What is a quality account?

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

Our Quality Account looks back on how well we have done in the past year at achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.
PART 1

Statement on quality from the Chief Executive

In this, the 70th anniversary year of the NHS, I am delighted to introduce the Quality Account for Gloucestershire Hospitals NHS Foundation Trust. Every NHS Trust is required to publish a Quality Account which sets out how the Trust is performing against the quality standards and priorities set both nationally by Government and locally by the Trust Board and its commissioners. It serves many purposes but our intention in Gloucestershire has been to develop an Account that connects local people and our staff with the huge achievements of the last year alongside the ongoing challenges, which have shaped our priorities for the coming year.

Since joining the Trust more than 18 months ago, I have been repeatedly struck by the number of examples where our staff are leading the way in delivering innovative, high quality care. As a result, barely a Monday goes by when my weekly staff message doesn’t contain a mention of a member of staff or team who have received acclaim for the things they are doing here in Gloucestershire or a patient hasn’t written to me thanking the Trust for the care they have received.

The highlights from the last year are almost too many to mention so please do take the time to dive into the full report but before you do, below are a few of the things that really have transformed outcomes and experience for our patients, of which I am especially proud.

In July, the Care Quality Commission (CQC) published its inspection report into the Trust’s services and rated 70% of our services either good or outstanding; we received acclaim from the Secretary of State for Health in respect of our A&E performance when he took the time to write to the Chair and me to acknowledge our standing as the most improved Trust in England having achieved the 4 hour waiting time standard in November 2017, the first time in more than four years; staff on ward 7a, alongside our patient experience team, won a national award for their project Small Steps, Big Changes; staff working in endoscopy services are still celebrating their achievements having received national accreditation for the service for the first time in more than a decade; three of our front line nursing staff were invited to join Prince Charles and others at Buckingham Palace in recognition of their contribution to the profession and finally, the work led by Mr Vinay Takwale and his colleagues in trauma and orthopaedic services is literally the talk of the NHS – there is barely a platform or conference when Professor Tim Briggs, National Lead for the Getting It Right First Time Programme isn’t sharing the news about what staff in Gloucestershire Hospitals achieved last year.

One of the things that concerned me most when I arrived in the Trust was that the higher than expected mortality rate affecting our patients, or put simply, more patients were dying than was expected given the nature of the population we serve. A year on, under the leadership of Medical Director, Dr Sean Elyan, I couldn’t be more pleased with the improvements that staff have achieved for our patients and their families – a 14% reduction in mortality over the year resulting in the Trust now reporting a lower than expected number of deaths.

Read about some of the things that have contributed to this huge achievement including the inspiring work to transform care and outcomes for patients who experience hip fracture which has resulted in a huge 37% reduction in the mortality of patients affected by this life changing event and the work done to improve the detection and treatment of sepsis – an infection which if left untreated, even for a short time, can result in the death of previously fit and healthy people – resulting in 96% of our patients receiving the Sepsis Six Bundle (as it’s often known) compared to 52% last year.

“Despite the huge number of achievements set out in this report, we still have much to do”

The NHS is often described as a ‘cradle to grave’ service and in the pages that follow you can hear about the things our staff in maternity services are doing to respond to the national Better Births transformation programme to ensure that every woman in Gloucestershire has the best possible experience and outcome at what is such a very special time for most. You can also read about the approach that staff right throughout the Trust are embracing to ensure that those who have reached the end of their life receive the very best possible care, by signing up to our End of Life Charter which means that whatever the underlying cause of a patient’s illness, and wherever they are cared for in the Trust, they get the same compassionate and expert care.

The Quality Account is not only our opportunity to reflect on and celebrate the things that we have achieved in the last year but equally importantly it is our chance to look to our quality priorities for the year ahead and, despite the huge number of achievements set out in this report, we still have much to do. Our overall rating by the CQC remains Requires Improvement which is not where we want
to be – our patients and staff deserve to be receiving and delivering the very best care in line with our vision of Best Care for Everyone.

To this end, this year we have embarked upon our ‘Journey to Outstanding’ or #J2O as it is becoming known on Twitter! Under the leadership of our new Chief Nurse, Steve Hams we are redoubling our efforts in the areas of falls and pressure ulcer prevention, infection control and nutrition and hydration which signals our commitment to delivering the ‘fundamentals of care’ to the very highest standards.

We know that our patients’ experience of outpatients is not what it should be and Caroline Landon; Chief Operating Officer will be working closely with fellow Director of Strategy and Transformation, Simon Lanceley to implement our outpatient improvement programme.

Under the leadership of our digital lead, Mark Hutchinson, this year will be the year that we can say that we have recovered from the challenging introduction of our new patient information system TrakCare and begin embarking upon realising the many benefits for staff and patients that a fully functioning electronic patient record will bring.

Emma Wood, our Director of People and Organisational Development, will be launching the Trust’s first talent management programme to ensure we support all staff to be the very best they can be, again reflecting our vision of Best Care For Everyone which doesn’t just talk to care for patients but is equally central to our approach to caring for our staff.

Finally, the NHS is nothing without its patients and staff. One of the ways that I keep in touch with what it feels like to be a patient or member of staff in one of our hospitals, is to ensure that I prioritise my time so that I am able to spend time out and about in our services listening to staff and patients, hearing first-hand about their personal experiences of delivering and receiving care. With this backdrop, I have never felt more aware of just how challenging it is for staff throughout the NHS and our hospitals are no exception.

It has been a long winter, vacancies in key areas persist and staff tell us that they are not always able to give the care they would like to give. 2018 will be a year when we really do ‘walk in your shoes’ – improving our patients’ and staff’s experience of work will be at the heart of everything we do. The correlation between staff who feel valued and fulfilled and excellent patient care is well established, both groups deserve the very best the NHS has to offer and I am therefore immensely proud to be a member of a Board which places this ambition centre stage.

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST QUALITY ACCOUNT 2017/18
Helping us improve the quality of care

Quality Accounts are an important way for us to report on quality and show improvements in our services we deliver to our local communities and stakeholders.

The quality of our services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about care provided. Each year our Quality and Performance Committee agrees a set of priorities which help us improve the quality of care we provide for our patients.

These priorities are identified because they are important to us, our regulators and/or commissioners and are decided following discussions with our Council of Governors, the Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Healthwatch Gloucestershire.

The following section is divided into four parts:

› Part 2.1: What are our priorities for 2018/19: explains why these priorities have been identified and how we intend to meet our targets in the year ahead.

› How well have we done in 2017/18: looks at what our priorities were during 2017/18 and whether we achieved the goals we set ourselves. Where performance was below what was expected we explain what went wrong and what we are doing to improve.

› Part 2.2: Statements of assurance from the Board

› Part 2.3: Reporting against core indicators.

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.

The Quality and Performance Committee is responsible for monitoring the progress of the organisation against our quality improvement priorities.

The Committee meets every month and reviews a series of measures which give us a picture of how well we are doing. The Quality and Performance Committee is a subcommittee of the Board and has clinical and managerial representation from across our Trust. It includes non-executive directors, executive directors, an observer governor, representation from Gloucestershire Clinical Commissioning Group and is currently chaired by Dr Claire Feehily, Non-Executive Director.
PART 2.1

Our priorities

Our priorities for improving quality

The table opposite provides an overview of our priorities for 2018/19. This table gives you an at-a-glance view of the work we will continue to undertake.

During the year we have reviewed all the information available to us relating to the quality of our services and as NHS England published a two-year scheme on the CQUIN goals the view was that our CQUIN priorities should also be our focus for 2 years so that we could deliver focused clinical quality improvements. CQUIN stands for Commissioning for QUality and INnovation. The system was introduced in 2009 to make a proportion of our income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

Progress against the priorities identified will be measured by agreed metrics and monitored by the Quality and Performance Committee throughout the year. We have aligned our priorities with the dimensions of quality we are measured against by the Care Quality Commission: Safe, Caring, Effective, Responsive and Well Led.

What are our priorities 2018/19?

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Objectives 2018/19</th>
<th>Supports Strategic Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing the impact of serious infections (CQUIN)</td>
<td>Timely identification of patients with sepsis in emergency departments and acute inpatient settings</td>
<td>Our patients will... be safe in our care, be treated promptly with no delays</td>
</tr>
<tr>
<td></td>
<td>Timely treatment for sepsis in emergency department and acute inpatient settings</td>
<td>Our staff will... put patients first</td>
</tr>
<tr>
<td></td>
<td>Antibiotic review</td>
<td>Our organisation will... use its resources effectively, be one of the best performing trusts</td>
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<tr>
<td></td>
<td>Reduction in antibiotic consumption per 1,000 admissions</td>
<td></td>
</tr>
<tr>
<td>Investigations and learning from deaths</td>
<td>To provide an annual summary on reviewing and learning from deaths.</td>
<td>Our patients will... be safe in our care, be treated promptly with no delays</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Our staff will... want to improve</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Our organisation will... be considered a good partner in the health and wider community</td>
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<tr>
<td>EFFECTIVE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivering high quality urgent and emergency care</td>
<td>To ensure our local response to the National Urgent and Emergency Care Review, includes the development of models of care that ensure patients are treated with the very best expertise and facilities in order to maximise their chances of survival and a good recovery</td>
<td>Our patients will... be safe in our care, be treated with care and compassion, be treated promptly with no delays, want to recommend us to others</td>
</tr>
<tr>
<td></td>
<td>Progress to delivering specialist input within 14 hours, daily Consultant review every day, timely diagnostics and interventions (4 key standards in national programme by 2018).</td>
<td>Our staff will... put patients first, want to improve</td>
</tr>
<tr>
<td></td>
<td>Improving services for people with mental health needs who present to the Emergency Department (CQUIN)</td>
<td>Our services will... make best use of our two sites, be organised to deliver centres of excellence for our population</td>
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<td></td>
<td></td>
<td>Our organisation will... use our resources efficiently, use our resources effectively to improve our performance</td>
</tr>
<tr>
<td>Improving the use of medicines (CQUIN)</td>
<td>To optimise the use of medicines commissioned by specialised services</td>
<td>Our patients will... be safe in our care</td>
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<tr>
<td></td>
<td>To introduce standardised doses of anti-cancer therapies</td>
<td>Our staff will... put patients first</td>
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<td></td>
<td></td>
<td>Our organisation will... use our resources efficiently, use our resources effectively</td>
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<tr>
<td>Preventing ill health by risky behaviours - alcohol and tobacco</td>
<td>› To support healthier behaviours</td>
<td>Our services will... promote health alongside treating illness</td>
</tr>
<tr>
<td>Preventing ill health (CQUIN)</td>
<td>› Improvement of health &amp; wellbeing of NHS staff – 5% improvement in two of the three annual staff survey questions on health &amp; wellbeing, MSK and stress</td>
<td>Our patients will... want to recommend us to others Our staff will... feel valued and involved, want to improve, recommend us as a place to work Our services will... promote health alongside treating illness Our organisation will... be one of the best performing trusts, be considered a good partner in the health and wider community</td>
</tr>
<tr>
<td>Time to care</td>
<td>› To ensure safe staffing levels and implement the new approach to measuring Care Hours per Patient Day (CHPPD) on wards. › To prevent falls and pressure ulcers › To improve end of life care</td>
<td>Our patients will... be safe in our care, be treated with care and compassion, be treated promptly with no delays, want to recommend us to others Our staff will... put patients first, want to improve, recommend us as a place to work, feel confident and secure in raising concerns Our services will... promote health alongside treating illness Our organisation will... use our resources efficiently, use our resources effectively, be one of the best performing trusts, be considered a good partner in the health and wider community</td>
</tr>
<tr>
<td>Harnessing the benefits of technology</td>
<td>› To develop the use of our clinical information system to support the ordering of tests and the communication of results, and preparing to use the system for prescribing. › To increase the use of the national e-referral system to allow patients to choose appointment times that suit them by publishing all of our first outpatient appointment slots available on NHS e-Referral Service (eRS) (CQUIN) › To establish Advice &amp; Guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care (CQUIN)</td>
<td>Our patients will... be safe in our care, be treated promptly with no delays Our staff will... put patients first, feel valued and involved, want to improve, recommend us as a place to work Our services will... make best use of our two sites, be organised to deliver centres of excellence for our population, use technology to improve Our organisation will... use our resources efficiently, use our resources effectively, be one of the best performing trusts, be considered a good partner in the health and wider community</td>
</tr>
<tr>
<td>Learning to improve</td>
<td>› To participate in and learn from the results of national audits, and reviews of our services › To respond to patient feedback and surveys around discharge › To build the capacity and capability of our staff to improve services through our Quality Academy › To learn from serious incidents</td>
<td>Our patients will... be safe in our care, be treated promptly with no delays Our staff will... put patients first, feel valued and involved, want to improve, recommend us as a place to work, feel confident and secure in raising concerns Our services will... make best use of our two sites, be organised to deliver centres of excellence for our population, use technology to improve Our organisation will... use our resources efficiently, use our resources effectively, be one of the best performing trusts, be one of the best performing trusts</td>
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How well have we done in 2017/18?

Safe: Reducing the impact of serious infections

Quality priority

- There should be timely identification of patients with sepsis in emergency departments and acute inpatient settings.
- There should be timely treatment for sepsis in the emergency departments and acute inpatient settings.
- Assessment of clinical antibiotic review should happen between 24 and 72 hours of patients with sepsis.
- There should be a reduction in antibiotic consumption per 1,000 admissions.

Background

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

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

Sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated quickly. Each month our hospitals’ Emergency Department (A&E) treats between 40 and 50 patients with sepsis.

How have we performed

In 2017/18, as in the previous year, reducing the impact of serious infections CQUIN has two main objectives:

- **Part A**: patients who meet the clinical criteria for sepsis should be screened for sepsis using the local tool
- **Part B**: those who present with red flag sepsis, severe sepsis or septic shock, must receive antibiotics within an hour. These patients should also receive a review after three days of antibiotics.

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

The delivery of antibiotics within an hour of diagnosis has improved and continues to be delivered to high levels.

This improved performance supported by the Gloucestershire Safety and Quality Improvement Academy (GSQIA) and the Trust has been recognised as one of the most improved hospitals in England.

Data

See following page.

Plans for improvement 2018/19

The quality improvement work will be continuing and we will work to meet and exceed the CQuIN targets set for 2018/19.

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**Figure 1:** Emergency Department – Proportion of patients who required screening for Sepsis who received screening

**Figure 2:** Emergency Department – Proportion of patients who received Antibiotics within 1 hour of diagnosis of Sepsis
Effective: Delivering high quality urgent and emergency care

Quality priority

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

Background

Urgent and Emergency Care is provided by a number of different practitioners. The vast majority is provided in primary care by General Practitioners, nurses, pharmacists and in other community settings such as Minor Injury Units.

The Emergency Departments at Gloucestershire Royal and Cheltenham General Hospitals see the sickest and most urgent patients and those referred from primary care. Ensuring that the patient is seen by the most appropriate practitioner first time is one of the ways to improve the quality of care and the speed with which it can be delivered.

The national benchmark for Emergency Departments is the 95% 4-hour standard: 95% of patients should be seen, treated and either discharged or admitted within 4 hours of arriving at the department.

In the last few years we have failed to meet this target. In 2017 we have worked hard to improve our systems, to reduce unnecessary steps in the patient pathway and to improve the quality of care we give.

How have we performed

We have seen a steady and sustained improvement in performance and quality across a number of metrics.

For example, in November 2017 we achieved the 95% 4-hr standard across both hospitals for the first time in 7 years; patient reported outcomes from the Friends and Family Test improved by 10%; the number of patients and the number of hours that patients were looked after in the corridors in the Emergency Department decreased, and the number of operations cancelled in the 2017/18 winter was significantly reduced.

Plans for improvement 2018/19

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

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

The recently awarded capital funding will include a number of developments in both Cheltenham General Hospital and Gloucestershire Royal Hospital that will improve and extend the facilities in the Emergency Departments in 2018/19.
Effective: Delivering high quality urgent and emergency care (cont.)

Quality priority
- Progress to delivering specialist input within 14 hours, daily consultant review every day, timely diagnostics and interventions (4 key standards in national programme by 2018)

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

A consultant is present on the admission unit in Cheltenham General Hospital from 8am to 8pm Monday to Friday and from 8am to 5pm Saturday and Sunday.

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

How have we performed
We participate in the national Society of Acute Medicine Benchmarking Audit (SAMBA) each year. The last audit was in 2017.

At Gloucestershire Royal Hospital 65% of patients were seen by a doctor within 4 hours and 67% of patients were reviewed by a consultant within 8 hours of admission; the figures for Cheltenham General Hospital were 88% reviewed by a doctor within 4 hours and 58% by a consultant within 8 hours of admission.

Data
See following page.

Plans for improvement 2018/19
A 1-hour diagnostic target was introduced for the admission unit in Gloucestershire Royal Hospital in 2017. This will be extended to Cheltenham General in 2018.

The Ambulatory Emergency Care (AEC) centre was extended to weekend 8am to 6pm (4pm for last referral) in Gloucestershire Royal Hospital in 2017. Hours will be extended to 8am to 10pm (8pm for last referral) in 2018. The use of the AEC allows rapid early assessment, investigation and treatment frequently avoiding the need for a patient to stay overnight. Patients get a more rapid service and hospital beds are kept for the sickest patients.

A 1-hour troponin pathway (test to rule out a heart attack) will be introduced in 2018 speeding up the treatment of patients who require it and facilitating the earlier discharge of patients who do not (who may be required to stay for 6-12 hours for repeat blood tests at the moment).

An Acute Medical Initial Assessment unit (AMIA) will be opened at Gloucestershire Royal Hospital in 2018. This will enable the early rapid assessment of patients referred by their General Practitioner for a medical opinion by a consultant or other senior doctor.

Figure 5: Gloucestershire Royal Hospital patients were seen by a doctor within 4 hours

Figure 6: Cheltenham General Hospital patients were seen by a doctor within 4 hours
Effective: Delivering high quality urgent and emergency care (cont.)

Quality priority

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

Background

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

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

How have we performed

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

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

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

- Audit against Nice Guideline standards for care (NCG16) in September 2017 demonstrated 100% compliance.
- The interview facility at Gloucestershire Royal Hospital has been improved and now meets national safety standards and those set by Royal College of Emergency Medicine and the Care Quality Commission.

Data

See following page.

The National picture is that Emergency Department attendances by patients in mental health crisis continue to rise by around 10% per year. The efforts and joint working of primary and secondary care in Gloucestershire ensure that despite significant monthly variation, referral rates have not matched the National trend.

Plans for improvement 2018/19

Funding and plans are in place to improve the interview facilities at Cheltenham General Hospital Emergency Department to provide a safe space, which meets national standards and provides equity of facilities in both Cheltenham and Gloucester.

Time to assessment by an Emergency Department practitioner and then by the Mental Health Liaison Team remains longer than we would aim for with too many patients in crisis spending longer than 4 hours in the Emergency Department. Further work to improve this will be undertaken.

The development of our team of Emergency Nurse Practitioners and Physician Associates aims to increase the number of staff able to undertake risk assessments and mental state examinations in the Emergency Department. The aim will be to reduce time to assessment and improve quality of care.

Work with Gloucestershire Police will continue to ensure that new legislation about care of patient's in crisis, held under section 136 of the Mental Health Act results in timely and high quality care. The Royal College of Emergency Medicine document "Mental Health in Emergency Departments – A toolkit for improving care" was revised in October 2017. Many of the described initiatives to ensure care are in place and work will continue to ensure further improvement for all age groups of patients.
Effective: The effective use of complex devices

Quality priority

- To ensure that the selection of internal cardiac devices remains consistent with the commissioning policy, service specification and relevant NICE guidance.

Background

Complex implantable cardiac devices are Implantable Cardioverter Defibrillators (ICD) and Cardiac Resynchronisation Therapy (CRT) devices. In the right patient, complex devices can reduce the risk of sudden death, improve quality of life and improve the prognosis in patients with heart disease.

Clinical decision making around device selection varies between units and this variance may impact on clinical outcomes as well as the overall cost of the complex devices.

The staffing of cardiology departments involved in implanting complex cardiac devices also varies across England which impacts on the effectiveness of decision making, results in variation of device programming and outpatient follow-up arrangements as well as on-call cover for related emergencies.

This CQUIN scheme promoted:

- Enhancement and maintenance of local governance systems to ensure compliance with national policies and specifications.
- Development of sub-regional network policies to encourage best practice when determining device choice including minimum standards for patient consent to ensure the best device is selected for that patient.
- To improve timely access for all patients who need referral for consideration of complex device implantation.
- To ensure that referral pathways and robust decision making

Plans for improvement 2018/19

This CQUIN has been retired and so therefore will not be reported on in 2018/19.

Effective: Improving the use of medicines

Quality priority

- To optimise the use of medicines commissioned by specialised services

Background

The prescribing and administration of a medicine is the most common therapeutic intervention that occurs to a patient within Gloucestershire Hospitals NHS Foundation Trust. Optimising their use provides a further opportunity for the NHS to improve patient outcomes, pathways and experience, whilst reducing expenditure, unwarranted variation and wastage.

How have we performed

This CQUIN has been designed to support Trusts and commissioners to realise this benefit through a series of modules that improve productivity and performance related to medicines. This includes the faster adoption of best value medicines with a particular focus on the uptake of best value generics, and biosimilar biologics as they become available, thus allowing us to treat more patients for the same amount of money.

Targets based upon income for quarters 1 and 2 were met in full, and delivery on quarter 3 was 99%.

Working with our clinicians, one project involved pharmacy further developing homecare services which utilise a dispensing and home delivery service for high cost specialist drugs. This utilises a zero rated VAT option that previously has only been available to community pharmacy. This not only saves money but reduces the number of times a patient has to attend the hospital. Over 2000 patients now have specialist medicines supplied in this manner. One in every four pounds spent on all medicines utilises this service, representing 85% of all outpatient prescribing.

Similarly delivery of our biosimilar biologics programme involving infliximab and etanercept is progressing well. Against a national target of 80%, January saw us deliver 97% of infliximab and 82% etanercept as the biosimilar product.

Data

See below.

Plans for improvement 2018/19

The quality improvement work for this CQUIN will be continuing.

Figure 11: Percentage of existing patients being prescribed biosimilar medicine within 12 months
Quality priority
To introduce standardised doses of anticancer therapies

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

How have we performed
With the elderly population increasing as well as advancement in chemotherapy treatments, this cost is increasing by approximately 8% per year.

Traditionally, chemotherapy doses have been unique to individual patients based on a dose per kg of body weight. Such specific dosing has been demonstrated not to provide additional clinical or patient benefit and significantly increases time and costs of preparation and costs of drug wastage.

Standardising chemotherapy doses across certain weight bands provides many advantages.

It allows chemotherapy to be prepared in advance; it simplifies the process reducing risk and it reduces waiting times for patients. Batch production within the Pharmacy Aseptic Manufacturing Unit (PAMU) can now occur, which minimises waste. Similarly if a patient is unwell on the day and can’t receive chemotherapy, that product can be kept for the next available patient. Working nationally, we are now aligning our doses to a unique weight band.

The target was 80% and we have achieved this for all three quarters.

Plans for improvement 2018/19
The quality improvement work for this CQUIN will be continuing.

Effective: Preventing ill health

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

Background
Our goal is to improve the support available to our staff to help promote their health and wellbeing in order for them to remain healthy and well. In 2015 Public Health England estimated the cost of sickness absence to the NHS at £2.4bn. Some reports have estimated this to be 27% higher than the UK public sector average, and 46% higher than the average for all sectors. However, there are many reasons that sickness absence rates in the health sector may be higher than average. Work can often be physically, emotionally and psychologically demanding and the NHS is one of few organisations that work 24 hours a day, 365 days per year. Despite these challenges, there is much we can do as an employer to improve staff health and wellbeing.

The benefits to us of a healthier workforce are clear:
> Improved patient safety and experience: The NHS health and wellbeing review led by Dr Steven Boorman outlined the link between staff health and wellbeing and patient care. This includes improvements in safety, efficiency and patient experience from introducing employer led health and wellbeing schemes.
> Improved staff retention and experience: NHS staff retention rates are shown to improve when staff feel their employer cares about their health and wellbeing. Not only does better staff retention mean lower recruitment costs but it also often leads to improved team cohesion and better working environments.
> Reduced costs: Although the overall cost of sickness absence is estimated at £2.4bn, even small reductions in sickness absence can have a large impact across the NHS. If sickness absence was reduced by 1 day per person per year then the NHS would save around £150m, equivalent to around 8,000 full time staff. These financial savings do not even take into account the reduced use of agency staff or the costs of recruitment to tackle staff retention issues, and therefore are most likely to understate the overall impact on NHS finances.
> Setting an example for other industries to follow: The NHS should be leading the way in implementing a health and wellbeing strategy and providing an example that others can follow.

Re-inforced public health promotion and prevention initiatives: NHS England’s Five Year Forward View emphasises the importance of closing the health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be compromised.

If we want to reinforce the message on health promotion and prevention then it is important that we are leading by example.

How have we performed
Question 9a – Does your organisation take positive action on health and wellbeing? Answering “Yes, definitely”
2017: 25% (drop of 4% on previous year)
Question 9b – In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Answering “No”
2017: 76% (drop of 1% on previous year)
Question 9c – During the last 12 months have you felt under a lot of pressure at work as a result of the work related stress? Answering “No”
2017: 62% (drop of 4% on previous year)

It is disappointing that scores in the 2017 staff survey have deteriorated. In the last 12 months we have undertaken the following to try and improve the overall health and wellbeing of staff, including:

> Completed the Workplace Wellbeing Charter assessment. We achieved accreditation and were awarded “Excellence” in the categories of leadership, absence management, health and safety and smoking; we were awarded “Achievement” in the alcohol and substance misuse category, and awarded “Commitment” to making progress in the categories of mental health, healthy eating and physical activity. We are now formulating and implementing action plans to drive these forward as priorities across the organisation, with a particular focus on MSK and stress.
> Distributed regular reminders to leaders about the importance of supporting the health and wellbeing of their team members through: 100 Leaders sessions; monthly
Leaders’ Learning Digests. This is ongoing.

- Launched a monthly staff recognition scheme – the Going the Extra Mile (GEM) awards – to recognise and celebrate great colleagues
- Launched a Diversity Network to support and promote the diversity of our workforce, particularly the nine legally protected characteristics. A programme of activity is being devised to offer support, signposting and celebration of vulnerable protected characteristics including disability and mental health.
- Established and promoted the new Freedom to Speak Up Guardian role
- Divisions and departments have been undertaking their own listening events and team meetings to discuss ways of improving staff engagement and health-wellbeing
- One Gloucestershire Sustainability and Transformation Plan (STP) has established a STP Health & Wellbeing Group. It has had particular focus on MSK and stress, along with supporting improvement in flu jab uptake

**Plans for improvement 2018/19**

There are some key actions we plan to take, in order to improve staff health and wellbeing in 2018/19. In order to drive forward and manage the delivery of these actions a ‘Staff Experience Improvement Group’ will be created to implement a range of staff engagement, health and wellbeing actions. The newly formed group will replace/merge the former Staff Health and Wellbeing Group and Staff Engagement Steering Group.

Key priorities for this new working group will include:

- The Development of a ‘One Stovp Shop’ for Staff Health and Wellbeing. The two greatest causes of staff absence are MSK and psychological issues. The Trust has many channels of support however current accessibility of these and our response to immediate need is challenging. A review of services will commence in Spring 2018 and will determine if more can be achieved within our financial envelope, the review will:
  - Identify the current return on investment for employee Health and Wellbeing services. To include: Occupational Health, Staff Support, Physiotherapy services.
  - Benchmark with other organisations ‘one stop shop’ / signposting provision
  - Make recommendations for the development of enhanced, more accessible staff wellbeing service provision.
- Improve the triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention.
- Launch an online engagement / communications tool, which will enable staff to provide feedback and improve two way communications with our workforce. This will also provide an opportunity for us to promote health and wellbeing resources, such as the ‘one stop shop’ in an easily accessible way.
- Further develop and deliver the action plans relating to the Workplace Wellbeing Charter. Specifically these relate to three categories, where we have made a ‘commitment’ to improve as part of the workplace wellbeing charter assessment process: Mental Health, Healthy Eating and Physical activity.

**Quality priority**

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

**Background**

Our Trust is taking action on junk food and obesity by ensuring that healthy food options are available for our patients, visitors and staff including those working night shifts.

**How have we performed**

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

The In-house restaurants areas produce homemade options. The Deli bar has salads, fresh soup, sandwiches, Paninis, cakes, hot menu options, fresh fruit and takeaway fresh fruit pots. At breakfast we have now available porridge, low sugar high fibre breakfast cereal. The hot breakfast option includes traditional fare as well as poached and scrambled egg, with potatoes items being baked rather than fried.

Traditional theme days promote different food types, throughout the year including BBQ in the summer, traditional Christmas fare, specialised dishes have been created with low calorific values these dishes are very popular with staff and visitor. Supporting the main meals we offer couscous, seasonal vegetables, potatoes and rice. Chips are available at a higher price than plain carbohydrates such as rice and new potatoes to encourage healthy choices.

To meet the CQUIN all chocolate bars are 250 kc or less and there are no price promotions on unhealthy food items including buy one get one free deals and a change to the impulse buy at till points have included healthy options. All homemade sandwiches are 400kcal or below and do not exceed the recommended fat levels.

We have reduced the number of sweetened hot and cold beverages in line with the CQUIN and government targets, reporting regularly to the Trust Health and Wellbeing Committee and the Healthy Workforce (NHS England).

The main focus is further compliance with the CQUIN and government targets, particularly these relate to three categories, relating to the Workplace Wellbeing Charter. Specifically these relate to three categories, where we have made a ‘commitment’ to improve as part of the workplace wellbeing charter assessment process: Mental Health, Healthy Eating and Physical activity.

**Plans for improvement 2018/19**

In Year Two (2018/19):

- 80% of drinks lines stocked must have less than 5 grams of added sugar per 100ml. In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).
- 80% of confectionery and sweets do not exceed 250 kcal.
- At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g[1].

We will be:

- Working with our suppliers to improve offers in the vending services
- Reviewing further what is provided out of hours for staff and visitors
- Looking at the patients’ menu again in spring/summer

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Quality priority

Improving uptake of flu vaccinations for frontline clinical staff

Background

Influenza is a highly contagious upper respiratory tract disease causing significant morbidity and mortality among high-risk groups. Immunization of frontline healthcare workers in the NHS is considered to be beneficial in reducing subclinical infection, staff sickness absences and protects patients.

Each year Public Health England launches the Seasonal Flu Campaign to help reduce influenza transmission by reinforcing the message that it is vital that frontline staff get vaccinated.

How have we performed

We have used many of elements recommended by NHS Employers to run our Flu campaign during 2017/18.

Communication

› We mixed up our communication channels and used screensavers, social media, the intranet and emails
› Kept staff updated throughout the campaign by providing regular updates

Our flu team

› Included staff from all parts of the organisation

Supported – all hands on deck

› Champions at all levels of the organisation

Ran a peer vaccination scheme

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

Myth busting

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

Accessibility

› Set up mobile flu vaccinations clinics

Data

76% of our patient facing staff received the flu vaccination this year, this is an 18% improvement on the previous year.

Plans for improvement 2018/19

Next year we are setting our sights high and want to ensure that at least 85% of our patient facing staff have received the flu vaccination.

We are developing our plans to ensure ease of access for our staff alongside a vibrant campaign to help staff understand the benefits of protecting themselves and their patients.
Quality priority
Supporting proactive and safe discharge using the Emergency Care Data Set and increasing the proportion of patients admitted via non-elective routes being discharged from acute hospitals to their usual place of residence within seven days.

Background
Our goal is that we enable patients to get back to their usual place of residence in a timely and safe way.

How have we performed
The Trust is building upon the work undertaken last year to implement and embed the SAFER Programme. This programme with its focus on improved patient flow is enabling us to improve our discharge rates to return patients to their place of safety within seven days of admission. Significant progress has been made against each of the core SAFER elements as detailed below:

The five elements of the SAFER patient flow bundle are:

- **S** – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
- **A** – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting. Medication and transport is then arranged and booked ready for that discharge date.
- **F** – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.
- **E** – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
- **R** – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – ‘stranded patients’) with a clear ‘home first’ mindset. This ‘stranded’ patient review takes place on a daily basis and covers all patients across the hospital with a length of stay greater than seven days.

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

Alongside this each ward is supporting their patients, where possible, to become part of the End PJ Paralysis scheme. This approach encourages patients to sit out and dress in their own clothes each morning thereby installing a sense of wellbeing, dignity and independence that is recognised by both staff and patients. Patients are also being encouraged to proactively ask staff about their discharge plans, asking staff each day what action is being taken that day to progress their discharge.

To support these proactive approaches we have looked to redesign our own internal Onward Care Team (OCT) which works with patients who have more complex discharge needs. This team has now aligned staff to each ward ensuring that each complex discharge is conducted in a safe and timely manner.

In order to share learning and provide challenge a daily Trust wide meeting is held attended by a multi professional team which seeks to unblock delays and identify trends that effect patient flow. These trends are then shared with the wider health and social care system including commissioners in order to improve and redesign patient pathways.

As part of the 7 day service programme we have introduced the Weekend Assessment and Discharge team aiming to increase flow and discharges at the weekends. This team consists of medics, nurses and senior therapists; this has resulted in a significant increase in discharges during the weekend period.

Data
See next page for data.

One of the Trust priorities this year has been to reduce the number of patients with a 14-day or more length of stay within our hospitals. A particular success has been the introduction of Gallery Ward – our medically stable for discharge ward. Launched in April 2017 the ward follows a therapy led model of discharge focussing on enabling patients to gain their independence as far as possible.

Plans for improvement 2018/19
Going forward the Trust will be seeking to embed more robust admission avoidance pathways seeking to maintain patients within their own place of safety.
homes. This includes the formation of the new Acute Medical Initial Assessment unit, which will support the Emergency Department by taking direct GP referrals and providing senior assessment and review from a whole system perspective.

In addition to the above, designated Frailty Beds will be introduced supporting these particularly vulnerable patients ensuring that their hospital stay is as timely and effective as possible thereby reducing the risk of deconditioning (having lost fitness or muscle tone, especially through lack of exercise).

Caring: Time to care

Quality priority

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

Background

From May 2016, all acute trusts with inpatient wards/units began reporting monthly CHPPD data to NHS Improvement.

Over time, this will allow us to review the deployment of staff within a specialty and by comparable ward. When looking at this information locally alongside other patient outcome measures, we will be able to identify how we can change and flex their staffing establishment to improve outcomes for patients and improve productivity.

The introduction of CHPPD for nurse and healthcare support staffing in the inpatient/acute setting is the first step in developing the methodology as a tool that can contribute to a review of staff deployment.

Work has begun to consider appropriate application of this metric in other care settings and to include other healthcare professionals such as Allied Health Professionals (AHPs).

As with other indicators, CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. The aim is to help ward sisters/charge nurses, clinical matrons and hospital managers make safe staffing decisions.

How have we performed

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

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

Plans for improvement 2018/19

The CHPPD will become an increasingly important measure during 2018/19, with the introduction of a more agile e-rostering system. It will be possible to undertake near real time assessment of patient acuity, which in turn will enable us to deploy our staff more effectively to meet increasing care needs of patients. We will also use CHPPD as part of our twice-yearly review of safe staffing levels and will conclude our work as part of the NHS Improvement workforce efficiency collaborative.
Quality priority
To prevent pressure ulcers.

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

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

Pressure ulcers are skin and deep tissue damage developing usually over bony prominences. Pressure ulcers are classified by the European Pressure Ulcer Advisory Panel (EPUAP, 2009), as four ‘grades’ from one to four. One is the most superficial, and four is the deepest (including loss of muscle, and often extending, and exposing bone).

How have we performed
The Trust is committed to reduce the number of pressure ulcers developing in patients in our care. To achieve this, the Tissue Viability Team has developed an action plan for 2017-18 comprising education, audit, equipment provision and innovation. Additionally, the Trust was invited to join the first NHS Improvement Collaborative on reducing pressure ulcers, and undertook two projects on reductions in heel ulcers, and those associated with medical equipment such as face oxygen masks.

Plans for improvement 2018/19
This innovation will continue into 2018, with further developments around ‘React to RED’ as a mnemonic to remind staff to increase prevention techniques where skin redness is noted.

Figure 14: Proportion of patients with new pressure ulcers

Data
See below.

Figure 15: Harm from falls per 1000 bed days (April 2014 – Nov 2017)

Quality priority
To prevent falls.

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

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

How have we performed
The current falls action plan is under review, the data within the Royal College of Physicians (RCP) report a fall rate of 6.6 per 1000 bed day rate taken from their college audit of acute hospitals. The NSPA historically report a 4.8 per 100 bed day rate but include hospitals with naturally low falls rates.

The Trust has a Falls Group made up of clinical experts and safety and improvement staff. It is chaired by a Divisional Director of Nursing.

Plans for improvement 2018/19
There will be a thematic review of the root causes of falls looking at the trends and also for any learning. The data within the Royal College of Physicians National Audit of Inpatient Falls (Nov 2017) will be reviewed and this will lead to a revision of the falls action plan, which will be presented, to our Quality and Performance Committee in late summer 2018.

The data above shows normal variation of harm from falls over an extended period of time with a mean fall rate of 0.7. The NSPA historically report a rate of 0.6 in an at hospital setting.
Quality priority
To improve end of life care.

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

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

We successfully appointed a Clinical Lead Nurse for End of Life and Specialist Palliative Care, a brand new role to help co-ordinate, deliver and drive forward end of life care.

Our Trust based web pages are up and running and our first staff email bulletin went out. This helps to share news on what is happening across the Trust, as well as feedback received from relatives and learning from incidents/complaints.

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

Our Clinical Commissioning Group has established a Clinical Programme Group for end of life care and we are one of only 11 CCG’s across the country to have done this. One of our medical consultants is deputy chair ensuring that we are at the heart of countywide developments. We will be working to break down cross-organisational boundaries and explore societal changes. Projects have already included a pilot of Just in Case Boxes to improve access to medications.

We have also established a Clinical Programme Group for end of life care and we are working with the countywide Clinical Programme Group to forward establish work programmes. Key projects which will be completed this year include a full review of shared care paperwork for the expected last days of life and a switch of standard medications prescribed at end of life which will result in more consistent supplies through more reliable drug company provision, as well as potentially producing a substantial cost saving without detriment to symptom relief.

The indicators will be monitored using a suitable approach depending on the data. This would provide continuous assurance that the service provided is at its highest standard.

Quality assurance data is used for judgement; wherever possible it should be benchmarked against comparable external data such as national audits and should be displayed over longitudinal periods. Following testing in the past year a new model to manage quality at a local level has been established and is based simply on the concept of what is important for the patient.

Plans for improvement 2018/19
Each department/specialty will identify a range of relevant evidence based indicators such as relevant national audits that can be regularly measured that would provide continuous assurance that the service provided is at its highest standard. The indicators will be monitored using a suitable approach depending on the data. This will include using Statistical process control charts for monitoring processes over time.

Through our End of Life Care Quality Group, we will be sending out quarterly emails to share learning around incident/concerns/complaints, as well as hearing about examples of best practice. We are also working with our Information & Technology colleagues to ensure key aspects of care are including within the new electronic patient record.

Our End of Life Care champions will be running their own event later in the year, showcasing their roles, how they can support colleagues and highlighting the growing resources available to all.

We will be continuing to work with the countywide Clinical Programme Group to forward established work programmes. Key projects which will be completed this year include a full review of shared care paperwork for the expected last days of life and a switch of standard medications prescribed at end of life which will result in more consistent supplies through more reliable drug company provision, as well as potentially producing a substantial cost saving without detriment to symptom relief.

We will be holding events during Dying Matters week and looking at ‘improving the conversation’, through initiatives like the ‘Knead to Know’ project. This initiative encourages conversations to happen whilst an activity, bread making, is taking place.

Positive and negative exceptions will be reported to the Divisional Quality Board with any necessary action, action arising from this report would be monitored at the Specialty quality meeting and an improvement plan established were performance is below the expected standard.
Quality priority
To respond to patient feedback and surveys on discharge.

Background
We receive feedback from patients about their discharge experience in a number of formats. These include;
- Friends and Family Test (FFT)
- National Survey Programme including In-patients
- Concerns, Complaints and Compliments
- Social Media links.

How have we performed
We use the learning from this feedback to assist us in improving the care and services we provide to our patients. This has resulted in a number of programmes, work streams and quality improvement projects focusing on improving discharge. Programmes and work streams include;
- SAFER programme focusing on "patients being in our hospital no longer than necessary".
- The Emergency Department: Good diagnosis in ED not only helps direct patients to the most appropriate care. It also helps avoid unnecessary admissions to hospital.
- The Acute Care Unit: A key priority in the Acute Care Units is ensuring patients are placed in the best possible location and that might well not be in hospital. There are numerous options for patients in ACU other than hospital admission.
- Wards: We are improving the way we discharge patients from our care.
- Discharge Waiting Area: The Discharge Waiting Area or Discharge Lounge plays a vital role in speeding the patient’s journey. It has a highly qualified team who can look after all patients once they have been declared medically fit for discharge. A number of new initiatives and processes have been introduced as part of these work programmes which, include;
  - Ward Rounds – Ward rounds are now structured using the SORT mnemonic, S Sick – Sick Patients, O Out – Out today or tomorrow, R Rest of the patients, T To come in?
  - Board Rounds – Every day patients are coming into our Emergency Department and need beds on our Wards. Good board rounds ensure the greatest numbers of beds are available for them.

Improving the quality of discharge summaries in the Paediatric setting
- Managing complex discharges – We flag up, as early as possible, patients who have complex conditions that will prevent them going home in a straightforward way.
- Information for families and patients – We will provide better information for families and patients by making sure our patients know the answer to 4 key questions
  - What is the matter with me? (main diagnosis)
  - What is going to happen today? (Tests, interventions etc.)
  - What is needed to get me home? (Clinical criteria for discharge)
  - When am I going home? (Expected date of discharge)

The project team offered a SAFER poster to each ward sister to display in every ward area.

- Single point of access (SPA) – The SPA is responsible for a range of patient services. The most important role of its staff is allocating beds in community hospitals as close to the patient’s home as possible. They also have access to enablement facilities, community rapid response teams and Intra Venous therapy teams.
- Tablets to take out (TTOs) ready the day before discharge–Pharmacy has reduced the average time it takes to turn round a prescription from three hours to ninety minutes and we are aiming to get TTOs ordered the day before.

A number of quality improvement projects have been taken through the Gloucestershire Safety and Quality Improvement Academy with a focus on reducing length of stay, improving the discharge experience and making care safer for our patients. These include;
- Improving the quality of information General Practitioners receive about newly started medication on their patients discharge paperwork
- Improving the care of older patients undergoing vascular surgery through the implementation of a comprehensive geriatric assessment
- Improving communication between secondary and primary care for patients who have an acute kidney injury.
- Reducing length of stay for infants with neonatal chronic lung disease who require home oxygen
- Improving the quality of medical handover at the weekend

Data
See below.

Plans for improvement 2018/19
The Patient Experience Improvement Team during 2018/19 will continue to work with Gloucestershire Safety and Quality Improvement Academy to facilitate discharge improvement work across the Trust.

This work links to our corporate strategic objective of improving the patient experience of care. We are working with the Point of Care Foundation to run a programme called the “Sweeney Programme” which will assist senior leaders in the Trust to focus on improvement work relating to our patient experience indicators and insights. In 2018/19 we will continue to use the feedback we receive from patients and carers about their discharge experience. This feedback will steer improvement work ensuring that we learn from patients who have not gone well and preventing reoccurrence in the future.

Figure 16: Inpatient Survey data published by CQC June 2016
Quality priority
To build capacity and capability of our staff to improve services through the Quality Academy.

Background
The Academy was created in June 2015 with the aim of developing a centralised source of Safety & Quality improvement education programmes to provide staff with the skills, tools and the support to contribute to the Trust vision to embed Continuous Quality Improvement into normal everyday working.

How have we performed
The initial aim of the Academy was to deliver a programme of Quality Improvement education and support internal to the Trust, with the longer-term aim of developing and delivering accredited education programmes external to the Trust whilst establishing an external reputation within the field of Safety & Quality Improvement.

The GSQIA has been shortlisted for a HSJ award of for building an improvement movement.

The work of the academy can be reviewed on the Trust website for GSQIA with regular communication on Twitter and Facebook.

Data
Following an initial target to train approximately 10% of staff (800) in Quality Improvement methodologies by the end of 2018, revised targets were proposed and included in the Trust objectives for 2017–2019. Progress so far is detailed, below right.

There are currently another 70 projects in progress. There are also 30 Gold QI coaches currently in training. 2 more cohorts due to start in June 2018 to achieve the 45 target.

Plans for improvement 2018/19
We will continue to train our staff in quality improvement and will have trained a further 900 Bronze, 70 Silver and 45 Gold Quality Improvement Coaches by April 2019.
PART 2.2

Statements of assurance from the board

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

These statements serve to offer assurance that our organisation is performing to essential standards, such as:

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

Information on the review of services

The purpose of this statement is to ensure we have considered quality of care across all our services. The information reviewed by our Quality and Performance Committee is from all clinical areas. Information at individual service level is considered within our divisional structure and any issues escalated to the Quality and Performance Committee. During 2017/18 Gloucestershire Hospitals NHS Foundation Trust provided and/or subcontracted 117 NHS services. The Trust has reviewed the data available to us on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of the NHS services by Gloucestershire Hospitals NHS Foundation Trust for 2017/18.

Information on participation in clinical audit

From 1 April 2017 to 31 March 2018, 37 national clinical audits and 5 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 95% 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 2017/18 are as follows:

- Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
- BAUS Urology Audits: Cystectomy
- BAUS Urology Audits: Nephrectomy
- BAUS Urology Audits: Percutaneous nephrolithotomy
- BAUS Urology Audits: Radical prostatectomy
- Bowel Cancer (NBOCAP)
- Cardiac Rhythm Management (CRM)
- Case Mix Programme (CMP)
- Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)
- Diabetes (Paediatric) (NPDA)
- Elective Surgery (National PROMs Programme)
- Endocrine and Thyroid National Audit
- Falls and Fragility Fractures Audit programme (FFFAP)
- Fractured Neck of Femur
- Inflammatory Bowel Disease (IBD) programme
- Major Trauma Audit
- Maternal, Newborn and Infant Review Programme Clinical Outcome
- National Audit of Breast Cancer in Older Patients (NABCP)
- National Audit of Dementia
- National Bariatric Surgery Registry (NBSR)
- National Cardiac Arrest Audit (NCAA)
- National Chronic Obstructive Pulmonary Disease Audit programme (COPO)
- National Emergency Laparotomy Audit (NELA)
- National Heart Failure Audit
- National Joint Registry (NJR)
- National Lung Cancer Audit (NLCA)
- National Maternity and Perinatal Audit
- National Neonatal Audit Programme (NNAP)
- Neonatal Intensive and Special Care
- National Ophthalmology Audit
- National Vascular Registry
- Oesophago-gastric Cancer (NAOGC)
- Pain in Children
- Procedural Sedation in Adults (care in emergency departments)
- Prostate Cancer
- Sentinel Stroke National Audit programme (SSNAP)
- Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
- UK Parkinson's Audit

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST QUALITY ACCOUNT 2017/18
## Participation in National Audits

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below. Alongside the number of cases submitted to each audit or enquiry as a percentage are the number of registered cases required by the terms of that audit or enquiry:

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>--</td>
<td>57% to date (70% required for minimum data standard)</td>
</tr>
<tr>
<td>BAUS Urology Audits: Cystectomy</td>
<td>42</td>
<td>100%+ based on HES for 2014/15/16 combined</td>
</tr>
<tr>
<td>BAUS Urology Audits: Nephrectomy</td>
<td>67</td>
<td>92% based on HES for 2014/15/16 combined</td>
</tr>
<tr>
<td>BAUS Urology Audits: Percutaneous nephrolithotomy</td>
<td>44</td>
<td>95% based on HES for 2014/15/16 combined</td>
</tr>
<tr>
<td>BAUS Urology Audits: Radical prostatectomy</td>
<td>133</td>
<td>HES % not provided</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>438</td>
<td>100% case ascertainment (data completeness: pre-treatment 70%, performance status 88%)</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>Full submission</td>
<td>100%</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>All patients admitted to critical care areas</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Angioplasty/ National Audit of Percutaneous Coronary Interventions (PCI)</td>
<td>Full Submission of Nationally mandated dataset.</td>
<td>100%</td>
</tr>
</tbody>
</table>

## Participation in National Audits

### Number Percentage

<table>
<thead>
<tr>
<th>Diabetes (Paediatric) (NPDA)</th>
<th>270 patients</th>
<th>100% of appropriate cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Surgery (National PROMs Programme)</td>
<td>Based on patient returns (patient reported outcome measures)</td>
<td>August to November 2017: Hip: 85.1% Knee: 98.6%</td>
</tr>
<tr>
<td>Endocrine and Thyroid National Audit</td>
<td>100 Thyroid and 20 Parathyroid (2016 case load)</td>
<td>100%</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit programme (FFFAP)</td>
<td>20 cases at GRH and 20 at CGH</td>
<td>67% (aim was 30)</td>
</tr>
<tr>
<td>Fractured Neck of Femur</td>
<td>Eligible cases: 74 GRH, 34 CGH</td>
<td>100% (Based on 100 cases if expected number of cases &gt;250)</td>
</tr>
<tr>
<td>Major Trauma Audit (TARN)</td>
<td>Ongoing case entry</td>
<td>Data accreditation 93.3% GRH, 91.2% CGH but data completeness 56%</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Review Programme</td>
<td>Data entered for all maternal deaths and still births</td>
<td>100%</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme</td>
<td>Current data collection:</td>
<td>50% of Acute Heart Failure 43% Chronic Neurodisability</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older Patients (NABCOP)</td>
<td>All data from COSD</td>
<td>100%</td>
</tr>
<tr>
<td>National Bariatric Surgery Registry (NBSR)</td>
<td>100% (to March 2016) Primary Procedures 133 and Revisional Surgery 10</td>
<td>Submission in arrears, working towards 100%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAAA)</td>
<td>121 (any resuscitation event)</td>
<td>100%</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease Audit programme (COPD)</td>
<td>208 admissions captured in 2017 across county</td>
<td>Online audit tool to capture all cases</td>
</tr>
<tr>
<td>Audit</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>232</td>
<td>100% Continual submission of emergency laparotomy patients</td>
</tr>
<tr>
<td>National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)</td>
<td>559</td>
<td>100% The NNAP uses the mandatory database, ‘Badger’ to access all records needed per question.</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>4086</td>
<td>100% Medisoft extraction</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>AAA 77 Carotid 56</td>
<td>100% extraction from NVR database</td>
</tr>
<tr>
<td>Oesophago-gastric Cancer (NAOGC)</td>
<td>Full clinical cohort</td>
<td>100%</td>
</tr>
<tr>
<td>Pain in Children</td>
<td>100 GRH, 107 CGH</td>
<td>100% (Based on 100 cases if expected number of cases &gt;250)</td>
</tr>
<tr>
<td>Procedural Sedation in Adults (care in emergency departments)</td>
<td>61 GRH, 50 CGH</td>
<td>100% (Based on 100 cases if expected number of cases &gt;250)</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>520 2016/17 (Current report) 507 This year</td>
<td>Varying levels of data completeness</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>All patients admitted with stroke entered – Approximately 800-900 every year</td>
<td>100%</td>
</tr>
<tr>
<td>Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme</td>
<td>21 cases (incidents) reported to SHOT</td>
<td>100% of eligible cases</td>
</tr>
<tr>
<td>UK Parkinson’s Audit</td>
<td>40 patients</td>
<td>100% of minimum sample</td>
</tr>
</tbody>
</table>

**National Confidential Enquiries**

<table>
<thead>
<tr>
<th>Programme</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Clinical Outcome Review Programme and: Medical and Surgical Clinical Review Programme</td>
<td>Chronic Neuro disability Young People’s Mental Health Cancer in Children, Teens and Young Adults Acute Heart Failure Perioperative Diabetes (ongoing)</td>
<td>Information returned for all national confidential enquiries</td>
</tr>
</tbody>
</table>
Clinical audit reports

The reports of 100% of national clinical audits were reviewed (or will be reviewed once available) by the provider in 2017/18. Where results or case ascertainment have been found to be below required standards, the following actions have been noted, with the intention of improving the quality of data submitted or the quality of care provided:

<table>
<thead>
<tr>
<th>Audit</th>
<th>Actions noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>Additional resource allocated to achieve the minimum standard. Look to achieve the Best Practice Tariff.</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>CRT numbers for the last year were lower than expected due to the unexpected retirement of a colleague. Local data analysis has found we are now back within range.</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>Quality improvements continue with foot examination, urine screening for albuminuria, blood pressure measurement and encouraging patients to attend structured education sessions. Moving forward, an issue relating to data capture has been reported to IT regarding the new dataset, some of this information is not available electronically, which may make it appear that the team has not been completing care processes required for the national audit.</td>
</tr>
<tr>
<td>Elective Surgery (National PROMs Programme)</td>
<td>Q1 is now handed out at Pre-admission clinic as per national guidelines. This has shown an increase in the returns rate. When looking at the monthly breakdown, it has shown an interesting pattern. Patients may be seen up to 6 weeks prior to surgery (and longer if cancelled or delayed) and their return will show in a different month to the actual surgery. Due to seasonal variability, this means that it looks like we have (in some months) more returns than surgeries performed. It was decided nationally, that from Oct 2017, PROMs data would no longer be collected for Varicose Veins and Groin Hernias, and distribution of Q1 was subsequently discontinued in these groups. Patients undergoing surgery between August and October 2017 will continue to be sent Q2 at the appropriate time. Work is ongoing to obtain permission to receive SEFT data which will allow for more time-sensitive and consultant level data to be obtained (at the point of Q2 return).</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit programme (FFFAP)</td>
<td>The action plan has been updated and additional resource has been allocated (extra hours) to give support to ward staff to try and properly implement the falls care bundle on the wards. A focus has been given to taking patients lying/standing BP and getting medication reviews completed (which remains an issue nationally).</td>
</tr>
</tbody>
</table>

Audit | Actions noted |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>Current assessment of resource/funding for subscription to audit tool.</td>
</tr>
<tr>
<td>Major Trauma Audit</td>
<td>Data completeness is 56% due to the Trauma co-ordinator post being vacant for 4 months. We are working on improving data collection and we are going to change the trauma notes to highlight the use of TXA and the discussion with TTL. M&amp;M cases discussed. Now the mortality is in line with the other trusts. We noticed that the Consultants don’t record their attendance at Trauma and this issue was discussed at the ED staff meeting and it will be disseminated to the other colleagues. More trauma calls to be put out and the cases to be discussed with TTL.</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Review Programme Clinical Outcome</td>
<td>No specific actions but learning points disseminated throughout the service</td>
</tr>
<tr>
<td>National Bariatric Surgery Registry (NBSR)</td>
<td>To get local access to the database, in order to maintain an up-to-date dashboard so that information/outcomes can be reviewed more quickly.</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Actions taken are split into: › Areas where simulation training would be beneficial for identifying deteriorating patients and need for increased awareness of DNACPR › Training needs surrounding outcomes of futile attempts and DNACPR identification › Analysing our benchmarking status nationally for various outcomes including numbers of CPR attempts, survival to discharge, demographics of patients, locations of arrests etc. › Investigate submission of potential non-arrests and unexpected non-survivors and highlighted by the NCAA.</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease Audit programme (COPD)</td>
<td>Increase use of discharge bundle (ensuring that respiratory staff are increasing their utilisation of the bundle, and looking at ways to have more time for staff to complete these tasks.) Use of coding department to better understand how many cases are being missed. Examine ways the existing patient tracking software can help us to identify eligible patients. Look at eligibility for best-practice tariff and how this might help bolster staff numbers. Consider education for staff to help the respiratory team find eligible patients.</td>
</tr>
</tbody>
</table>
Audit / quality improvement project | Example of actions
--- | ---
ENT | Testing and introduction of biopsy and dental extraction lists to improve ENT cancer wait times
Maternity triage | Development of triage assessment forms, development and implementation of a data capture tool to reduce waiting times for women attending maternity triage
Neonatal unit | Introduction of ‘Family Integrated Care’ to the Neonatal unit to improve infants care, integration with families and staff satisfaction
Communication with deaf BSL users | Introduction of ‘communication needs alert’ on TrakCare, including presence of Gloucestershire Deaf Association telephone contact details. Design, implementation and promotion of countertop notices and ‘Deaf Communication Card’
Renal services – Children to adult transition clinics | Engagement with patients transitioning from child to adult services to ensure they have a positive experience.
Pharmacy | Improving communication between pharmacists and nursing staff in order reduce TTOs sent in the afternoon. Development of ward communication sheet.
Elderly care | Use of UP forms to facilitate timely patient engagement and decision-making around ceilings of treatment, multi-disciplinary team approach.
Oncology | Implementation of a scalp cooling service for patients at risk of chemotherapy induced hair loss
Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Gloucestershire Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee 1,771.

Duty of Candour

For many years our Trust has delivered the ‘being open’ standards recommended for patients who have suffered avoidable serious harm or death. These standards require us to inform the patient or family of the event and provide an explanation and apology for what went wrong. Depending on the family’s wishes, this can take the form of meetings, letters and/or sharing the serious incident report.

The Duty of Candour is new legislation that came into force at the end of October 2014. It extends the definition from ‘serious harm and death’ to include ‘moderate harm.’ Arrangements within our divisions for investigating incidents which have, or have the potential to have caused moderate harm, varied.

The Safety Department works to ensure that all reported patient safety incidents that trigger the Duty of Candour are managed in accordance with statutory and contractual requirements.

In October 2016 a new Duty of Candour Co-ordinator post and two Patient Safety Investigation posts were created. These new posts report to the Head of Patient Safety Investigations who reports directly to the Trust’s Director of Safety.

The Duty of Candour co-ordinator screens all moderate and harm incidents through our Datix reporting system with the Divisional Risk Managers, daily.

Trust staff report around 20–30 moderate harm incidents per week. It is necessary for each incident to be reviewed and consideration given to a) whether this has been correctly reported and b) whether on initial review it is considered that the patient has or may (in the future) suffer moderate harm or above. Of those 20–30 incidents, it is estimated that 2–3 cases per week fulfill the criteria for Duty of Candour.

For those cases where the criteria is met a detailed root cause analysis is undertaken and a comprehensive investigation report and action plan, prepared.

Involvement with the investigation and a final copy of the investigation report is routinely offered to all patients/carers that are involved with or affected by the incident. Where an Inquest is scheduled HM Coroner also receives a copy of our investigation report and action plan. During April 2017 – March 2018:

- 129 incidents following preliminary investigation were considered to have caused moderate harm or above (or had the potential to) and have received a detailed investigation by a Patient Safety Investigator.

On the basis that around 20-30 potential moderate harm or above cases are reported per week and 2-3 cases accepted, there are approximately 900 cases in the period April 2017 to March 2018, that on further investigation have not met the threshold for a detailed harm investigation. However a significant proportion of those 900 will be followed through Divisional Governance arrangements for a moderate risk investigation and appropriate learning.
Information on the use of Commissioning for Quality & Innovation (CQUIN) framework

Gloucestershire Hospitals NHS Foundation Trust’s total CQUIN plan for 2017/18 was £8,849,227. As NHS Gloucestershire Clinical Commissioning Group had a block contract in place in 2017/18 the CQUIN payment is in effect fixed at £6,944,873. However we will not know the CQUIN position for the other commissioners until early June when CQUIN eligibility has been agreed based on a review of our target compliance. It is also dependent on agreement of the year end income positions that the CQUIN is associated with.

As a guide however the current Trust Total CQUIN income position for 2017/18 is estimated at £8,703,254 if we were to achieve 100% target eligibility.

The level of the Trust’s income in 2017/18 conditional upon the quality and innovation goals is £7.3m (2016/17: £8.5m). In line with national rules this represents 2.0% of income for National CCG commissioned CQUINS (£5,893,674 – includes the 0.5% STP) and 2.0% Specialised Commissioned CQUINS (£1,387,918)

As in previous years goals are linked to the improvements required through the NHS Outcomes Framework, NHS Operating Framework 2016/17 and delivering the Forward View 2016/17-2020/21.

For 2017/19 the scheme shifted focus to prioritising STP engagement and delivery of financial balance across local health economies:

- 1.5% was assigned to deliver against mandated National CQUINS
- 0.5% of National CQUIN will be subject to provider engagement and commitment to STP process (principals specified in contract) – CQUIN values include this financial element
- 0.5% National CQUIN will be subject to a risk reserve, which is subject to the system delivering its control total in line with national guidance (£1,673,551)
- Specialised CQUIN is offered at 2.0% eligible contract value

In 2017/18 the Trust agreed a year end contract settlement with Specialised Commissioning and GCCG; GCCG CQUINS were included as a block agreement with no further financial risk for GCCG commissioned CQUINS. This was fixed at 100% achievement.

Of the 2.5% of eligible contract value, 2% was fixed as part of the settlement and 0.5% relating to delivery of the system risk reserve, remained variable. GHT committed to continue to deliver and report CQUINS as most will be continuing in 18/19 and they contribute to quality outcomes in line with Trust objectives.

To date there is no contract settlement with Worcestershire CCG and Associates (2% equates to £267k) and there will be financial implications to non-achievement of the WCCG commissioned CQUINS.

Specialised Commissioning CQUINS remained variable in the 17/18 contract settlement with NHSE therefore there remain financial implications to non-achievement.

The agreed National and Specialised commissioned CQUINS for 17/18 – 18/19 are described in the table opposite.

<table>
<thead>
<tr>
<th>CQUIN Description 17/18 Value</th>
<th>17/18 Lost income to end Q4</th>
<th>18/19 Potential Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine Optimisation</td>
<td>To support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services.</td>
<td>517,260</td>
</tr>
<tr>
<td>Dose Banding</td>
<td>Implementation of nationally standardised doses of SACT using the dose-banding principles and dosage</td>
<td>517,260</td>
</tr>
<tr>
<td>Complex Devices (being retired 18/19)</td>
<td>This scheme seeks to ensure that device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance and that contractual requirement are in place for providers while new national procurement and supply chain arrangements are embedded</td>
<td>172,420</td>
</tr>
<tr>
<td>Spinal Hub</td>
<td>To establish and operate regional spinal surgery networks, data flow and MDT for surgery patients. To promote the better management of spinal surgery by creating and supporting a regional network of a hub centre and providers</td>
<td>172,420</td>
</tr>
<tr>
<td>Enhanced Supportive Care (New 18/19)</td>
<td>Implementation of the Enhance Supportive care approach for cancer and non-cancer services-early referral to a Supportive Care Team to secure improved outcomes and avoidance of inappropriate aggressive treatment</td>
<td>N/A</td>
</tr>
<tr>
<td>Armed Forces Covenant</td>
<td>Embedding AF covenant</td>
<td>8,558</td>
</tr>
</tbody>
</table>
## CCG Commissioned CQUINS

<table>
<thead>
<tr>
<th>CQUIN</th>
<th>Description</th>
<th>17/18 Value (2% of eligible CV)</th>
<th>17/18 Lost income to end Q4</th>
<th>18/19 Potential Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Wellbeing</td>
<td>Improving the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) HR/staff survey questions</td>
<td>327,428</td>
<td>Staff survey did not achieve: £327,428</td>
<td></td>
<td>£861,450</td>
</tr>
<tr>
<td>b) Food</td>
<td>327,428</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Flu vaccinations</td>
<td>327,428</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)</td>
<td>Timely identification, treatment and review of patients with sepsis in ED and acute inpatient settings, Reduction in antibiotic consumption per 1,000 admissions</td>
<td>982,279</td>
<td>*£454,306 (46%) – Q4 3 out 4 elements not fully achieved</td>
<td>£861,450</td>
</tr>
<tr>
<td>Improving services for people presenting to A&amp;E with MH issues</td>
<td>Ensuring that people presenting at A &amp; E with MH needs have these needs met more effectively through an improved, integrated service, reducing their future attendance at A&amp;E</td>
<td>982,279</td>
<td>Q4 report not available yet</td>
<td>£861,450</td>
</tr>
<tr>
<td>Advice and Guidance</td>
<td>To improve GP access to consultant advice prior to referring patients in secondary care.</td>
<td>982,279</td>
<td>*£122,785 (16%) – Q4 report not available yet</td>
<td>£861,450</td>
</tr>
<tr>
<td>E-referrals: 1 year CQUIN only</td>
<td>Providers to publish ALL GP referrals to consultant-led 1st outpatient services on the NHS e-Referral Service. ALL First Outpatient Appointment slots available on NHS e-Referral Service by 31 March 2018.</td>
<td>982,279</td>
<td>*£368,355 (50%) – Q4 report not available yet</td>
<td>No 18/19</td>
</tr>
</tbody>
</table>

---

## CQUIN

<table>
<thead>
<tr>
<th>Description</th>
<th>17/18 Value (2% of eligible CV)</th>
<th>17/18 Lost income to end Q4</th>
<th>18/19 Potential Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Proactive &amp; safe discharge – suspended 18/19</td>
<td>Supporting proactive and safe discharge. Emergency Care Data Set (ECDS). Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline.</td>
<td>982,279</td>
<td>*£589,367 (100%)</td>
</tr>
<tr>
<td>Local CQUIN – Supporting Proactive and Safe Discharge</td>
<td>This new for 18/19 local CQUIN replaces the retired National Proactive and Safe Discharge (above) – based on the SAFER discharge bundle as a measure of the quality of discharges.</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Preventing ill health by risky behaviours – alcohol and tobacco (2018-19 only)</td>
<td>To help deliver on FYFV objectives particularly around the need for a ‘...radical upgrade in prevention...’ and to ‘...incentivising and supporting healthier behaviour’ (alcohol and tobacco) Also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving.</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>STP Engagement ‘CQUIN’</td>
<td>Expanded STP engagement for which the provider is required to meet the conditions and requirements to achieve this ‘CQUIN’</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Block contract agreement in place 17/18; not fully variable 18/19
2017/18 Performance to date

CCG commissioned

1. Q1 – Q3 performances across the board were generally good with no financial impact due to the year-end contract agreement with GCCG.
2. Still waiting full Q4 outcome report from commissioners.
3. There is an ongoing issue with WCCG as local variations were agreed with GCCG but not WCCG. This has led to a higher level of WCCG non-achievement that has not been easy to capture retrospectively.
4. With no block agreement we have incurred financial penalties but this is difficult to quantify.
5. The WCCG CQUIN value overall is £266k; 2% of eligible contract value

CQUINs that missed their milestones Q1-Q3:

1. Reducing the impact of Serious Infections (Antimicrobial Resistance and Sepsis):
   - In Q1 fell short of the upper payment for treatment time target (90% within 1 hour) for both ED (71%) and Inpatient Department (51%).
   - In Q2 there was improvement to ED (91%) and IP (71%). All other elements within this CQUIN (Timely Identification and Antibiotic Review) were fully achieved for this period.
   - Q3: the percentage of antibiotic prescriptions documented and reviewed within 72 hours was not achieved by 1%-74% against a target of 75%. The reduction of antibiotics by 1% usage target is not required to be met until Q4 Sepsis screening and identified patients receiving IV antibiotics within 1 hour: targets of above 90% achieved.
   - Q4 targets: Timely outcome IPED achieved; Timely treatment IPED: not achieved; Antibiotic review: not achieved; reduction in antibiotics: 2 of the 3 elements not achieved.
2. Improving services for people presenting to A&E with MH issues: Partial achievement; good work between providers, however, required meetings have not taken place and data submission is part of ECDS (currently not possible). No Q4 outcome yet
3. Advice & Guidance: partial services rolled out ahead of milestone. Quality standards for response times not consistently met. No Q4 outcome yet
4. E-referrals: working on the polling range issue and some targets were extended to Q3 rather than Q2. Partial gap analysis is late but expected to achieve 90% roll out target. No Q4 outcome yet
5. Supporting Proactive and Safe Discharge: Not achieved; no reports submitted; This CQUIN is being suspended 18/19 in line with National guidance.

Specialised commissioned

1. Medicines Optimisation: full achievement to Q3 (£364,237), Appealing not achieved Q4 milestones (£187,509)
2. Dose Banding SACT: full achievement Q1–Q4 achieved (£517,260)
3. Spinal Hub failed to achieve Q1 and Q2 (~£86,210); Q3 achieved (£43,105); failed Q4, appealing (£43,105)
4. Cardiac Devices failed to achieve Q2 (~£42,105); achieved Q3 and Q4 (£86,210)
5. Armed Forces failed to achieve Q2–Q4 (£6,418)

2018/19 CQUINS:

Following on from the 17/19 agreed two year contracts with commissioners we will be continuing the CQUINS started in 17/18 for 18/19 (as detailed in Table 1), with the addition of the National CQUIN Preventing ill health by risky behaviours – alcohol and tobacco and a locally derived CQUIN based on the SAFER discharge bundle as a measure of the quality of discharges-replacing the retired Supporting Proactive Discharge CQUIN.

Specialised Commissioning 2018/19 proposal in line with National Guidance has now been agreed:

1. Medicines Optimisation and Dose banding: continuing with some revision of milestones –achievable.
2. Spinal Hub: continuing, with some revision expected
3. Cardiac Devices: retired
4. C1 Enhanced Supportive Care for cancer pathways: new scheme for 18/19 now that the Complex Cardiac Devices scheme has been retired.
5. Armed Forces covenant: to be continued from 18/19

In line with National Guidance 18/19 schemes for acute provider’s will total 1.50% CVC, (a local scheme will attract the weighting created by the suspension of the proactive and safe discharge indicator (0.25%).

The remaining 1% of ECV (£3.3m) will be attached to the expanded STP engagement for which the provider is required to meet the conditions and requirements to achieve this ‘CQUIN’
Information Governance

The Trust’s Information Governance Toolkit score for 2017/18 has been published as 76%, and is graded green. The Information Governance Toolkit is available on the Health and Social Care information Centre (HSCIC) website (fgt.hscic.gov.uk). The information quality and records management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

The effectiveness and capacity of these systems is routinely monitored by our Trust’s Information Governance and Health Records Committee. A performance summary is presented to our Trust Board annually.

Information governance incidents including any data breaches classified using HSCIC guidance at level 1 or level 2 in severity are reviewed and investigated throughout the year and reported internally through the Trust’s Information Governance and Health Records Committee.

In addition any level 2 severity incidents are reported to the Information Commissioner’s Office in accordance with HSCIC reporting guidelines.

Further action on information risk

GHNHSFT will continue to monitor and assess its information risks, in light of the incidents on the opposite page.

The processes and controls within the teams involved have been reviewed in order to identify and address any weakness and ensure the improvement of systems where required. Extensive communication to trust staff specifically highlighting the need to ensure safe keeping of handover sheets has been introduced as a regular reminder. Additional controls have been implemented including tighter controls on each ward in terms of who can print them and how they are distributed. Further plans in progress to improve ease of confidential disposal of handover sheets. A review of data processing procedures that resulted in information being copied to server in USA has been carried out by system supplier and assurance received that these have been corrected.

Summary of Serous Incident requiring investigations involving personal data as reported to the Information Commissioner’s Office in 2017–18 (Level 2)

<table>
<thead>
<tr>
<th>Date of incident</th>
<th>Nature of incident</th>
<th>Nature of data involved</th>
<th>No. of data subjects potentially affected</th>
<th>Notification steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 April 2017</td>
<td>Lost or stolen paperwork</td>
<td>A doctor’s ward handover sheet found in a public place by a member of Trust Staff</td>
<td>25</td>
<td>Patients not contacted, as information had been contained within the trust</td>
</tr>
<tr>
<td>15 April 2017</td>
<td>Lost or stolen paperwork</td>
<td>Ward Nursing handover sheet found in a public place by a member of Trust Staff</td>
<td>27</td>
<td>Patients not contacted, as information had been contained within the trust</td>
</tr>
<tr>
<td>14 Sep. 2017</td>
<td>Non-secure Disposal – paperwork</td>
<td>MDT meeting notes including an identifiable list of patients received by another care provider in a box delivered from stores</td>
<td>17</td>
<td>Patients not contacted, as information secured and destroyed by NHS care provider</td>
</tr>
<tr>
<td>20 Sep. 2017</td>
<td>Lost or stolen paperwork</td>
<td>Ward handover sheet found in a public place by a member of Trust Staff</td>
<td>20</td>
<td>Patients not contacted, as information had been contained within the trust</td>
</tr>
<tr>
<td>29 Sep. 2017</td>
<td>Disclosed in Error</td>
<td>Copy of discharge summary data transferred to a server located in the USA in error.</td>
<td>18</td>
<td>Patients not contacted, as information had been secure at all times.</td>
</tr>
<tr>
<td>12 October 2017</td>
<td>Lost or stolen paperwork</td>
<td>Ward handover sheet found in a public place by a member of Trust Staff</td>
<td>35</td>
<td>Patients not contacted, as information had been contained within the trust</td>
</tr>
<tr>
<td>01-Nov-17</td>
<td>Lost or stolen paperwork</td>
<td>A doctor’s ward handover sheet found in a public place by a member of Trust Staff</td>
<td>30</td>
<td>Patients not contacted, as information had been contained within the trust</td>
</tr>
<tr>
<td>10-Nov-17</td>
<td>Disclosed in Error</td>
<td>Emergency department discharge summaries sent in error to another health and social care provider</td>
<td>8</td>
<td>Patients not contacted, as information secured and destroyed by health and social care provider</td>
</tr>
<tr>
<td>24-Nov-17</td>
<td>Lost or stolen paperwork</td>
<td>Ward handover sheet found in a public place by a member of Trust Staff</td>
<td>30</td>
<td>Patients not contacted, as information had been contained within the trust</td>
</tr>
</tbody>
</table>
Quality of data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data (please note this is for the period April 2017 to February 2018).

The percentage of records in the published data which included the patient’s valid NHS number was:
- 99.8% for admitted patient care
- 100% for outpatient care
- 99% for accident and emergency care

The percentage of published data which included the patient’s valid General Medical Practice Code was:
- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care

Gloucestershire Hospitals NHS Foundation Trust will, as always, be taking actions to improve data quality.
We have a data quality action plan which is aligned to Schedule 6 of the contract with our lead commissioners.
This action plan covers our requirements to submit our statutory reporting requirements.

Clinical coding

Gloucestershire Hospitals NHS Foundation Trust was not subject to the “Payment by Results clinical coding audit” during 2017/18.

The Care Quality Commission (CQC)

Gloucestershire Hospitals NHS Foundation Trust has had a number of inspections since first registering with CQC. The last full inspection occurred in March 2015 and was an announced comprehensive inspection.

Our current registration status is “Requires Improvement”. CQC carried out a focused announced inspection 24–27 January 2017 and a focused unannounced inspection at Gloucestershire Royal on 6 February 2017.

This focused inspection was to follow-up on concerns from the previous full inspection. As such, not all domains were inspected in all core services.

The inspection team inspected the following seven core services at Gloucestershire Royal Hospital:
- Urgent and emergency services
- Medical care (including older people’s care)
- Surgery
- Maternity and gynaecology
- Services for children’s and young people
- End of life care
- Outpatients and diagnostic imaging

They did not inspect the critical care services (previously rated outstanding). The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2017/18.

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

There is a Responsive Action plan which responds to all the CQC “must do” and “should do” actions. Progress against this plan is being monitored through the Quality and Performance Committee.

CQC ratings for Gloucestershire Royal Hospital

<table>
<thead>
<tr>
<th>Service</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-Led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Medical care</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Surgery</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>N/A</td>
<td>Requires Improvement</td>
<td>N/A</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Maternity and gynaecology</td>
<td>Requires Improvement</td>
<td>N/A</td>
<td>N/A</td>
<td>Requires Improvement</td>
<td>N/A</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>Good</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Outpatients and diagnostic imaging</td>
<td>Requires Improvement</td>
<td>N/A</td>
<td>N/A</td>
<td>Requires Improvement</td>
<td>N/A</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Overall</td>
<td>Requires Improvement</td>
<td>N/A</td>
<td>N/A</td>
<td>Requires Improvement</td>
<td>N/A</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>
### CQC list of “Must do” actions: Areas for improvement from CQC inspection in 2017

<table>
<thead>
<tr>
<th>“Must do” area for improvement</th>
<th>Status 31 March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review processes to monitor the acuity of patients to ensure safe staffing levels.</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure wards are compliant with legislation regarding the Control of Substances Hazardous to Health</td>
<td>In progress</td>
</tr>
<tr>
<td>Review processes for ensuring effective cleaning of ward areas and equipment and patient waiting areas.</td>
<td>In progress</td>
</tr>
<tr>
<td>Review the governance and effectiveness of care and treatment through national audits.</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure patient records are kept securely always.</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure equipment is replaced to ensure safe diagnosis and treatment. (In report this relates to cardiac equipment)</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure the medical day unit is suitable for the delivery of care and protects patient’s dignity and confidentiality.</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure all staff are trained and understand their responsibilities in a resuscitation situation.</td>
<td>Complete</td>
</tr>
<tr>
<td>Ensure resuscitation equipment is readily available and accessible to staff.</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure steps are taken to reduce the current typing backlog in some specialities.</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure specialties have oversight of their waiting lists.</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure that all information related to patient’s mental capacity and consent for ‘Do Not Attempt Cardio-Pulmonary Resuscitation’ (DNA CPR) is available in the patient records.</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure trust staff comply with the requirements of the Mental Capacity Act (2005)</td>
<td>In progress</td>
</tr>
<tr>
<td>Ensure the Emergency Department is consistently staffed to planned levels to deliver safe, effective and responsive care.</td>
<td>In progress</td>
</tr>
<tr>
<td>Review support staff functions to ensure the emergency department is adequately supported.</td>
<td>In progress</td>
</tr>
</tbody>
</table>
Learning from deaths

During 2017/18 2,147 of Gloucestershire Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 547 in the first quarter
- 428 in the second quarter
- 527 in the third quarter
- 645 in the fourth quarter

All cases are reviewed by medical examiner as per Trust policy. So record reviews by quarter:

- 547 in the first quarter
- 428 in the second quarter
- 527 in the third quarter
- 557 in the fourth quarter (not all case reviews completed)

Total investigations in the first 3 quarters of 2017/18 are 1025 undertaken by specialties of which 377 were subjected to detailed investigation. We do not currently have the investigations by quarter available so this figure is a combined figure.

In summary 100% of cases are reviewed by the medical examiner.

In the period 1 April 2017 – 31 December 2017 (the first three quarters of 2017/18 –

- 1025 of 1502 (68.2%) of cases were investigated by the relevant specialty
- 377 of 1502 (25.1%) had a detailed review undertaken.

In the period 1 April 2017 – 31 December 2017 (the first three quarters of 2017/18 –

- 22 death investigations are judged to be more likely than not to have been due to problems in the care provided to the patient.

This represents 22 of 1502 (1.46%) deaths in the period

Summary of learning from case record reviews and investigations conducted in relation to the deaths identified above:-

- Important to optimise the handover between medical/nursing teams for sick patients (particularly on transfer) resulting in lack of follow-up of investigation results
- Care when discharging sick patients from ED to avoid missed opportunities for continuing care
- Reviewing blood results on patients discharged from ED
- Prioritising urgent CT head scans in at risk patients
- Patient falls: identifying patients at risk and minimising these risks
- Ensuring initiation of non-invasive ventilation where appropriate
- Identifying the deteriorating patient
- Prompt treatment of sepsis.

Description of the actions and learning:

- Review of handover documentation and handover processes with junior doctors
- Optimising the use of ED documentation in transfer to ward care
- Change and development of new paperwork in the emergency department being assessed as pilot project
- New policy on indications for CT head scans and monitoring against these standards
- Trust wide falls group established by Chief Nurse and reporting to Quality and Performance Committee
- Increased input of respiratory senior team to acute medical unit and at ward level
- Continued work though the Trust deteriorating patient group to ensure appropriate timely management of patients
- Continued embedding of sepsis six pathway across the Trust with clear evidence of improved outcome for patients with sepsis.

An assessment of impact is that this work has been significant as service change has resulted from death reviews within this reporting period.

The number of case record reviews taking place before this period is not available as this was not recorded.

Seven day services

The Trust is working towards delivery on the National 7 day service standards and have undertaken a self-assessment during February 2018, against the 4 key standards for 7 Day Services for actions 18/19. Namely

- Consultant review
- Consultant on-going review
- Access to diagnostics
- Access to Consultant Directed interventions

The Trust have undertaken self-assessment against 6 key areas.

There are 6 sections of the tool to complete:

1. Leadership and governance
2. Data capture and information quality
3. Performance and change management
4. Policy and Procedures
5. Workforce readiness
6. Risks and mitigating actions

The Trust is developing an action plan for the 4 key standards into 18/19, with feedback from NHS England and from our audit findings.
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.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>GHNHSFT</th>
<th>National average</th>
<th>Highest trust fig</th>
<th>Lowest trust fig</th>
<th>Explanation of why GHNHSFT considers that the data from the HSQC are as described</th>
<th>Actions GHNHSFT intends to take to improve indicator and quality of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) SHMI for trust for the reporting period</td>
<td>2015/16</td>
<td>1.13</td>
<td>1.00</td>
<td>1.178</td>
<td>0.68</td>
<td>1.0872, within the expected range using NHS Digital’s published banding (W)</td>
<td>The Trust’s figures are within expected range. We run a Trust Mortality Review Group, chaired by the Medical Director, which reviews this indicator and other more granular parameters in relation to mortality. We also use the Dr Foster Intelligence System to monitor mortality indicators.</td>
</tr>
<tr>
<td></td>
<td>2016/17</td>
<td>1.12</td>
<td>1.00</td>
<td>1.23</td>
<td>0.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2017/18</td>
<td>1.09</td>
<td>1.00</td>
<td>1.11</td>
<td>0.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period</td>
<td>2015/16</td>
<td>20.9%</td>
<td>28.5%</td>
<td>54.6%</td>
<td>0.6%</td>
<td>*last data published June ‘17 for data period July ’16–Jun ’17</td>
<td>As above.</td>
</tr>
<tr>
<td></td>
<td>2016/17</td>
<td>21.0%</td>
<td>31.1%</td>
<td>58.6%</td>
<td>11.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2017/18*</td>
<td>26.1%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patient safety incidents / number which resulted in severe harm or death</td>
<td>2015/16</td>
<td>11,517 / 40</td>
<td>9,465 / 39</td>
<td>23,990 / 60</td>
<td>3,510 / 26</td>
<td>*2015/16 Published September 2016. No new data release</td>
<td>Our comparative reporting rate for incidents in all acute Trusts shows us as being in the middle 50% reporters.</td>
</tr>
<tr>
<td></td>
<td>2016/17</td>
<td>6,932 / 22</td>
<td>4955 / 19</td>
<td>23,990 / 60</td>
<td>3,510 / 26</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2017/18*</td>
<td>14,762 / 1</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate per 100 admissions of patient safety incidents resulting / rate per 100 admissions resulting in severe harm or death</td>
<td>2015/16</td>
<td>30.04 / 0.2</td>
<td>35.77 / 0.18</td>
<td>73.46 / 0.82</td>
<td>18.6 / 0.35</td>
<td>*2015/16 Published Sep-16. No new data release</td>
<td>Our comparative reporting rate for incidents in all acute Trusts shows us as being in the middle 50% reporters.</td>
</tr>
<tr>
<td></td>
<td>2016/17</td>
<td>41.82 / 0.13</td>
<td>39.89 / 0.15</td>
<td>71.81 / 0.6</td>
<td>21.15 / 0.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2017/18</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of C diff (per 100,000 bed days) among patients aged over two</td>
<td>2015/16</td>
<td>11.4</td>
<td>15.0</td>
<td>62.6</td>
<td>0.0</td>
<td>*Last Publication in July 2017 / with data up to end March 17</td>
<td>The Trust will continue to monitor C diff rates on a monthly basis and an improvement plan has been developed which has been implemented. The plan will be monitored via the Quality Delivery Group.</td>
</tr>
<tr>
<td></td>
<td>2016/17</td>
<td>12.5</td>
<td>13.2</td>
<td>82.7</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2017/18*</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients risk assessed for VTE</td>
<td>2015/16</td>
<td>93.3%</td>
<td>96.1%</td>
<td>100.0%</td>
<td>88.6%</td>
<td>*Data period: Apr16 – Dec16. Published March 2017</td>
<td>An audit of VTE assessments has been commissioned and an improvement plan will be put in place once the issues have been diagnosed.</td>
</tr>
<tr>
<td></td>
<td>2016/17</td>
<td>93.5%</td>
<td>95.6%</td>
<td>100.0%</td>
<td>78.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2017/18</td>
<td>90.0%</td>
<td>95.3%</td>
<td>100.0%</td>
<td>77.0%</td>
<td>Data only includes Q1 – 3 (GHNHSFT did not submit data for Q1 17/18)</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Year</td>
<td>GH/NHST</td>
<td>National average</td>
<td>Highest trust fig</td>
<td>Lowest trust fig</td>
<td>Explanation of why GH/NHST considers that the data from the HSCIC are as described</td>
<td>Actions GH/NHST intends to take to improve indicator and quality of services</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>----------</td>
<td>------------------</td>
<td>-------------------</td>
<td>-----------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Percentage of patients aged 0–15 readmitted to hospital within 28 days of being discharged</td>
<td>2011/12*</td>
<td>9.88%</td>
<td>10.26%</td>
<td>14.94%</td>
<td>6.40%</td>
<td>The data on the HSIC has not been updated beyond 2011/12. This indicator is no longer reported locally. The preferred national and local indicator is now readmissions within 30 days which is broadly consistent with this indicator.</td>
<td>*Published March 2014. No further data as at 01/03/2018.</td>
</tr>
<tr>
<td>2012/13</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013/14</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014/15</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015/16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016/17</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017/18</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmissions within 28 days: age 16 or over</td>
<td>2011/12*</td>
<td>10.52%</td>
<td>11.45%</td>
<td>13.80%</td>
<td>9.34%</td>
<td>No national data has been published since 2011/12. This indicator is no longer reported locally. The preferred national and local indicator is now readmissions within 30 days which is broadly consistent with this indicator.</td>
<td>*Published March 2014. No further data as at 01/03/2018.</td>
</tr>
<tr>
<td>2012/13</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013/14</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014/15</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015/16</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016/17</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017/18</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsiveness to inpatients’ personal needs</td>
<td>2015/16</td>
<td>66.5</td>
<td>68.9</td>
<td>86.1</td>
<td>59.1</td>
<td>Last Data Published August 2017 for 2017/18 FY</td>
<td>Patient experience insight data is used to drive improvements. There will be a focused Trust project on improving discharge experience.</td>
</tr>
<tr>
<td>2016/17</td>
<td>67.7</td>
<td>69.6</td>
<td>86.2</td>
<td>58.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017/18</td>
<td>63.6</td>
<td>68.1</td>
<td>85.2</td>
<td>60.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Friends &amp; Family Test Q12d (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)</td>
<td>2015/16</td>
<td>69.0%</td>
<td>65.0%</td>
<td>85.4%</td>
<td>46.0%</td>
<td></td>
<td>Staff Experience insight data is used by the organisation to improve staff experience.</td>
</tr>
<tr>
<td>2016/17</td>
<td>64.0%</td>
<td>70.0%</td>
<td>84.8%</td>
<td>48.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017/18</td>
<td>61.0%</td>
<td>70.0%</td>
<td>93.0%</td>
<td>42.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient Reported Outcome Measures (PROMs) collect information on the effectiveness as perceived by the patients themselves of the NHS care they have received. Since April 2009, patients undergoing four different types of elective surgery – hip replacement, knee replacement, and groin hernia repair – have been invited to complete lifestyle questionnaires before and after their operations. Their responses are converted into scores and when taken with other clinical information, they allow the effectiveness of treatments to be assessed and hospital providers to be compared. Two well-established general health and lifestyle surveys are used – EQ-SD & EQ-VAS (EuroQol five-dimensional descriptive health questionnaire and visual analogue scale) – alongside condition-specific questionnaires – Aberdeen Varicose Vein Questionnaire, Oxford Hip Scores and Oxford Knee Scores – each of which pose questions relating to the individual experience of the patient with the condition.

Patients complete these surveys and questionnaires before and after their operations and the difference in their scores are used as a measure of the improvement resulting from their operation being carried out.

The figures we have reported in the figure below are the percentage of patients reporting an improvement in their health and well-being after their procedure as measured by each of the questionnaires. The figure for the Trust is shown against the England average improvement rate for comparison.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>EQ-SD Trust %</th>
<th>EQ-SD England %</th>
<th>EQ VAS Trust %</th>
<th>EQ VAS England %</th>
<th>Condition-specific measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groin</td>
<td>50.8%</td>
<td>50.9%</td>
<td>37.9%</td>
<td>37.6%</td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td>89.2%</td>
<td>89.6%</td>
<td>63.8%</td>
<td>66.5%</td>
<td>97.0%</td>
</tr>
<tr>
<td>Knee</td>
<td>80.9%</td>
<td>81.6%</td>
<td>54.8%</td>
<td>56.4%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Varicose veins</td>
<td>50.0%</td>
<td>52.7%</td>
<td>31.4%</td>
<td>40.3%</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

<table>
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</tr>
</thead>
<tbody>
<tr>
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<td>53.4%</td>
<td>51.3%</td>
<td>52.6%</td>
<td>39.2%</td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td>81.3%</td>
<td>89.1%</td>
<td>59.1%</td>
<td>67.2%</td>
<td>91.6%</td>
</tr>
<tr>
<td>Knee</td>
<td>85.2%</td>
<td>81.1%</td>
<td>54.1%</td>
<td>57.4%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Varicose veins</td>
<td>47.6%</td>
<td>51.9%</td>
<td>33.3%</td>
<td>40.3%</td>
<td>85.7%</td>
</tr>
</tbody>
</table>

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST QUALITY ACCOUNT 2017/18

Figure: Patient Reported Outcomes Measures

April – March 2016

<table>
<thead>
<tr>
<th>Procedure</th>
<th>EQ-SD Trust %</th>
<th>EQ-SD England %</th>
<th>EQ VAS Trust %</th>
<th>EQ VAS England %</th>
<th>Condition-specific measure</th>
</tr>
</thead>
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</tr>
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</tr>
</tbody>
</table>

April – March 2016

<table>
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<th>EQ VAS England %</th>
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</thead>
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<td>40.3%</td>
<td>85.7%</td>
</tr>
</tbody>
</table>
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.

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.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2016/17</th>
<th>2017/18</th>
<th>National target (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium difficile year on year reduction</td>
<td></td>
<td></td>
<td>37 cases per year</td>
</tr>
<tr>
<td>MRSA bacteraemia at less than half the 2003/4 level: post 48hrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSSA</td>
<td>3</td>
<td>4(2)</td>
<td></td>
</tr>
<tr>
<td>Never events</td>
<td>2</td>
<td>6(2)</td>
<td></td>
</tr>
<tr>
<td>Risk assessment for patients with VTE</td>
<td>93.5%(6)</td>
<td>83.98%(1)</td>
<td></td>
</tr>
<tr>
<td>Crude mortality rate</td>
<td>1.3%</td>
<td>1.2%(3)</td>
<td></td>
</tr>
<tr>
<td>Dementia 1a: Case finding</td>
<td>88.5%</td>
<td>0.8%(7)</td>
<td></td>
</tr>
<tr>
<td>Dementia 1b: Clinical assessment</td>
<td>100%</td>
<td>65.0%(7)</td>
<td></td>
</tr>
<tr>
<td>Dementia 1c: Referral for management</td>
<td>100%</td>
<td>11.00%(7)</td>
<td></td>
</tr>
<tr>
<td>% patients spending 4 hours or less in ED</td>
<td></td>
<td></td>
<td>95.0%</td>
</tr>
<tr>
<td>Number of ambulance handovers delayed over 30 minutes *(&lt;=1hr)</td>
<td>1884</td>
<td>506(1)</td>
<td>0</td>
</tr>
<tr>
<td>Number of ambulance handovers delayed over 60 minutes</td>
<td>26</td>
<td>16(1)</td>
<td>0</td>
</tr>
<tr>
<td>Indicator</td>
<td>2016/17</td>
<td>2017/18</td>
<td>National target (if applicable)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Emergency readmissions within 30 days: elective &amp; emergency</td>
<td>6.4%</td>
<td>6.9%(1)</td>
<td></td>
</tr>
<tr>
<td>% stroke patients spending 90% of time on stroke ward</td>
<td>85.6%</td>
<td>89.3%(4)</td>
<td>80.0%</td>
</tr>
<tr>
<td>% of women seen by midwife by 12 weeks</td>
<td>87.3%</td>
<td>89.5%(5)</td>
<td>90.0%</td>
</tr>
<tr>
<td>Number of written complaints</td>
<td>913</td>
<td>1031</td>
<td></td>
</tr>
<tr>
<td>Rate of written complaints per 1000 inpatient spells</td>
<td>5.4</td>
<td>6.26%(9)</td>
<td></td>
</tr>
<tr>
<td>Max 2 week wait for patients urgently referred by GP</td>
<td>89.2%</td>
<td>82.3%(8)</td>
<td>93.0%</td>
</tr>
<tr>
<td>Max 2 week wait for patients referred with non cancer breast symptoms</td>
<td>93.2%</td>
<td>90.4%(3)</td>
<td>93.0%</td>
</tr>
<tr>
<td>Max 31 days decision to treat to first definitive treatment</td>
<td>96.8%</td>
<td>96.3%(7)</td>
<td>96.0%</td>
</tr>
<tr>
<td>Max 31 days decision to treat to subsequent treatment: surgery</td>
<td>94.7%</td>
<td>94.8%(3)</td>
<td>94.0%</td>
</tr>
<tr>
<td>Max 31 days decision to treat to subsequent treatment: drugs</td>
<td>100.0%</td>
<td>99.8%(1)</td>
<td>98.0%</td>
</tr>
<tr>
<td>Max 31 days decision to treat to subsequent treatment: radiotherapy</td>
<td>99.3%</td>
<td>99.1%(1)</td>
<td>94.0%</td>
</tr>
<tr>
<td>Max wait 62 days from urgent GP referral to 1st treatment (excl. rare cancers)</td>
<td>74.9%</td>
<td>75%(3)</td>
<td>85.0%</td>
</tr>
<tr>
<td>Max wait 62 days from national screening programme to 1st treatment</td>
<td>92.5%</td>
<td>92.2%(1)</td>
<td>90.0%</td>
</tr>
<tr>
<td>18 week max wait from the point of referral to treatment (admitted patients adjusted)</td>
<td>77.6%(2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 week max wait from point of referral to treatment (non-admitted patients adjusted)</td>
<td>87.1%(2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways</td>
<td>78.9%(2)</td>
<td></td>
<td>92.0%</td>
</tr>
<tr>
<td>Average occupied bed days</td>
<td>5469</td>
<td>10507</td>
<td></td>
</tr>
<tr>
<td>Average bed delays</td>
<td>285</td>
<td>332</td>
<td></td>
</tr>
<tr>
<td>Delayed Transfer of Care rate</td>
<td>5.21%</td>
<td>3.16%</td>
<td></td>
</tr>
<tr>
<td>Number of delayed discharges at month end</td>
<td>N/A</td>
<td>30(10)</td>
<td></td>
</tr>
</tbody>
</table>

(1) 2017/18 complete year
(2) 2016/17 data period: April 16 to November16
(3) Unvalidated 2017/18 figure up to March 2018
(4) Unvalidated Position: April 17 to March 18
(5) Unvalidated Position: April 17 to January 18
(6) 2016/17 reporting period April 16 to December 16. We were unable to report from December 2016.
(7) 2017/18 figure only from September 17 to March 18
(8) 2017/18 figure up to February 2018
(9) This figure is the Year to date figure to the end of Q3, as activity for Q4 has not yet been confirmed.
(10) Unvalidated
ANNEX 1

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

NHS Gloucestershire CCG Comments in Response to Gloucestershire Hospitals NHS Foundation Trust Quality Report 2017/18

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2017/18.

The past year has continued to present major challenges across both Health and Social care in Gloucestershire and we are pleased that GHNHSFT have worked jointly with partner organisations, including the CCG and colleagues within the local authority during 2017/18 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers. We wish to acknowledge the Trust’s continued contribution and ongoing commitment to the development of the Sustainability and Transformation Plan for Gloucestershire (STP).

Following the CCG inspection in January 2017, GHNHSFT were awarded an overall rating of ‘requires improvement’ which was the same as the previous rating awarded in 2015. However, it is pleasing to see that there were some areas that had improved, in particular ‘End of Life care’ was rated as ‘good’. The CCG recognise the comprehensive action plan that has been developed in response to the inspection and welcome the Trusts commitment to ensuring the ‘fundamentals of care’ are of the highest standard at all times. The CCG have good visibility of the action plan and the progress that is being made against the deliverables.

The 2017/18 Quality Report is clear, easy to read and identifies how the Trust performed against the agreed quality priorities for improvement for 2017/18 and also outlines their priorities for improvement in 2018/19. The report is open and transparent and it is noted that the Trust have acknowledged the areas where the achievements have not been realised as quickly as they had aimed for. The CCG endorses the quality priorities that have been selected for 2018/19, whilst acknowledging the very difficult financial challenges GHNHSFT have to address in the coming year. The CCG are particularly pleased to see that ‘Pressure Ulcers’ and ‘Falls reduction’ have been prioritised for improvement.

The CCG recognises the significant pressures that GHNHSFT experienced during the winter months but are pleased to note that the 4 hour A&E performance has significantly improved and congratulate the Trust on their achievement. The 10% improvement in patient reported outcomes of the emergency department is particularly pleasing to see. The focussed work that enables those with mental health needs who attend an emergency department is welcomed and the collaborative approach between the Trust and Gloucestershire’s main Mental Health provider is demonstrating significantly improved outcomes for those in need of this level of support.

The CCG would like to congratulate the Trust for their comprehensive work regarding the Safety and Quality Improvement Academy and the quality improvement initiatives delivered to date. This approach is endorsed by the CCG and welcomes the strengthening of a culture of continuous quality improvement. This approach is particularly evident within addressing expected mortality rates and it is encouraging to see that there has been a 14% reduction in mortality over the last year. The CCG are pleased to see that two areas in particular have contributed to this improvement, those being significantly improved outcomes for those with a hip fracture and the detection and timely treatment of sepsis, specifically within the Emergency department.

The CCG understands the issues that have arisen in relation to the implementation of Trakcare. The CCG note that the Trust now fully understands the operational and safety issues encountered and are sighted on the recovery plan. The CCG recognise the work now being undertaken to address the issues although the flow of information from the Trust has been severely disrupted and this has potentially led to a reduction in the quality of care for patients and the effectiveness of communication with the wider health community in Gloucestershire.

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

The CCG notes the work that GHNHSFT have undertaken in relation to proactive and safe discharge planning. Whilst it recognises that not all elements of the work programme were achieved in year, the ongoing commitment and energy is welcomed.

We are pleased to see the proposed improvement plans that aim to reduce infection rates at GHNHSFT, in particular C-diff. The CCG aim to work closely with the Trust to provide support where required and monitor anticipated improvement within this area.

The CCG acknowledges the content provided on
staff wellbeing and in particular the staff survey results. The CCG found the staff survey results disappointing but recognise the wider work planned to address this. The CCG were extremely pleased to see such a large increase in the uptake of flu vaccinations amongst staff and acknowledge the significant efforts that went into this year’s campaign. The CCG is aware of the improved focus of patient experience with the Trust and is looking forward to seeing some closer working with the new Healthwatch provider in 2018/19.

GHNHSFT need to be in a strong position to manage both present and future challenges. The CCG will continue work with the Trust to deliver acute services that provide best value whilst having a clear focus on providing high quality, safe and effective care for the people of Gloucestershire.

Gloucestershire CCG confirms that to the best of our knowledge we consider that the 2017/18 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT. During 2018/19 the CCG will work with GHNHSFT, all stakeholders including the people of Gloucestershire, to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the acute hospital services provided to the residents of Gloucestershire and beyond.

Dr Marion Andrews-Evans
Executive Nurse & Quality Lead
NHS Gloucestershire CCG
The committee was pleased to note that the Trust remains in financial special measures but is still not meeting all of the cancer targets. These are challenging times for the NHS Trust (GHNHSFT) Quality Account 2017/18.

The committee is aware of the issues arising from the implementation of the TrackCare system at the Trust in 2016, and the impact that this has had on the recovery from the financial deficit position. Committee members will continue to closely monitor this situation.

On behalf of the committee I particularly wish to thank Deborah Lee and Peter Latchcki for their engagement with the committee, and their willingness to answer the many questions asked by committee members. I would also like to thank Dr Sally Pearson for her many years work with the committee, and wish her well for the future.

Cllr Carole Allaway Martin
Chairman
Health and Care Scrutiny Overview and Committee

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Quality Account 2017/18. I consider that this is an open and honest Quality Account that does not shy away from the challenges faced by the Trust, it is clear where improvement is still needed, and has both patients and staff wellbeing at its centre.

These are challenging times for the NHS both at the national and local level. Whilst there is still much to do I feel that the new leadership team has reinvigorated the Trust and has a clear sense of direction.

The committee remains concerned that the Trust is still not meeting all of the cancer targets. The committee welcomes the introduction of standardised doses of anticancer therapies. Given that the 4 hour A & E target is an indicator of how well the patient flow is through the hospital the committee welcomes the significant improvement in performance against this target. It was also good to see the positive partnership working across health and social care partners over the ‘winter’ period which delivered a robust response to significant demand.

The committee was pleased to note that the Trust has been awarded £39.5m capital funding to modernise hospital buildings, transform services and deliver even better patient care. Committee members particularly welcome that some of this funding will be spent on creating a safe space at Cheltenham General for staff to better manage people presenting with mental health issues.

The committee remains concerned that the Trust remains in financial special measures but acknowledges the work that the Trust is doing to redress this situation. Committee members are impressed that given this challenging financial situation the Trust has been able to improve and deliver better services to the patient, e.g. trauma and orthopaedic services and sepsis management. It is important not to overlook the turnaround in performance, through robust partnership working, with regard to delayed transfers of care.

The committee is aware of the issues arising from the implementation of the TrackCare system at the Trust in 2016, and the impact that this has had on the recovery from the

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

We have been engaged by the council of governors of Gloucestershire Hospitals NHS Foundation Trust (‘the Trust’) to perform an independent assurance engagement in respect of Gloucestershire Hospitals NHS Foundation Trust’s quality report for the year ended 31 March 2018 (the ‘Quality Report’) and certain performance indicators contained therein. This report is made solely to the Trust’s Council of Governors, as a body, in accordance with our engagement letter dated 14 May 2018. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018 to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

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

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

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge on page 81 of 93 of the quality report, and
- Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer on page 82 of 93 of the quality report.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and Ernst & Young LLP

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual 2017/18’ issued by NHS Improvement.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS Foundation Trust Annual Reporting Manual 2017/18’, which is supported by NHS Improvement’s Detailed Requirements for quality reports 2017/18;
- the quality report is not consistent in all material respects with the sources specified in detailed in Section 2.1 of the ‘Detailed guidance for external assurance on quality reports 2017/18’ and the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the ‘NHS Foundation Trust Annual Reporting Manual 2017/18’ and supporting guidance and the six dimensions of data quality set out in the ‘Detailed Guidance for External Assurance on Quality Reports 2017/18’.

We read the Quality Report and consider whether it addresses the content requirements of the ‘NHS Foundation Trust Annual Reporting Manual 2017/18’ and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We refer the other information contained in the quality report and consider whether it is materially inconsistent with the other information sources detailed in Section 2.1 of the ‘Detailed guidance for external assurance on quality reports 2017/18’. These are:

- Board minutes for the period April 2017 to May 2018
- Papers relating to quality reported to the Board over the period April 2017 to May 2018
- feedback from commissioners, dated 20/05/2018
feedback from governors, dated May 2018
feedback from local Healthwatch organisations, dated 15/05/2018
feedback from Overview and Scrutiny Committee dated 10/05/2018
the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2017
the latest national patient survey, dated 2017
the latest national staff survey, dated 2017
Care Quality Commission inspection, dated 05/05/2017, and
the Head of Internal Audit’s annual opinion over the trust’s control environment, dated May 2018.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Gloucestershire Hospitals NHS Foundation Trust's quality agenda, performance and activities.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Gloucestershire Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the ‘NHS Foundation Trust Annual Reporting Manual 2017/18’ to the categories reported in the Quality Report; and
- reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the ‘NHS foundation trust annual reporting manual 2017/18’ and supporting guidance. The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Gloucestershire Hospitals NHS Foundation Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2018 and the Detailed requirements for quality reports 2017/18 published in January 2018 (updated in February 2018) issued by NHS Improvement;
- the Quality Report is not consistent in all material respects with the sources specified in ‘Detailed guidance for external assurance on quality reports 2017/18’; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with NHS Foundation Trust Annual Reporting Manual 2018 and the Detailed requirements for quality reports 2017/18 published in January 2018 (updated in February 2018) issued by NHS Improvement.

Ernst & Young LLP
Reading, 29 May 2018

The following foot note should be added to the assurance report when it is published or distributed electronically:

Notes:
1. The maintenance and integrity of the Gloucestershire Hospitals NHS Foundation Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the web site.
2. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.
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.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality account. In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to May 2018
  - papers relating to quality reported to the board over the period April 2017 to May 2018
  - feedback from commissioners dated 20/05/2018
  - feedback from governors dated 04/05/2018
  - feedback from local Healthwatch organisations dated 15/05/2018
  - feedback from Overview and Scrutiny Committee dated 10/05/2018
  - the trust’s complaints report to be published, under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, in June 2017
  - 2017 National patient Surveys
  - 2017 National Staff Survey
  - the Head of Internal Audit’s annual opinion over the trust’s control environment dated 18/05/2018
  - the Quality Account presents a balanced picture of the NHS Foundation Trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- The Quality Account has been prepared in accordance with NHS Improvement’s annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The directors confirm to the best of their knowledge and belief they have complied with all of the above requirements in preparing the Quality Account, with the exception of the statement relating to data quality.

The data underpinning the measure of performance reported in the Quality Account, up to the end of November 2016, is robust and reliable and conforms to specified data quality standards and prescribed definitions and has been subject to appropriate scrutiny and review.

Following the implementation of a new Patient Administration System in December 2016, the Trust was unable to assure the data quality of information extracted from the system to support:

- Referral to Treatment times – Reporting still suspended
- Dementia assessment and referral – re-commenced reporting in October'17 (September Data)
- Monthly activity return – Re-Commenced reporting August 2017 (July Data)

A suspension of reporting was agreed with NHS Improvement as the regulator and a recovery plan is in place. Key elements of the action plan address:

- Changes to the system
- Addressing backlogs of data
- Improving data quality
- Re-establishing reporting.

By order of the Board,

Deborah Lee, Chief Executive

Peter Lachecki, Chair
Glossary

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

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

CGH: Cheltenham General Hospital

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

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

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

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

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

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

Emergency Department: Otherwise known as A&E

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

GRH: Gloucestershire Royal Hospital

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

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

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

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

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

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

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

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

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

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

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

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

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

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