	2018/19	1.0462	1.0012	1.2058	0.7069		
	2019/20	1.0128	1.0036	1.1957	0.6909		
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	2015/16	20.90%	28.50%	54.60%	0.60%	2019/20 data period: Dec18 - Nov19 (latest published data as at 11/05/20)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group & End of Life Steering Group (delivery) and Q&P Committee (assurance).
	2016/17	21.00%	31.10%	58.60%	11.20%		
	2017/18 *	32.10%	32.80%	59%	12.60%		
	2018/19	35%	35.84%	60%	12%		
	2019/20	33%	36.81%	59%	11%		
Number of patient safety incidents / number which resulted in severe harm or death	2015/16	11,517 / 40	9,465 / 39	23,990 / 60	3,510 / 26	Pre 2019/20: data covers the last 6 months in the financial year. 2019/20 data period: Apr19 - Sep19 (latest published data as at 11/05/20).	The actions to be taken have already been described within this report and are monitored by the improvement group Safety and Experience Review Group (delivery) and Q&P Committee (assurance).
	2016/17	6,932/22	4955/19	23,990/60	3,510/26		
	2017/18	7,523 / 35	5,449 / 19	19,897 / 51	1,311 / 0		
	2018/19	6,780 / 12	5,841 / 19	22,048 / 72	1,278 / 12		
	2019/20	7,216 / 15	6,276 / 19	21,685 / 95	1,392 / 20		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	*GHT considers that this data is as described for the following reasons.*	*GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.*
Rate per 1000 bed days of patient safety incidents resulting / rate per 1000 bed days resulting in severe harm or death	2015/16	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	Pre 2019/20: data covers the last 6 months in the financial year. 2019/20 data period: Apr19 - Sep19 (latest published data as at 11/05/20).	
	2016/17	41.82/0.13	39.89/0.15	71.81/0,6	21.15/0.06		
	2017/18	45.00 / 0.21	42.55 / 0.15	124.0 / 0.05	24.19 / 0.00		
	2018/19	41.32 / 0.07	46.06 / 0.15	95.94 / 0.32	16.90 / 0.16		
	2019/20	44.88 / 0.09	49.78 / 0.16	103.84 / 0.01	26.29 / 0.31		
Rate of C diff (per 100,000 bed days) among patients aged over two	2015/16	11.4	15	62.6	0	As at 11/05/20	The actions to be taken are within an improvement plan and are monitored by an improvement committee The Infection prevention and Control Committee (Delivery) and Q&P Committee (assurance).
	2016/17	12.5	13.2	82.7	0		
	2017/18	17.4	13.1	90.4	0		
	2018/19	16.9	11.7	79.7	0		
	2019/20	not available	not available	not available	not available		
Percentage of patients risk assessed for VTE	2015/16	93.30%	96.10%	100.00%	88.60%	2019/20 data period: Apr19 - Dec19 (as at 14/05/2020)	The actions to be taken are that we have a Task and Finish Group set up to improve this indicator been described within this report and are monitored by the improvement group. The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17*	93.50%	95.60%	100.00%	78.70%		
	2017/18	90.00%	95.30%	100.00%	77.00%		
	2018/19	93.71%	96.70%	100%	74.30%		
	2019/20	93.79%	99.03%	100%	71.72%		
Percentage of patients aged 0-15 readmitted to hospital within 28 days of being discharged	2011/12*	9.88%	10.26%	14.94%	6.40%	As at 14/05/20	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
Readmissions within 28 days: age 16 or over	2011/12*	10.52%	11.45%	13.80%	9.34%	As at 14/05/20	
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	n/a	n/a	n/a	n/a		
	2019/20	n/a	n/a	n/a	n/a		
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	As at 14/05/20	
	2016/17	67.7	69.6	86.2	58.9		
	2017/18	65.8	68.6	85.0	60.5		
	2018/19	65.1	67.2	85.0	58.9		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	*GHT considers that this data is as described for the following reasons.*	*GHT intends to take or has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by these actions listed.*
	2019/20	not available	not available	not available	not available		
Staff Friends & Family Test Q12d (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2015/16	69.0%	65.0%	85.4%	46.0%	2019/20 data period: Survey in Oct19-Dec19 (as at 14/05/20)	The actions to be taken are monitored by the improvement group Staff and Experience Improvement Group (delivery) and People and OD Committee (assurance).
	2016/17	64. 0%	70.0%	84.80%	48.9%		
	2017/18	61%	70 %	93 %	42%		
	2018/19	65%	70%	87%	41%		
	2019/20	64%	70%	88%	41%		

PROMs

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

(i) groin hernia surgery (ii) varicose vein surgery (iii) hip replacement surgery and (iv) knee replacement surgery during the reporting period.

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

Part 3: Other information

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

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

Indicator	2017/18	2018/19	2019/20	National target (if applicable)	Notes/ Other information
Maximum 6-week wait for diagnostic procedures	0.28%	0.45%	3.16%	<1%	Mar20 snapshot
Clostridium difficile year on year reduction	56	56	97	2019/20: 114	Total Apr19-Mar20
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	4	6	2	0	Total Apr19-Mar20
MSSA	100	80	18	<=8	Total Apr19-Mar20
Never events	6	2	6	0	Total Apr19-Mar20
Risk assessment for patients with VTE	87.03%	93.20%	93.19%	>95%	2017/18 = Jul to Mar based on submissions (did not have data Q1) Apr18-Mar19
Crude mortality rate	1.24%	1.09%	1.19%	No target	Total Apr19-Mar20
Dementia 1a: Case finding	0.80%	1.90%	0.80%	>=90%	Total Apr19-Mar20
Dementia 1b: Clinical assessment	65.00%	27.90%	29.40%	>=90%	
Dementia 1c: Referral for management	11.00%	2.80%	0%	>=90%	
% patients spending 4 hours or less in ED	86.70%	89.60%	81.58%	>=95%	Total Apr19-Mar20
Number of ambulance handovers delayed over 30 minutes *(<=1hr)	506	666	1218	Annual Target TBC (<=40 per month STP)	Total Apr19-Mar20
Number of ambulance handovers delayed over 60 minutes	15	14	35	0	Total Apr19-Mar20
Emergency readmissions within 30 days - elective & emergency	6.9%	6.9%	7.0%	<8.25%	Total Apr19-Mar20
% stroke patients spending 90% of time on stroke ward	88.2%	90.8%	87.70%	>=80%	2019/20: Apr- Feb.
% of women seen by midwife by 12 weeks	89.50%	89.80%	88.90%	>90%	Total Apr19-Mar20
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
Cancer – urgent referrals seen in under 2 weeks from GP	82.30%	90.10%	92.50%	>=93%	Total Apr19-Mar20 (unvalidated)

Indicator	2017/18	2018/19	2019/20	National target (if applicable)	Notes/ Other information
2 week wait breast symptomatic referrals	90.40%	95.90%	97.50%	>=93%	Total Apr19-Mar20 (unvalidated)
Cancer – 31 day diagnosis to treatment (first treatments)	96.30%	94.60%	93.40%	>=96%	Total Apr19-Mar20 (unvalidated)
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	94.80%	95.30%	93.60%	>=94%	Total Apr19-Mar20 (unvalidated)
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.80%	99.90%	99.40%	>=98%	Total Apr19-Mar20 (unvalidated)
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.10%	99.30%	94.90%	>=94%	Total Apr19-Mar20 (unvalidated)
Cancer 62-day referral to treatment (urgent GP referral)	75%	74.80%	73.10%	>=85%	Total Apr19-Mar20 (unvalidated)
Cancer 62-day referral to treatment (screenings)	92.20%	96.50%	95.40%	>=90%	Total Apr19-Mar20 (unvalidated)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	Not reported in 2017/18	79.75%	79.79%	92%	Mar20 snapshot
Delayed Transfer of Care rate	2.39%	3.15%	2.96%	<=3.5%	Mar20 snapshot
Number of delayed discharges at month end	34	43	15	<=38	Mar20 snapshot

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

To be added

Statement from NHS Gloucestershire Clinical Commissioning Group

Statement from Healthwatch Gloucestershire (HWG)

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

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

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

Annex 2: Statement of directors' responsibilities for the quality report

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

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

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- 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 2019 to March 2020
  - papers relating to quality reported to the board over the period April 2019 to March 2020
  - feedback from commissioners dated
  - feedback from governors dated

    Our Governors have contributed to identifying the priorities for next year 2020/21 and have also provided us with feedback on this year's Quality Account.
  - feedback from local Healthwatch organisations dated
  - feedback from overview and scrutiny committee dated
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2019 – check on website

    https://www.gloshospitals.nhs.uk/contact-us/feedback-and-complaints-pals/
  - the 2018 national patient survey published by CQC 20/06/2019

    https://www.cqc.org.uk/provider/RTE/survey/3
  - the 2018 national staff survey published November 2019

    https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2019/
  - the Head of Internal Audit's annual opinion of the trust's control environment dated
  - CQC inspection report dated 07/01/2019

    https://www.cqc.org.uk/provider/RTE

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

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

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

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

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

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

By order of the board

.....Date.....Chairman

.....Date.....Chief Executive

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS – JUNE 2020
Via MS Teams commencing at 14:30

Report Title
Digital: Quality & Benefits
Sponsor and Author(s)
Author: Leah Parry, Digital Transformation Lead Sponsor: Mark Hutchinson, Exec. CIO
Executive Summary

Purpose
This paper starts to describe some of the benefits already being realised by the use of Sunrise EPR. We will begin to share monthly the updates to how we can drive and improve the quality and reliability of care by using Sunrise EPR.

Key issues to note
- Initial review of releasing time to care study demonstrated that whilst time nurses spent documenting notes went up by 1.6% but in contrast to this the amount of time nurses spent delivering patient care increased by 16.1%
- This means that an additional two hours per shift is now spent delivering patient care
- Real time intervention of care through use of tracking boards has the potential to be significantly improved
- EPR Usage reports have been embedded into medical quality reviews

Conclusions
N/A

Implications and Future Action Required
- DDG member to support the uptake of real time tracking board reviews by matrons and ward managers
- EPR Usage to be embedded into other divisions as per medicine approach

Recommendations

The Council is asked to NOTE the report for ASSURANCE.

Impact Upon Strategic Objectives

The progression of the digital agenda will allow the following strategic objectives to be delivered:
- Outstanding Care
- Quality improvement
- Care without boundaries
- Involved people
- Centres of excellence
- Financial balance
- Digital future
- Driving research

Impact Upon Corporate Risks

Progression of the digital agenda will allow us to significantly reduce a number of corporate risks.

Regulatory and/or Legal Implications
Progression of the digital agenda will allow the Trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery.

Equality & Patient Impact
Progression of the Digital agenda will improve the safety and reliability of care in the most efficient and effective manner.

Resource Implications			
Finance	**X**	Information Management & Technology	**X**
Human Resources	**X**	Buildings	

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS – JUNE 2020

DIGITAL QUALITY & BENEFITS

1. COVID- 19 Digital Benefits

There is no doubt that a significant amount of work has been carried out to support and enable the organisation throughout this turbulent time. The use of Sunrise EPR has delivered some known benefits and some unexpected benefits. Some of the ways that Sunrise EPR has allowed us to manage through this pandemic:

1) The use of NEWS2 lists to know instantly where our sickest patients are in the trust. The ACRT, senior nurses and the yellow lanyard team all have access to lists that show where patients with high NEWS2 scores are. The yellow lanyard team have reported that this has helped them know where to prioritise their support and how to plan their day.
2) The use of remote accessing NEWS2 flow sheets to review patients that are acutely unwell and intervene quickly, even when on another site.
   "I was on call and able to spot and manage a deteriorating patient in Cheltenham from Gloucester. They subsequently were diagnosed with COVID and as the registrar on call I would not have been able to provide the intervention that I did without access to observations on Sunrise EPR" Registrar GS
3) The use of Sunrise EPR to aid with senior nursing support and the deployment of staff. Prior to deploying staff to wards senior nurses are reviewing lists and wards remotely (largely by colleagues who are self-isolating) and able to make informed staffing decisions.
   " A ward were requesting another member of qualified staff but on review of both the NEWS2 list and the ward tracking board I was able to identify that they were actually in a very good position and in fact I redeployed a member of their staff next door where they had far sicker patients" Senior Nurse LB
4) The use of Sunrise EPR to ensure that wards and nurses feel supported when things are difficult.
   On a senior nurse call at 9.30am, I heard the following from our Deputy Chief Nurse. "Can one of the matrons at GRH please go and see ward 4a. They have 4 or 5 patients with a NEWS of 4-7 this morning, which is not like them at all. Can we go and see that they are ok and they have the support that they need" The matron responded with of course and was able to go and support that ward manager
5) Being able to report on our patients that are on oxygen for a COVID return. Prior to the go live of E-observations, to meet this requirement a manual process involving someone on the ward counting patients and someone else ringing round the wards to put the data into a spreadsheet to then submit it.

2. Releasing Time to Care

When considering the move to an electronic patient record there is no doubt that, the capture of information and use of a digital record offers organisations huge benefits. The ability to extract and use that information has recently been demonstrated by GHFT's ability to report instantly on the number of patients on oxygen. The accessibility of clinical information using digital tools to allow timely information at the point clinicians need it has been confirmed by when one of the chief registrars was able to identify a deteriorating patient and intervene whilst on call from Gloucester. The benefits of an EPR are easy to extrapolate however there needs to be some

recognition that the time it takes to capture the information is likely to be longer than if capturing the same information on paper.

In 2018, Schenk et al carried out a study looking at the impact of adopting an electronic patient record n nursing work and caring efficiency. Within this study, they used time in motion technology to review nursing practice. Post the go live of the electronic patient record nurses were found to be spending more time with patients in their rooms or by their beds and less in other ward based locations. Whilst the study did find that they spent more time documenting their care, they spent more time overall delivering nursing interventions and less time reporting or communicating to colleagues.

In contrast to the Schenk study, studies by Yee et al (2012) and Poissant et al (2005) did not identify an increase in documentation time post the roll out of an electronic patient record- however; they did note that this was dependent on both data quality and digital literacy.

2.1 GHFT's Review

In order to review the impact of Sunrise EPR on our colleagues' time we undertook our own exercise. Prior to the go-live, of Sunrise EPR the EPR team carried out a two month exercise to shadow colleagues across various different professions in an attempt to understand how they currently spent their time, and what opportunities there were in the roll out of an electronic patient record. From a nursing staff perspective nurses across medicine, surgery, Cheltenham and Gloucester royal were shadowed. Following a similar method to Schenk et al, but using old fashioned "time in motion studies" captured on paper nursing colleagues were shadowed and 5 minute blocks of time were allocated to the following categories:

- **Communication**
  Within this category fell conversations to professionals, emails, sending of referral paperwork, conversations with families etc.

- **Documentation**
- This included anytime colleague were capturing any kind of documentation in relation to the patients within their care, from nursing documentation, medical notes, datix completion etc.

- **Inefficient time**
  Whilst difficult to describe this was a category that was used to identify different tasks that the complete roll out of an EPR would prevent. The list below is a set of examples:

  Drug chart - Looking for
  Duplicating information across forms
  Paper Forms - Looking for
  Looking for patient when off ward
  Patient files (nursing) - Looking for
  Patient notes - Looking for
  Stationary - Looking for
  Whiteboards - Manual updates
  Chasing TTOs/ results
  Distributing Patient files to clinics
  Duplicating/ inefficient verbal communication

- **Patient Care**
  This category involved anything that could be aligned and perceived by a non-medical member of staff (i.e. an EPR team member) as relating to patient care. E.g. medication, personal care, discussions about care, dressings, obs etc.

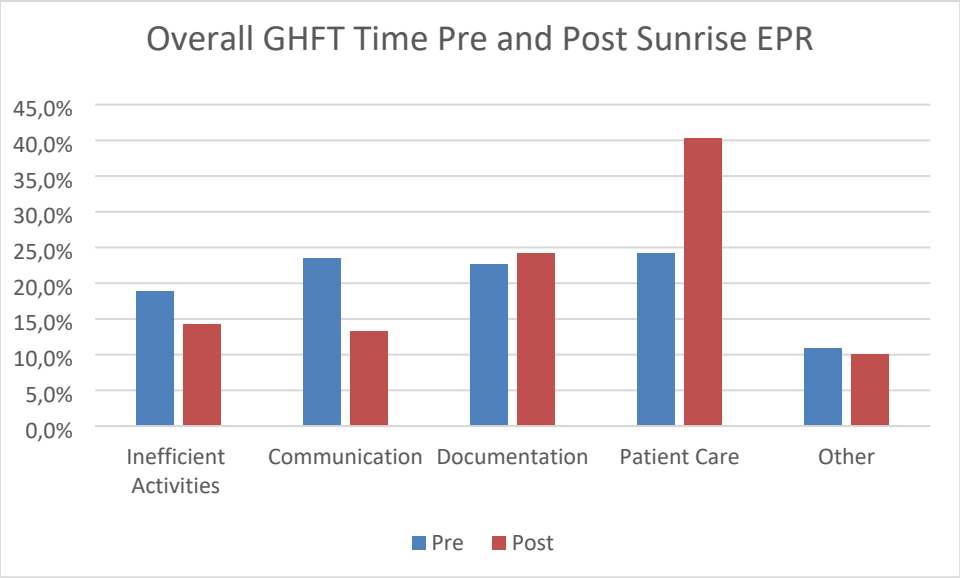
- **Other**
  This was a catchall category that consisted of things such as; doing training, looking at rotas, taking a break, checking emails etc.

From the middle of February to the week ending March 13th a number of the extended team partook in a repeat exercise, spending time shadowing nurses on wards across the medical and surgical division at both Gloucester Royal Hospital and Cheltenham General Hospital. This has

allowed us to compare the time being spent on patient care both pre Sunrise EPR (data collection July & August 2019) and post Sunrise EPR go live.

2.2 Results

Overall GHFT Results



Overall, there has been change across all domains with time spent on inefficient activities reducing by approximately 4.7%. This improvement anecdotally from comments and reflections is likely down to having access to nursing notes, with no need to go and look for them, or no need to wait for them to become available. There is still a significant amount of time to be reduced that further EPR roll out will aid with for example further documentation, the easy access and view of when a result has come back and the electronic prescribing of drugs.

Time spent communicating has also decreased by approximately 10.2%, again anecdotally this is possibly due to the access of information within the record, the ability to see clearly where a patient is and what their needs are, reducing some of the unnecessary often duplicate communication between colleagues.

Similar to the Schenk study the time taken to document has increased by 1.6 %, acknowledging that it does spend a little bit more time to complete an electronic patient record. It has been noted by some nursing staff that this is twofold, some people take a bit more time to use a computer but others are now completing documentation that they should have before but are not being prompted by the EPR.

Most importantly, our exercise has shown that time spent carrying out patient care as increased by 16.1%. This is an important metric as it means that even though a little more time is spent inputting information into a patient record, more time is available to provide the care that our patients need. Some of this may be due to the reduction of waste activities, but some of this may also be because nurses are spending more time in patient areas as they complete their documentation, whereas previously they may have gone to a nurse's station to do so.

It is interesting to note the Cheltenham and Gloucester differences in the findings. Overall, all domains increased or decreased in the same direction at both sites.

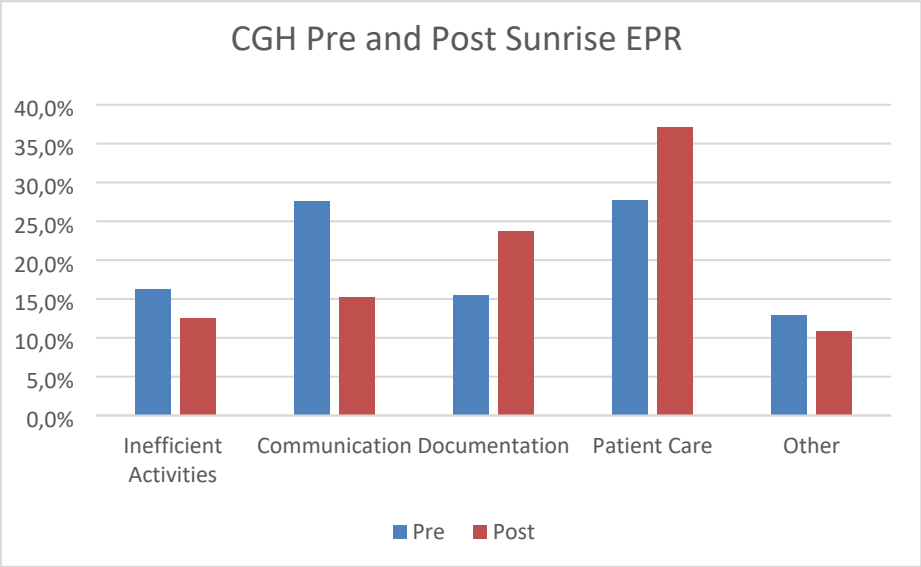
Domain	CGH	GRH
Inefficient Activities	↓ 3.7%	↓6.7%

Communication	↓12.3%	↓9.4%
Documentation	↑8.3%	↑3.8%
Patient Care	↑9.4%	↑18.9%
Other	↓ 2.0%	↓ 0.9%

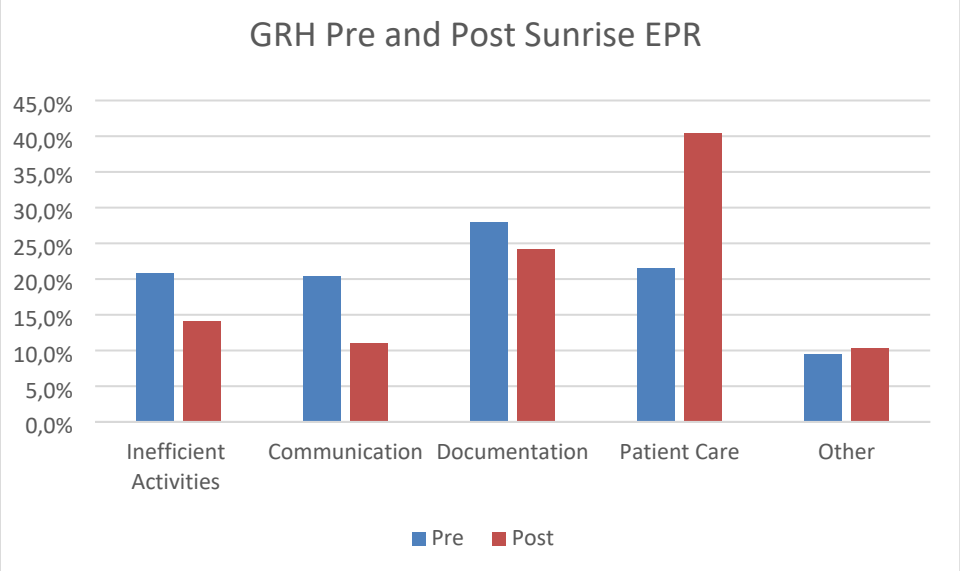
It is important to reference the slightly differing starting points at this stage as with Cheltenham starting with a patient care percentage of 27.7% (increasing to 37.2% post Sunrise EPR). Whereas Gloucestershire Royal Hospital started with a patient care percentage of 21.4% (increasing to 40.36% post Sunrise EPR).

For charts describing the GRH and CGH difference, please see overleaf.

Cheltenham Results



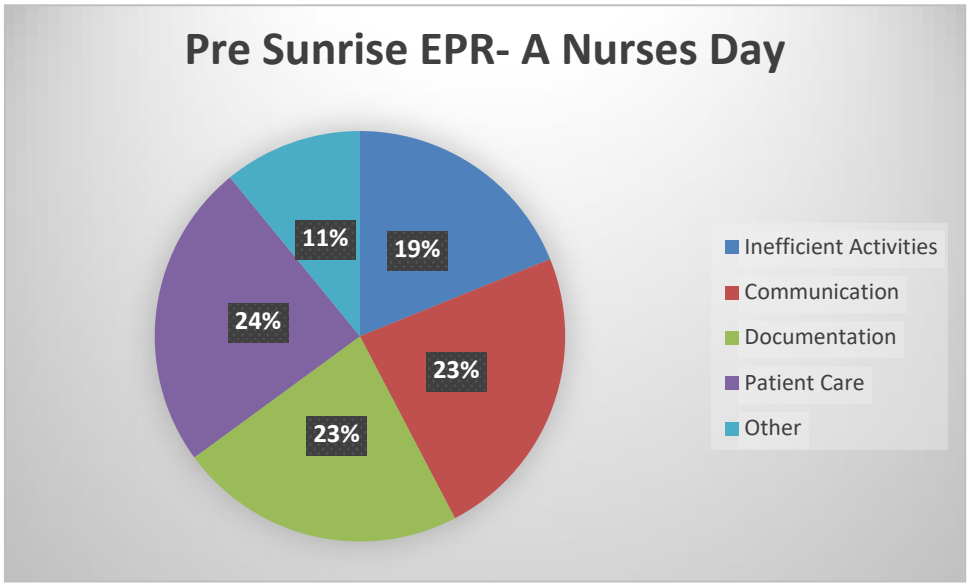
GRH Results

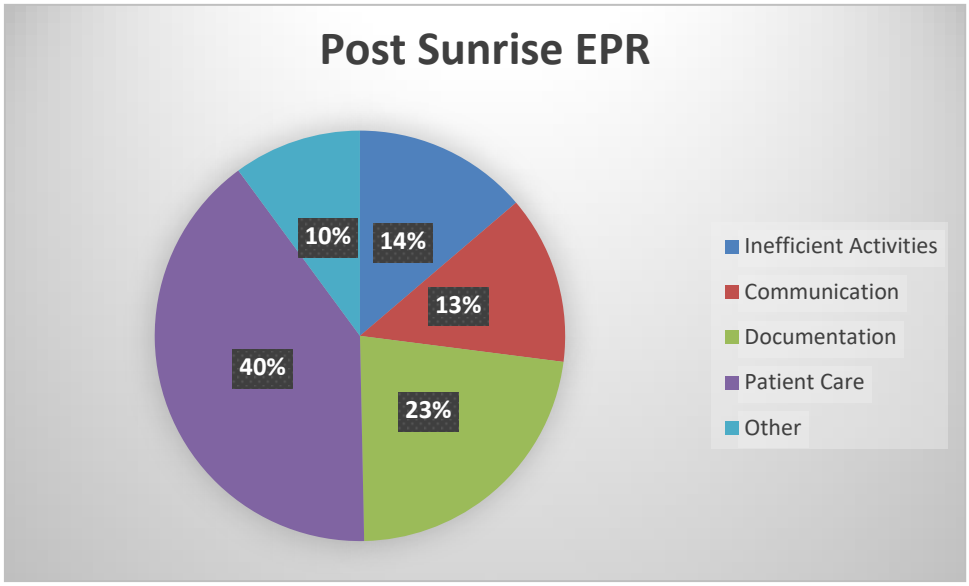


2.3 Conclusion

There is no doubt that our results have followed the same pattern as the Schenk study and that although time to document has increased, the overall time spent with patients providing care has increased. Increased documentation time is likely to be because of several factors. Whilst we are aware that it takes a bit more time to log into a computer and capture information, some colleagues have commented that they are documenting more now as they are prompted more often to capture certain information.

In term of the increase in time-spent patient caring, a cross-site increase of 16.1% is the difference between a nurse on an average 12-hour shift spending 174 minutes carrying out patient care (2.9 hours) and 289 minutes (4.8 minutes) post the implementation of Sunrise EPR. That is an increase of nearly 2 hours of patient care, per shift, that our nursing colleagues are now able to provide.





	Per Shift/ Day	Per Ward/Day	Per Ward/ Week	Per Ward/Month	Per Ward/Year	Trust (based on 42 wards)
Time	2 hours	8 hours	56 hours	224 hours	2,688 hours	112,896 hours
Potential Saving	£27.58	£110.32	772.24	£2088.96	£25,067	£1,052, 835

NB: Based on all wards currently using Sunrise EPR. Above based on staffing ratio assumptions (4 RNs per ward) and mid-range B5 AFC hourly rate. Also only takes into consideration day shift savings

Clearly, it is difficult to extrapolate 2 hours of a shift and turn them into a saving, however the above goes to illustrate the net result and potential impact that the first roll out of Sunrise EPR has had on the organisation.

2.4 Next Steps

A repeat exercise is planned for august/ September with a view of completing some repeat studies prior to any go live of Order comms. This will give us further insight into the impact of EPR now that E-Observations have been rolled out. This model of evaluation gives us an approach that we can continue to review at various stages of roll out.

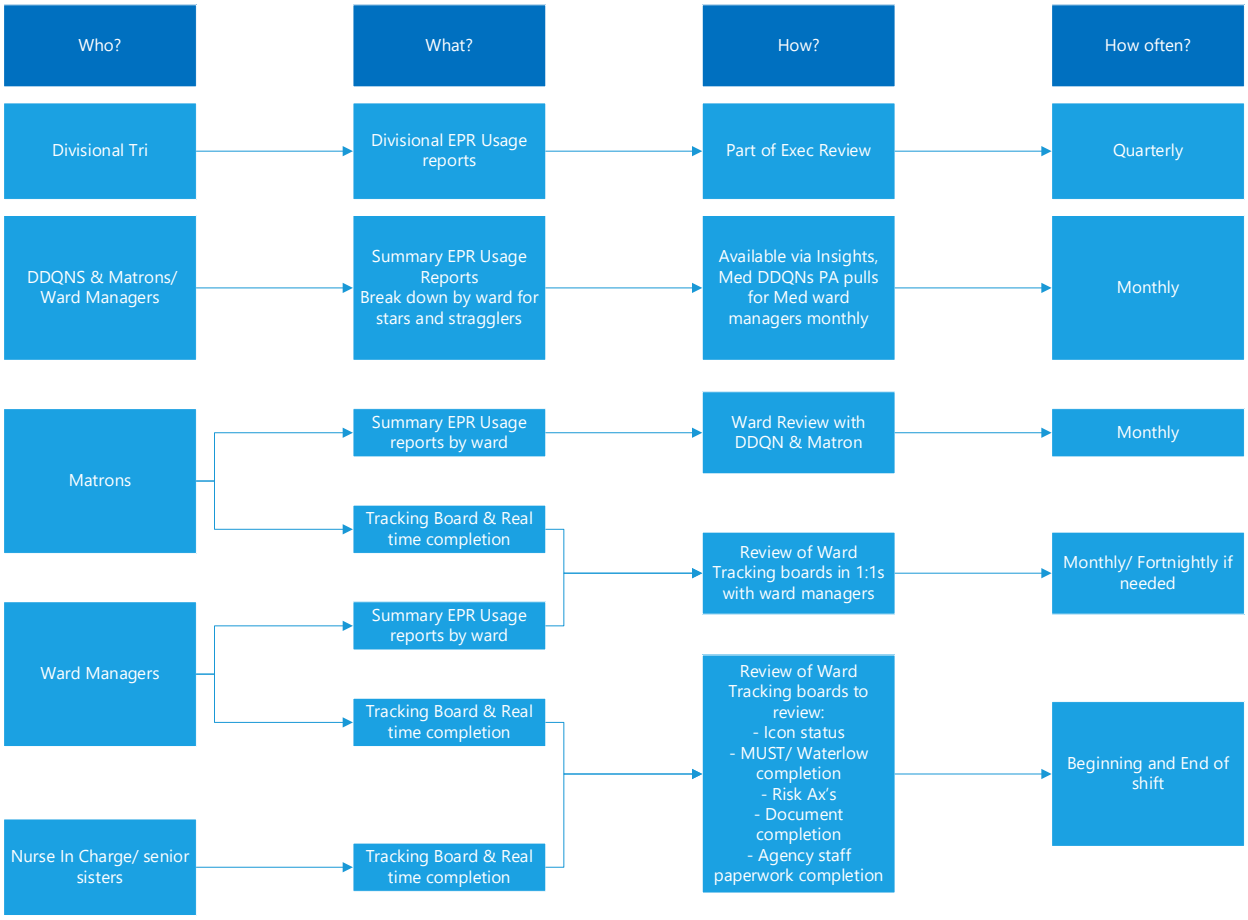
3. Improving Quality Using Sunrise EPR

Sunrise EPR gives us access to a multitude of information that can be used to ensure the consistent delivery of high quality care. GHFT's approach to improving quality can be split into two different methods.

a) **Real Time Ward Management** *Using Tracking boards* to intervene at the point of care, and ensure our patients are cared for appropriately and are staff are documenting appropriately. This real time intervention would have been hugely difficult on paper but Sunrise EPR allows ward managers and matrons to review tracking boards and to intervene.

b) **Retrospective Quality** reviews between DDQNs and matrons or Ward Managers Using Insight Reports. These allow senior leaders to review performance and support colleagues in driving up standards of care that need improving.

The below is a framework that we are suggesting would allow the optimal benefits to be extrapolated. So far, the medical DDQN has embedded EPR reviews in his monthly ward manager reviews and has assigned a member of staff to work alongside QI and Sunrise EPR. The aim is that this is mirrored across all directorates as appropriate.



3.1 Real Time Tracking Board Reviews

The real time opportunity to intervene in care is one of the biggest benefits to arise from the use of nursing documentation on Sunrise EPR. By introducing 2-3 twenty-minute reviews of Sunrise EPR within a shift, a ward manager has the opportunity to ensure:

- Documentation has been complete to an acceptable standard
- Risk assessments are in place and the subsequent care is in place
- Discharge planning information is accurate

The following approach has been devised and 1:1 meetings with ward managers had started just prior to the COVID outbreak. The ability to review tracking boards in this manner can be done remotely.

Our digital journey

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Daily Sunrise Checkpoints

	AM Review	PM Review	Early Eve Review
Review Time	8.30	13.00	18.00
Aim	Establish a sit rep of the current status of patients on the ward, their discharge potential, care they are receiving and quality of documentation		
Chat with Nurse in Charge	9.00	13.30	18.30
Aim	To provide nurse in charge with clear steer, deliver expectations, take into consideration any concerns/ reasoning, ensure documentation is high quality. Identify issues for escalation/ concern		

So far, 3 Medical ward managers and 2 matrons have reviewed the approach and feel that it is a hugely helpful way of understanding the level of care happening on wards. By covering a slightly different topic at each review point and using the information available on Sunrise EPR ward managers and matrons can be assured of the level of care being provided in their areas.

It is a request to the Digital Delivery Group that support for the roll out of this approach continue with appropriate ward managers and matrons spending time understanding how these reviews will provide assurance about care and subsequently drive up the quality of care demonstrated in the EPR Usage reports.

The crib sheet below is what has been used to guide these checkpoint reviews for either matrons or Ward Managers. There is some requirement to adapt them per ward area, but the principal and approach are the same. In time and with confidence the crib sheet is unlikely to be required.

	Make Note of	AM Review	PM Review	Early Eve Review
Tracking Board-	Side rooms free:			
	Beds Free:			
	Reason for admission needs amending:			
EDDS for today	Who does Sunrise say is going home:			
	Who does the N-I-C say is going home:			
D! present	Who hasn't got an EDD: Who has a D! and therefore needs an EDD inputting today:			
Obs due	Which patients are due obs based on frequency:			
Obs taken outside of freq	Which patients have had obs taken outside their frequency with no documentation as to why:			
Doc Icons outstanding	Which patients have an A! R! on the tracking board:			
MUST	Which patients don't have a MUST on the tracking board:			
	Which patients don't have a MUST in the last 7 days:			
Waterlow	Which patients don't have a MUST:			
Any other comments	E.g. concerns, staffing, equipment etc.			

3.2 EPR Usage and E-Observation Reports

Working very closely with the Divisional Diretors of Quality and Nursing we have continued to refine the EPR Usage charts and E-Observation reporting metrics that are available via Insights. They have been designed alongside ward managers, DDQNs and the CNIO to allow the reviewing and monitoring of EPR Usage in order to drive the consistency and reliability of care. The usage chart is split into three sections to demonstrate:

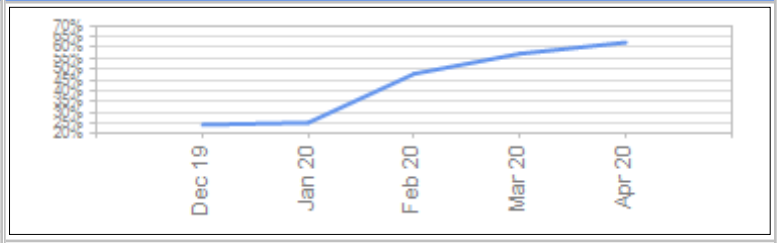
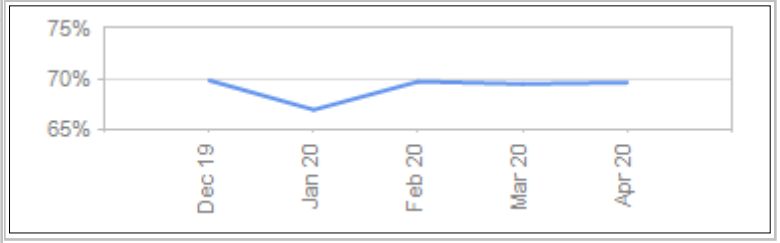
- Accountability of completing admission paperwork for those directly admitted
- Accountability of completing the right documentation for all patients on the ward
- Accountability of completing pertinent information in relation to Discharge planning
- Completion of Obs In line with the GHFT policy

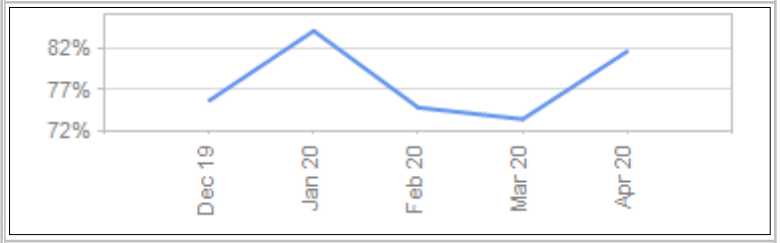
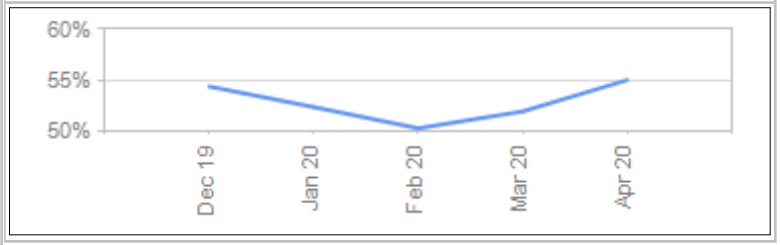
The reports are available via Insights at any point and can be accessed across the following levels; ward, directorate, site and whole trust.

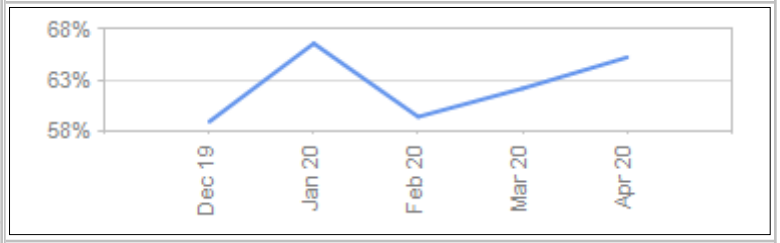
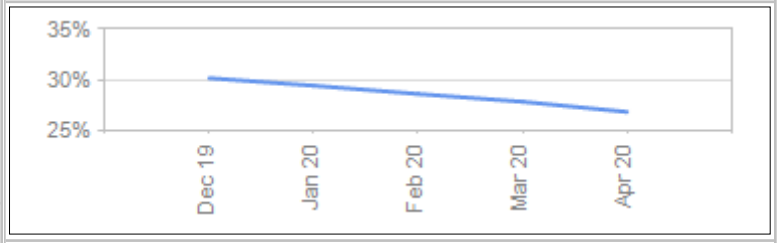
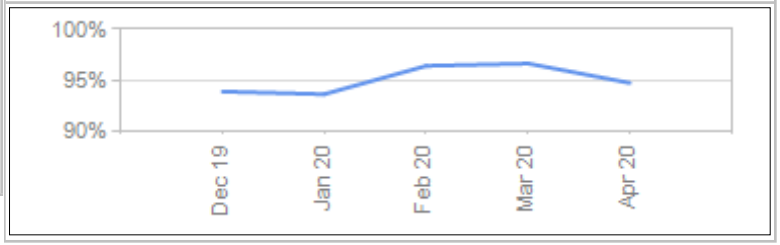
An example of the trust wide report for Sunrise EPR Usage can be seen overleaf. Understandably, during the last month some of our quality markers have decreased, most markedly in the discharge planning section. We now have the opportunity to embed the use of these reports to drive up quality of care.

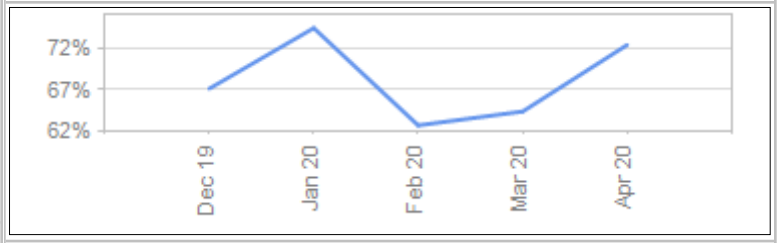
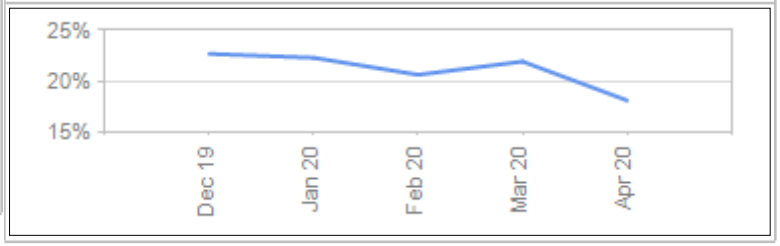
EPR Usage Metrics					
Division	Diagnostic & Specialist, Medical, Other, Surgical, Women & Children			**Site**	GRH, CGH
Ward	Multiple wards	**Date From**	01-03-2020	**Date To**	31-03-2020

Patients Directly Admitted to Your Ward
This section describes the quality of your wards admission documentation for patients who were directly admitted to your ward - within 24 hours of admission

Metric Name	Number complete	Total patients	Percentage complete	Description	Trend
Nursing Admission Document completed within 24 hours	2833	4962	57.1%	The number and percentage of patients who have had an admission document saved as complete within 24 hours	
The measures below then look at the quality of the data captured within those completed admission documents. We don't want to make it mandatory to complete all aspects before you can save as in some situations there must be a justifiable reason that all sections shouldn't be completed, e.g. someone gets taken to emergency theatre post admission. So the below measures will let you know which aspects are and aren't being completed consistently.					
Patient Property Question Completed	1971	2835	69.5%	Did your team ask if a patient understood the trust policy and document an answer	
MRSA Screening	2159	2837	76.1%	Was screening completed on	

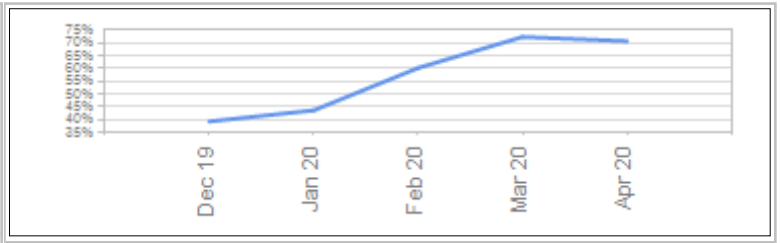
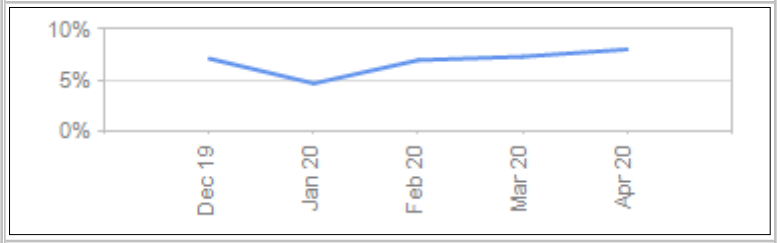
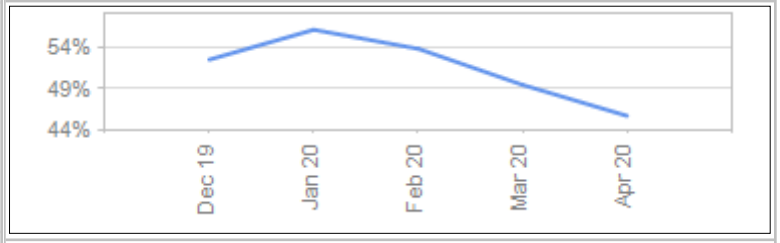
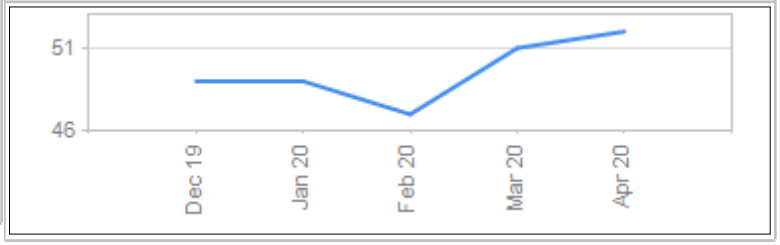
				admission	
CPE Screening	2083	2835	73.5%	Was screening completed on admission	
Alcohol Assessment (Audit C)	1447	2835	51.0%	Was an alcohol assessment and Audit C score calculated	
Smoking Screening	1622	2835	57.2%	Smoking status established and therapy/referral offered	
Delirium Screening	1471	2831	52.0%	Was it documented that either the patient was too unwell to screen, or has an answer to clinical diagnosis of delirium on admission, or has an answer to is the patient experiencing delirium or confusion	
Dementia	658	1087	60.5%	For patient aged 75+ was it	

Screening				documented that either the patient was too unwell to screen, or was an answer to has the patient got a clinical diagnosis of dementia	
Safeguarding Screening	1761	2831	62.2%	Were safeguarding questions considered and documented	
Pain Assessment	1830	2835	64.6%	Were all patients screened for pain on admission	
Risk Assesments Complete	789	2831	27.9%	Were all Risk assessments completed	
MUST	2742	2837	96.7%	MUST completed	

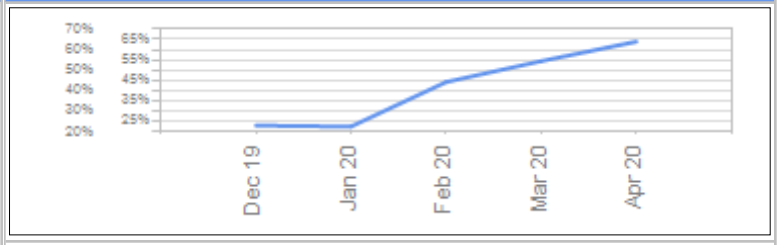
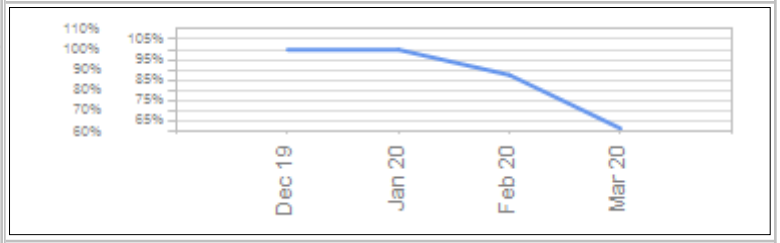
Waterlow	2398	2837	84.5%	Waterlow completed	
Manual Handling	1827	2837	64.4%	Manual Handling needs assessed	
Falls Assessment Age 65+	361	1645	21.9%	Has the patient been suitably screened for a falls risk, this includes lying and standing bp and the falls questions	

Providing Appropriate Levels of Care
This section describes the quality of your wards documentation to all patients and those identified as needing extra

Metric Name	Number completed	Number expected	Metric value	Description	Trend
Inpatients who had at least 1 Assessment and Cares Flowsheet time column entered every 12	3614	5000	72.3%	Patients should have a record of the care they received documented at least once a shift by the nurse caring for them	

hours of their visit					
Patients that have had a SSKIN bundle document created within 8 hours of a Waterlow of =10 being documented	355	5884	6.0%	Any patient that has a waterlow of greater than 10 should have a SSKIN bundle. This is the measure of how many did	
Intentional Rounding when a patient is not Independent	22459	44488	50.5%	If a patient has been documented as NOT independent, they should subsequently have intentional rounding carried out. This looks at the occurrence of this	
Average time Average time between recording that a patient isn't independent and intentional rounding			49 minutes	If a patient has been documented as NOT independent, they should subsequently have intentional rounding carried out. This looks at the timeliness of this	

Discharge Planning and Helping Patient Flow
This section looks at the measures put in place to monitor how proactively your ward are reviewing discharge needs for patients

Metric Name	Number completed	Total expected	Percentage complete	Description	Trend
Number of inpatients who had a Discharge Planning Flowsheet entered within 24 hours of their admission date & time	2699	4960	54.4%	This measure shows how many of your patients had their discharge date and needs considered within 24 hours of being admitted to your ward (this will only look at patients directly admitted to your ward)	
Number of inpatients who had at least 1 Discharge Planning Flowsheet time column entered every calendar day of their visit	2055	3177	64.7%	This looks at whether your patients had their EDD and discharge plans updated on a daily basis. Even if they haven't changed we should be updating to say that there is no change	
% of Patients who had at least 1 discharge planning flowsheet completed before 11am	1874	2055	91.2%	Of patients who had at least 1 discharge planning flowsheet time column entered every calendar day of their visit, the number who had at least one flowsheet completed before 11am	
Discharge Checklist	727	5101	14.3%	No of patients that had a discharge checklist completed prior to discharge	

COVID-19: Phase Two Planning - Temporary Service Changes

1. Introduction

In response to the next phase of the COVID-19 pandemic, the Board of Gloucestershire Hospitals NHS Foundation Trust has approved a number of temporary service changes aimed at separating as much as possible services caring for COVID and non-COVID patients. These changes will:

- limit the risk of transmission of the virus to patients and staff during the next phase of the pandemic,
- enable clinicians to restore many of the services paused in response to phase 1 so that the amount of cancer surgery, planned care and specialist diagnostic activity is increased, especially to those patients who are most vulnerable,
- give confidence to our local population that both our hospitals are safe places to receive acute care.

These service changes are being implemented as emergency (temporary) changes in line with the Memorandum of Understanding (MOU) agreed with Gloucestershire Health Overview and Scrutiny Committee (HOSC). The changes will be enacted on a three monthly basis, at which point the ongoing necessity will be reviewed, again in line with the requirements of the MOU.

2. Purpose

The purpose of this document is to make you aware of the temporary service changes approved by the Trust's Board for implementation on 9th June 2020.

3. Principles

The service changes are designed around the following key principles:

- To build on the success of our phase 1 response by continuing to separate COVID and non-COVID pathways by site and by pathway to reduce risk of COVID transmission to and between patients and staff.
- To use our two hospital sites to achieve this by making Cheltenham General Hospital (CGH) the focus for elective operating, cancer care & non-COVID diagnostic imaging and Gloucestershire Royal Hospital (GRH) as the 'front door' for acute emergency medical and surgical pathways.
- To centralise our key points of entry including the Emergency Department (ED), also known as A&E, acute medical take and emergency general surgery so we can better control flow in to our hospitals and separate four key pathways: COVID positive, suspected COVID, possible COVID and non-COVID patients.
- To designate Cheltenham Intensive Care Unit (ICU) as a non-COVID unit - this is a key dependency for increasing cancer and planned care operating in this second phase.

- To design a model of care to accommodate both a continuation of the current level of COVID-positive patients as well as a possible second surge.

4. Temporary service changes

The following service changes have been approved for implementation to form part of our response to the next phase of COVID-19:

- All 999 and undifferentiated GP referrals will be centralised at GRH. This would include centralising the Acute Medical Take to GRH.
- CGH Emergency Department (ED) facility will become a Minor Injury and Illness Unit (MIIU), open 7-days a week, 8am to 8pm.
- CGH MIIU will be supported by a Consultant led Ambulatory Emergency Care (AEC), service open Monday to Friday, 8am to 6pm, to see differentiated GP referrals and patients previously discharged.
- The Acute Stroke Unit (ASU) will move to CGH. The Hyper Acute Stroke Unit (HASU) will remain at GRH, and Stroke Rehab at The Vale Community Hospital.
- The Intensive Care Unit (ICU) at CGH will be designated as a non-COVID unit.
- A greater proportion of non-COVID-19 Cardiac patients will transfer to the Cardiac Care Unit (CCU) at CGH.
- Continued use of Private Sector capacity (Winfield and Nuffield) for non COVID planned care (subject to national agreement beyond June).
- Benign Gynaecology day case activity will move to CGH.
- Urology 999 front door pathway will move to GRH, planned pathways will remain at CGH supported by a Urology Assessment Unit (UAU).
- Vascular emergency and elective inpatient pathways will move to GRH, the daycase venous service will remain at CGH.
- Radiology services at CGH will focus on outpatient care for our vulnerable patients and support a largely non-Covid bed base and Ambulatory Emergency Care.

These temporary service changes will be managed and communicated separately to the Gloucestershire *Fit for the Future* programme which remains paused at this time. None of these changes should be considered pre-emptive of any future substantial service change which will remain subject to public consultation.

5. Benefits of changes

The service changes will enable the following benefits to be delivered:

- Utilise our estate in way that minimises infection risk to patients and staff and promotes public confidence in safety of both hospitals.

- Provide non-COVID (Green) imaging and critical care at CGH which is crucial to recovering cancer and elective care operating and recommencing of diagnostic investigations of “vulnerable” patients.
- Deploys workforce in a way that supports their resilience and wellbeing.
- Restores beds currently closed at Cheltenham General as part of our phase 1 response, supporting flow.
- Potential to increase theatre and imaging productivity at Cheltenham (as a Green site), through change to Infection Prevention & Control (IPC) requirements.
- Enable rapid COVID diagnostics through Point Of Care Testing at GRH emergency front door.
- Supports asymptomatic staff testing of Cheltenham workforce on cyclical basis to further reduce transmission risk.

Next Steps

The service changes will go-live on Tuesday 9 June 2020. To help patients better understand these changes a public information campaign has been launched. This will focus on emergency care access throughout the county given the change to the service at CGH.

The changes will be enacted on a three monthly basis, at which point the ongoing necessity would be reviewed, in line with the requirements of the MOU.

END

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS' – JUNE 2020
Microsoft Teams Commencing at 14:30

Report Title
Governors' Log Report
Sponsor and Author(s)
Author: Natashia Judge, Corporate Governance Manager Sponsor: Sim Foreman, Trust Secretary
Executive Summary

Purpose
To update the Council of Governors on the themes raised via the Governors' Log since the last full Council of Governors meeting on 18 December 2019.

Key issues to note
The Governor's Log is now available to view within the Governor Resource Centre on Admin Control.

Submissions related to a number of themes have raised throughout the year so far:

- ED attendances caused by lack of GP availability
- Publicity on positive achievements
- Withdrawing service to abusive patients
- Phlebotomy waiting times and temperatures
- Shifting the mindset around complaints
- Radiographer training
- Treatment of patients who self harm
- COVID-19 Legal Challenges
- Psychological services with paediatric inpatients
- Serious Case Reviews related to Gloucestershire Children's Services
- LEG Podcast
- COVID-19 and Temporary Service Reconfiguration
- Oncology Services

All questions received have been actioned and closed.

Conclusion
Despite COVID-19: the Governors' Log continues to be a well-used and helpful mechanism.

Recommendations
That the Council receive the report for information.
Impact Upon Strategic Objectives
The Governors' Log supports the Involved People strategic objective.
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
N/A

Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	**X**

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals
NHS Foundation Trust

REF	01/20	STATUS	Closed		
SUBMITTED	09/01/20	DEADLINE	23/01/20	RESPONDED	12/01/20
GOVERNOR	Maggie Powell				
LEAD	Rachael De Caux				
THEME	ED attendances caused by lack of GP availability				

QUESTION

It is often said that people attend the Emergency Department because they are unable to get a timely appointment with their GP. Is any record kept of people attending the ED because they are not registered with a GP? Anecdotal evidence from Healthwatch suggests this is an issue with students.

ANSWER

Monday to Friday between 0800-1700 there are very few inappropriate attendances that could have been better managed in primary care. We are fortunate to have excellent access to GP appointments in the Gloucestershire ICS and a priority for the System has been to invest in additional primary care capacity Out of Hours. This capacity can however become saturated in the Gloucester City area. A key reason is the socio-economic diversity that exists in Gloucester City and there is a patient cohort with chaotic lives who prefer to attend an ED then book a routine GP appointment.

There are particular issues in attendances out of hours and over the weekend. However, these are often individuals who have appropriately contacted 111 and have been redirected to the ED or have been appropriately triaged to a GP appointment but do not want to (appropriately wait) for that appointment and so attend ED. This can be because it is more convenient due to work or family commitments.

Very few unregistered patients attend ED as a proportion of total attendances. We do not record if a patient is a student but for this purpose we have used 18-22 year olds as a proxy for students.

- Last year 3,098 patients attended ED who were not registered with a practice (excluding overseas visitors)
- So far this year we have had 1,937 (Apr-Dec) and are forecast to have 2,582 by financial year end.
- The % of these who are 18 to 22 (proxy for students) was 8.5% in 2018/19 and is 10.9% in 2019/20 so it is rising.
- The unregistered patients presenting to our EDs are mainly not students.
- However the ratio of unregistered patients who are 18-22 has been higher than that of the total attendances since December 18.
  The Breaking the Cycle event reviewed 103 ED attendances on Monday 11th November from 1pm until approx. 9.30pm.

A number of patients attended with an expectation that their GP was not appropriate but did not seem to have tried to make an appointment. 3 patients told the researcher that they had tried their GP but no appointment was available. Our CCG colleagues were acting on all the data and providing feedback to primary care in real time.

Examples of when we have tried to engage with the public include:

- Presentation at the Annual Members Meeting
- Public engagement relating to the Centres of Excellence
- A&E Live event including 3+radio interviews, 1 TV interview, multiple tweets etc
- Ambulatory care public messaging with explanation of the service and patient/relative leaflet

Gloucestershire Hospitals
NHS Foundation Trust

REF	02/20	STATUS	Closed		
SUBMITTED	09/01/20	DEADLINE	23/01/20	RESPONDED	12/01/20
GOVERNOR	Maggie Powell				
LEAD	Simon Lanceley				
THEME	Publicity on positive achievements				

QUESTION

On 31st December 2019, the "I" newspaper reprinted a feature from the Financial Times about Yeovil District Hospital. This was a readable and positive account of the developments improving efficiency and quality in a previously "requiring improvement" hospital. Much of what was described seemed familiar: introducing an ambulatory emergency care unit, acting on suggestions from frontline staff, regular meetings to manage flow etc. Given that the public debate on "Cheltenham A & E" seems rooted in a rather dated perception of what actually happens, has any thought been given to ways of improving public understanding of the positive achievements that have been made, presenting actual examples in a way easily understood by the general public.

ANSWER

The NHS in Gloucestershire has worked in close partnership this winter to:

- Raise awareness of winter preparations (winter plan)
- A&E avoidance
- Fit for the Future (future provision of urgent and specialist hospital services including acute and emergency care)

Winter plan: Local media and press stakeholders were invited to a media briefing attended by Gloucestershire CCG, Gloucestershire Health and Care NHS FT, Gloucestershire Hospitals NHS FT and Gloucestershire County Council (public health and social care) in November 2019 when Executive leads presented/talked through this year's plans for the winter period. This was followed by by live interviews in the BBC's radio studio on London Road, Gloucester. Patient case studies featured heavily as a means of demonstrating how the plans would impact on patients, their carers and families.

A&E avoidance: A significant public campaign titled Stop! Think...was launched in December and will run throughout the winter months. The campaign features strong images of a child injured and in need of life saving treatment. As well as being visually evocative the campaign messaging urges the public keep A&E clear for real emergencies. The campaign has been integrated through both traditional and digital methods including radio (Beacon FM), print (The Local Answer), delivered to households in county as well as digital (FaceBook and Glos Live digital).

Running parallel to this programme was a day of live social media from GHNHSFT's A&E departments on Monday 6 January 2020. This featured the wide range of staff who ensure A&E and more broadly our hospitals continue to provide care in times of immense pressure.

Fit for the Future: As well as a supporting public engagement document outlining ideas on how the future provision of urgent and specialist hospital services could be provided, a website (micro site) was also established which features a number of case studies including acute and emergency care. This has been underpinned by a comprehensive programme of engagement fronted by clinical leaders and using patient case studies to help illustrate thinking and possibilities. Opportunities to inform/brief media partners continue throughout the programme.

However, we are aware that more can be done to help improve broader understanding of the case for change - particularly in response to strong opposition. System partners continue to review messaging and approaches and response to strategic priorities. In that spirit I'd like to thank you for sharing this article. The Communications Team are reviewing the article with the view of making contact with Yeovil District Hospital and adopt any approaches which would support us in achieving our goals.

REF	03/20	**STATUS**	Closed		
SUBMITTED	21/02/20	**DEADLINE**	06/03/20	**RESPONDED**	25/02/20
GOVERNOR	Nigel Johnson				
LEAD	Steve Hams				
THEME	Withdrawing service to abusive patients				

QUESTION

Following on from recent media articles. The NHS will refuse to treat patients who are sexist and racist, as new figures show rising levels of abuse Any patient inflicting discriminatory or harassing behaviour on staff could be barred from receiving care – unless the case is an emergency. From April, any patient or hospital visitor found to be inflicting discriminatory or harassing behaviour on staff could be barred from receiving care, unless the case is an emergency. Previously, patients could only be refused help if they were aggressive or violent.

Whilst I fully support this I have a couple of questions:

1. How does this apply to an elderly person in the early stages of dementia, who perhaps uses language that is now deemed inappropriate. Would that person be refused treatment?
2. How will this be enforced by the Trust? (is there a criteria that the Trust have to follow)

ANSWER

The NHS has made provision in its 2020/21 NHS Standard Contract (Service Conditions) [Number 7] Withholding and/or Discontinuation of Service.

The provision for withholding or discontinuing a service has always been part of the NHS Standard Contract, however this year the contract has been updated, specifically point 7.2.3 has been added and is detailed below:

who displays abusive, violent or threatening behaviour unacceptable to the Provider, or behaviour which the Provider determines constitutes discrimination or harassment towards any Staff or other Service User (within the meaning of the Equality Act 2010) (the Provider in each case acting reasonably and taking into account the mental health of that Service User);

https://www.england.nhs.uk/wp-content/uploads/2019/12/3-full-length-service-conditions-20-21.pdf (page 12 onwards)

The Service Conditions go on to explain a range of actions that must be taken by the provider.

In relation to the specific points:

1. The Service Conditions at 7.2.3 asks the provider to take into consideration the mental health/mental capacity (and cognitive function) of the individual, in relation an elderly lady in the early stages of dementia, a detailed assessment would be undertaken to ensure that all care needs could be met by a wide range of providers. The patient would meet the ‘mental health’ criteria and as such would not have a discontinuation of service.
2. We are currently awaiting national guidance, but will be focused on ensuring patients have a timely mental capacity assessment, staff have support to raise concerns, we have been considering schemes from other organisations, North Bristol NHS Trust have introduced a Red Card Scheme https://www.nbt.nhs.uk/news-media/latest-news/north-bristol-hands-red-card-racism which is gaining momentum throughout the NHS.

REF	04/20	**STATUS**	Closed		
SUBMITTED	28/02/20	**DEADLINE**	13/03/20	**RESPONDED**	10/03/20
GOVERNOR	Alan Thomas				
LEAD	Deborah Lee				
THEME	Phlebotomy waiting times and temperatures				

QUESTION

What is the Trust doing to address waiting times and fluctuating temperatures within West Block Outpatients?

ANSWER

Excess demand, overcrowding and long waiting times has been an escalating issue in phlebotomy services on both hospital sites and reflects the increased demands placed on the service and limited physical capacity to expand.

To this end, following a protracted negotiation with commissioners and the GP Local Negotiating Committee (LNC), significant change is now agreed. From July 2020, all requests from primary care and community services for blood tests will be provided in community setting such as GP practices and community hospitals. This not only has the benefit of reducing demand on hospital phlebotomy but will provide services closer to people's home. In addition, a third phlebotomy room has now been established (2nd March) in West Outpatients at CGH to provide immediate improvement to waiting times.

This practice already exists in around 50% of the County but due to inherited arrangements, practices of some of the former Primary Care Trust including that covering Cheltenham were not funded for this service and used the hospital.

A pilot of offering appointment times has not been rolled out pending evaluation of the impact of moving large volumes of work back to primary care and community service locations due to cost and complexities with the appointment system.

REF	05/20	**STATUS**	Closed		
SUBMITTED	01/03/20	**DEADLINE**	16/03/20	**RESPONDED**	
GOVERNOR	Alan Thomas				
LEAD	Steve Hams				
THEME	Shifting the mindset around complaints				

QUESTION

In the light of the recent Healthwatch England Report on Complaints (https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20191126%20-%20Shifting%20the%20mindset%20-%20NHS%20complaints%20.pdf) - 'Shifting the Mindset - A Closer Look at Hospital Complaints' - what engagement has the Trust, both internally and with the wider Gloucestershire Health and Care System, to ensure that this report has some local effect?

ANSWER

The report has been reviewed internally and a gap analysis will be presented to the new QDG by the Safety Team in May 2020 (Covid-19 dependant). Once this has been received we will take to the system quality group once set up.

REF	06/20	**STATUS**	Closed		
SUBMITTED	04/03/20	**DEADLINE**	18/03/20	**RESPONDED**	20/03/20
GOVERNOR	Anne Davies				
LEAD	Deborah Lee				
THEME	Radiographer training				
QUESTION					
I was approached recently by a constituent, concerned about safety, who had been informed that radiology staff, trained in a practical session on the use of twelve different beds, were given no supportive material that they could refer back to subsequently. Is this indeed the case and if it is what follow on assistance is given to trainee radiographers?					
ANSWER					
All clinical staff, including trainee radiographers, attend manual handling training and the attached information is provided to them as well as access to on-line resources. They are trained on one bed and one chair only.					

REF	07/20	**STATUS**	Closed		
SUBMITTED	14/03/20	**DEADLINE**	27/03/20	**RESPONDED**	20/03/20
GOVERNOR	Alan Thomas				
LEAD	Deborah Lee				
THEME	Treatment of patients who self harm				

QUESTION

Recent comments by the Royal College of Psychiatrists suggest that 'poor treatment and aftercare for people who self-harm or attempt suicide is putting their lives at risk. Many patients treated in A&E for self-harm do not receive a full psychosocial assessment from a mental health professional to assess suicide risk. Experts are now calling for all self-harm patients to be offered a safety plan - an agreed set of bespoke activities and guidelines to help them deal with depressive episodes'.

Notwithstanding everything else that is going on in the Trust, self-harm remains a big issue. What assurance can be given to patients about their care in these circumstances?

ANSWER

All patients with deliberate self harm are assessed for risk using a comprehensive pro forma. The assessment is initially undertaken by doctors or nurses who are trained in using the assessment tool. Low risk patients can be discharged to community services whether that be GP or mental health services or self-help. Patients with moderate to high risk are assessed by a mental health worker prior to discharge.

Patients with DSH are a disparate group and a one size fits all approach does not work. Some patients are well known to services and may come in with their mental health worker. All frequent attenders have plans in place, Gloucestershire's frequent attended service is well developed. It is extremely rare that a patient needs to be admitted for mental health reasons. It is also extremely rare to see patients presenting with any of the major mental health illnesses.

We don't offer therapy and only very rarely provide medication to patients with DSH in the ED. The role of the ED and mental health workers is to risk assess and signpost to community services.

REF	08/20	**STATUS**	Closed		
SUBMITTED	23/04/20	**DEADLINE**	07/05/20	**RESPONDED**	05/05/20
GOVERNOR	Alan Thomas				
LEAD	Deborah Lee				
THEME	COVID-19 Legal Challenges				

QUESTION

Given the report in the HSJ recently - https://www.hsj.co.uk/coronavirus/nhs-told-to-expect-huge-number-of-legal-challenges-after-pandemic/7027448.article - about future legal challenges, is the Trust in a good place, (governance) audit-wise, to meet potential challenges?

ANSWER

The Trust has carefully considered its position with respect to future liabilities arising from the COVID-19 pandemic. It is also worthy of note, that the forecasts regarding future legal activity are being promoted by claimant solicitors with an interest in current healthcare matters.

With respect to audit requirements, the Trust has taken specific advice on whether any provisions should be made as part of the 2019/20 accounts for liabilities arising from COVID-19 and have been advised this is not warranted or justified, both by the Trust's External Auditors and the Regional NHSI Team.

The Trust has taken specific advice with respect to its Health & Safety Executive obligations and the occasions on when a RIDDOR reportable event should be considered. Guidance is clear and to date has not been triggered. This advice centres on the fact that the threshold for confirming that a patient or member of staff has contracted COVID-19 through virtue of their employment is set at a high burden of proof and must be "reliably attributable to their work and verified by a registered medical practitioner's statement".

The Chief Coroner has also issued guidance which makes it clear that an inquest is not the right forum for addressing concerns about government or public policy which could be a precursor to a legal indemnity claim.

Finally, the article refers to claims arising from a "breach of human rights". Legal considerations of human rights issues are an established part of the inquest process and that is not new, nor is it COVID-19 related. In addition, the Trust has not veered from its usual good practice of ensuring that all care is compliant with statutory requirements set out under the Mental Capacity Act, including the Deprivation of Liberty Standards and there is no current evidence to suggest that increased liabilities will flow from the pandemic.

REF	09/20	**STATUS**	Closed		
SUBMITTED	14/05/20	**DEADLINE**	29/05/20	**RESPONDED**	29/05/20
GOVERNOR	Alan Thomas				
LEAD	Deborah Lee/ Mark Pietroni				
THEME	Psychological services with paediatric inpatients				

QUESTION

I had asked a question about psychological services within paediatric in-patients (or rather the lack of them). The answer provided suggested that there were plans in place to re-instate services, but I am more concerned about why they were withdrawn in the first place, and where they went. And is this issue one that solely applies to paediatrics?

ANSWER

We do have Psychology support for Paediatric inpatients with complex and chronic conditions which is provided by CAMHS. This individual (employed by GHC) was redeployed during the initial COVID response by GHC but it now back working with our Paediatric inpatients at 50% capacity. She was required to fully discharge all Paediatric patients on her caseload at beginning of COVID19 but new patients admitted were not able to access the usual level of support however, this was not raised as an issue by the service at any point during the pandemic.

During the COVID response we have been able to get CAMHS assessment of acute problems e.g. self-harm via the Mental Health Liaison Team. However routine referrals to CAMHS have been stopped by GHC.

REF	10/20	**STATUS**	Closed		
SUBMITTED	14/05/20	**DEADLINE**	29/05/20	**RESPONDED**	
GOVERNOR	Alan Thomas				
LEAD	Deborah Lee/ Steve Hams				
THEME	Serious Case Reviews related to Gloucestershire Children's Services				

QUESTION

The media gave space the other day to describe criticisms of Gloucestershire Children's Services after the publication of two serious case reviews revealed some shocking lapses in care. GHT were mentioned as having given 'evidence' to the reviews. What has the Trust learnt from these cases about the care of vulnerable children that may present within the Trust?

ANSWER

The Trust is always called upon to provide details of our contacts with any person subject to a statutory review in Gloucestershire and other parties of interest to the review panel. We are usually also required to provide a review of our care and contacts with the persons of interest to the review, which is then presented alongside similar evidence from other agencies to provide a fuller picture of what was happening in the life of the subject, prior to the serious incident or their death, than any one agency would have.

The Trust has worked collaboratively through the Safeguarding Children Strategic Health group with our multi-agency partners and the key learning points from previous reviews have been:

- Hearing the child's voice
- Process for medical assessments
- Safeguarding supervision for staff to embed learning and support frontline staff
- Single agency training

The two latest reviews have not raised any new learning for the Trust, but have reinforced the importance of some of the decisions we have made already, following previous reviews.
In particular –

1) Our view that senior medical opinion is needed at risk assessment/strategy meetings about children of concern to enhance best decision making.
This will require additional resource to facilitate additional child protection work amongst consultant paediatricians and is currently a project in process with CCG designated professionals requiring resource allocation from Children's commissioning
2) Our view that there needs to be an agreed integrated multiagency /multiprofessional team for assessment, medical investigation and support of children where allegations of sexual abuse are the concern.
This is a current piece of work between agencies coordinated by the Designated Doctor and CCG.
3)The importance of our staff understanding legal orders and Special Guardianship.
This was the focus of Women's and Children's divisional level 3 Safeguarding Children training in 2019 and is a level 3 topic within the new Safeguarding Children training menu.
4) That terminology around 'Did not Attend' (DNA) for clinic appointments has to be changed to 'Was not brought' as no child chooses not to attend an appointment – their responsible adult makes the choice not to bring them.
Trust policy has highlighted this for several years and clinic letters to GPs when a child was not brought to a clinic appointment asked the GP to consider whether not being brought to the appointment constituted a safeguarding concern. Since the end of 2019 all outpatient letters to GPs have reflected this wording, following a recommendation from a Serious Adult Review.
5) Professional curiosity has been stressed in many previous reviews and has been built into safeguarding training for more than 3 years; respectful challenge is encouraged through training

and supervision practice
Whilst never a pleasant topic to contemplate, sexual abuse is included in all Trust safeguarding training, with more detail around children being included in a specific training session available to registered healthcare professionals working with children.

REF	11/20	**STATUS**	Closed		
SUBMITTED	14/05/20	**DEADLINE**	29/05/20	**RESPONDED**	29/05/20
GOVERNOR	Alan Thomas				
LEAD	Deborah Lee/ Simon Lanceley				
THEME	LEG Podcast				

QUESTION

I listened to an excellent podcast discussion about COVID issues by members of the LEG. It did, indeed, cover a lot of ground. I felt, though, that an opportunity was missed in that the discussion was one between 'professionals' and did not include any lay contribution, ie from the point of view of a 'user' of the services being described. The podcast is on the Content Management System. Is this available to the public?

ANSWER

The podcast has been shared widely internally and has been adopted as a learning resource, for example Post Graduate Medical Education (PGME) team are inviting students and trainees to listen and discuss with their supervisors. The contributors are keen to do a follow-up podcast to reflect on the second phase of COVID and this could be a good opportunity to include lay contribution. We decided not to make this available publically as it was designed for staff working daily in a COVID environment and uses language that taken out of context could cause unnecessary concern, but if we include a lay representative in the follow-up podcast this could be designed for internal and external distribution.

REF	12/20	**STATUS**	Closed		
SUBMITTED	28/05/20	**DEADLINE**	10/06/20	**RESPONDED**	01/06/20
GOVERNOR	Nigel Johnson				
LEAD	Steve Hams/Simon Lanceley				
THEME	COVID-19 and Temporary Service Reconfiguration				
QUESTION					
Is there a cost attached to the Extended use of the Private Sector (Winfield and Nuffield) for non COVID planned care? Are there contractual arrangements already in place? Who is meeting the costs? Will the Staffing be for this continue to be provided by the Winfield and Nuffield?					
ANSWER					
Yes – but this is covered through national contracts NHSE agree Yes, but we also provided medical cover					

REF	13/20	**STATUS**	Closed		
SUBMITTED	28/05/20	**DEADLINE**	10/06/20	**RESPONDED**	01/06/20
GOVERNOR	Nigel Johnson				
LEAD	Steve Hams/Simon Lanceley				
THEME	COVID-19 and Temporary Service Reconfiguration				
QUESTION					
Can you explain what is meant by supporting asymptomatic staff testing of Cheltenham workforce on cyclical basis to further reduce transmission risk. Does cyclical mean testing staff every week in this case or every day?					
ANSWER					
Frequency to be confirmed, but essentially we would continually test staff to ensure CGH can continue to support non-COVID pathways and maintain cancer and elective operating.					

REF	14/20	**STATUS**	Closed		
SUBMITTED	28/05/20	**DEADLINE**	10/06/20	**RESPONDED**	01/06/20
GOVERNOR	Nigel Johnson				
LEAD	Steve Hams/Simon Lanceley				
THEME	COVID-19 and Temporary Service Reconfiguration				
QUESTION					
Under Option 2 overnight staff could be moving across sites to help close rota gaps. To reduce the potential risk of transmission- I assume staff would stay within their green and red zones? Could you clarify?					
ANSWER					
Where possible we have ensured that staff remain within either a 'red' or 'green' clinical area – the correct use of PPE and an awareness of symptoms mitigates a large proportion of the 'potential' risk of staff mixing between red and green areas.					

REF	15/20	**STATUS**	Closed		
SUBMITTED	23/05/20	**DEADLINE**	05/06/20	**RESPONDED**	01/06/20
GOVERNOR	Maggie Powell				
LEAD	Charles Candish				
THEME	Oncology Services				

QUESTION

Healthwatch Gloucestershire has been hearing from users of oncology services. Whilst they understand the need in recent weeks to delay and postpone treatment, they have expressed concern that they have not been able to have the discussions they would have had wished about the impact of such delays on future treatment and on prognosis. I appreciate that services are returning (and especially note the re-opening of the FOCUS Support Centre) but wonder whether there are lessons to be learnt here – especially if non-COVID services are closed down again in the future.

ANSWER

Dealing with cancer treatments during this ongoing COVID pandemic has been incredibly hard for our patients, and we understand this.

The clinical staff have been balancing the risks and benefits of each individual treatment, with the risks of potential COVID infection itself. Whilst the clinical teams have been working from national guidance from NHSE and NICE we have strived to individualise each patient's treatment plan to maximise benefit and minimise harm.

Each patient has been contacted to discuss any delayed treatments and the reasoning behind this – at every turn this has been with the patient's best interests at heart. Please be reassured that due to the diminishing prevalence of COVID, we are now advising patients to resume the majority of SACT and RT treatments under our guidance, again with the appropriate discussion and support. These discussions maybe by phone/video or face to face where needed. In addition, our FOCUS support centre has now re opened and cancer CNS's are available to support patients as needed.

The Oncology team would value, and indeed encourage, specific feedback from patients where they feel there has not been enough discussion and contact concerning their cancer treatment during these exceptional times. We can then offer further appointments as needed. Please contact either myself, or Dr Sam Guglani, in this regard.