PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Thursday 10 September 2020 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies	Chair		12:30	
1.	Staff story	Emma Wood			
2.	Declarations of interest	Chair		13:00	
3.	Minutes of the previous meeting	Chair	Approval		YES
4.	Matters arising	Chair	Approval		YES
5.	Update from the Chair	Chair	Approval		YES
6.	Chief Executive Officer's report	Deborah Lee	Information	13:05	YES
7.	Trust risk register	Emma Wood	Approval	13:20	YES
8.	Board Assurance Framework	Sim Foreman	Assurance	13:30	YES
	PEOPLE AND ORGANISATIONAL DEVELOPMENT				
9.	Equality, Diversity & Inclusion action plan	Emma Wood	Information	13:40	YES
10.	People and Organisational Development report	Emma Wood	Information	13:50	YES
11.	Assurance report of the Chair of the People & OD Committee	Balvinder Heran	Assurance		YES
	BREAK			14:00	
	QUALITY AND PERFORMANCE				
12.	Safeguarding annual report	Steve Hams	Approval	14:10	YES
13.	Quality and Performance report	Steve Hams Rachel de Caux Mark Pietroni	Assurance	14:20	YES
14.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance		YES

	FINANCE AND DIGITAL				
15.	Digital report	Mark Hutchinson	Assurance	14:30	YES
16.	Finance report	Karen Johnson	Assurance	14:40	YES
17.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance		YES
	ADDITIONAL PAPERS				
18.	Provider license: Self-certifications	Sim Foreman	Approval	14:50	YES
	STANDING ITEMS				
19.	Review of the minutes of the Council of Governors	Chair	Information		YES
20.	Governor questions and comments	Chair		15:00	
21	New risks identified	Chair		15:10	
22.	Any other business	Chair			
CLOSE				15:15	

Date of the next meeting: Thursday 08 October 2020 at 12:30 via MS Teams

Public Bodies (Admissions to Meetings) Act 1960 "That under the provisions of Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted."

Due to the restrictions on gatherings during the COVID-19 pandemic, there will be no physical attendees at the meeting. However members of the public who wish to observe virtually are very welcome and can request to do so by emailing ghn-tr.corporategovernance@nhs.net at least 48 hours before the meeting. There will be no questions at the meeting however these can be submitted in the usual way via email to ghn-tr.corporategovernance@nhs.net and a response will be provided separately.

Board Members	
Peter Lachecki, Chair	
Non-Executive Directors	**Executive Directors**
Claire Feehily	Deborah Lee, Chief Executive Officer
Rob Graves	Emma Wood, Director of People and Deputy Chief Executive
Balvinder Heran	Rachael de Caux, Chief Operating Officer
Alison Moon	Steve Hams, Director of Quality and Chief Nurse
Mike Napier	Mark Hutchinson, Chief Digital and Information Officer
Elaine Warwicker	Karen Johnson, Director of Finance
Associate Non-Executive Director	Simon Lanceley, Director of Strategy & Transformation
Marie-Annick Gournet	Mark Pietroni, Director of Safety and Medical Director

MINUTES OF THE TRUST BOARD MEETING HELD VIA MS TEAMS ON THURSDAY 09 JULY 2020 AT 12:30

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Mark Pietroni	MP	Director of Safety and Medical Director
Elaine Warwicker	EWa	Non-Executive Director
IN ATTENDANCE:		
Imran Atcha	IA	Patient story
Sim Foreman	SF	Trust Secretary
Katie Parker-Roberts	KPR	Head of Quality and Freedom to Speak Up Guardian
Simon Pirie	SP	Guardian for Safe Working
APOLOGIES:		
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were five governors present.		

ACTION

129/20 PATIENT STORY

KPR introduced IA who shared the story of both his parents contracting COVID and being admitted to the Trust.

IA updated on the patient experience of his mother for whom English was a second language and who was not a confident user of technology. IA praised Nurse Khoboso for going above and beyond in the care she provided to his mother and advised she had sent messages on support after discharge.

IA had been able to visit his father who was receiving end of life care on a COVID ward and to make arrangements for him to be discharged and be cared for at home. A bed and portable oxygen were provided quickly for both his parents. IA advised that the family were provided with information about end of life care but even whilst making funeral arrangements whilst his father was still alive, he did not give up hope. Sadly IA's father died at home after being discharged. IA advised he had

worried his mother would also die but she made a recovery. IA explained that his daughter was a nurse and she was able, along with other friends, to support the care provided to both his parents which had made the discharge possible.

MN expressed his sympathies to IA and his family and thanked him for being so brave. MN asked if IA felt there was anything that could have been done differently. IA replied that the care provided to his parents in hospital had been very good and the nurse became the link for the family. The only negative aspects being contact limited to phone calls due to the pandemic, how the non-tech savvy might be affected and concerns from his father about the bathroom when he was on the ward.

IA reported that he had been unable to be granted a death certificate for his father and almost had to show the body on video but for the fact that two nurses had just seen it. This should be borne in mind in future as it was distressing.

In response to a question from the Chair on how the Trust had been viewed by the community in recent months, IA advised he could only speak on behalf of his family and his own experiences. Through the Friendship Café he was aware the Trust was continuing to try and engage and this should continue. SH stated IA's story had shown how horrible COVID was for the community and expressed thanks to the Muslim community in Gloucester city for their incredible support during the pandemic.

CF asked if IA felt that he had been provided with sufficient support and knowledge to care for his parents at home and if that would have been possible without having a nurse in the family and ability to contact a friend who was a doctor. IA stated that he was lucky to have family support and that without it then things may have been different.

The Chair expressed condolences to IA and thanked him for sharing his story at a difficult time.

RESOLVED: The Board NOTED the patient story.

KPR and IA left the meeting.

130/20 DECLARATIONS OF INTEREST

There were none.

131/20 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meetings held on Thursday 9 July 2020 as a true and accurate record for signature by the Chair.

132/20 MATTERS ARISING

RESOLVED: The Board NOTED the report and APPROVED the closed matters.

		ACTION

133/20 CHIEF EXECUTIVE OFFICER'S REPORT

DL presented the report and advised the Trust had been very busy in the previous week, attracting media coverage related to the declaration of an internal incident. This was a planned response to address increased demand and provide an opportunity to reset and reprioritise in order to restore flow. Adverse weather the previous evening had also impacted when the Trust was busy and DL paid tribute to the incredible work by staff to deal with the flood water and restore usual ways of working in three hours. The increased activity could in part be attributed to the heatwave but there were a number of other contributory factors; such as more people staying at home or holidaying in the county. The Trust had delivered safe and good care as part of its response and DL expressed thanks to all involved, including staff governors.

DL advised the response had taken place alongside the work on the restoration of services paused at the start of the pandemic. The Trust was making good progress and leading the way on diagnostics, and cancer recovery. The national "ask" of the NHS on restoring services was significant and the Trust would strive to do its best and deliver this, but the scale of the challenge must not underestimated at a time when the virus was still circulating and there was need to be ready to respond to a surge or local outbreak.

DL highlighted work on "nothing about us without us" to recognise and listen to the voices of those who were differentially impacted by COVID and involved when organising the next phase of the response. DL shared a quote "we've been in the same storm, but not the same boats" as a reminder that everyone faced very different challenges to the same pandemic.

The Board noted the publication of the NHS People Plan and that one of its key messages, to rest people before winter, was a potentially at odds with the messaging on service recovery. It was recognised too that some staff manage anxiety and stress through caring for their patients.

DL celebrated the approval of the outline business case for the £39.5m capital funding to invest in the Trust's estate.

DL and the Chair had attended the "Fab Academy" to celebrate fabulous staff and recognise the empowerment of the workforce to seize the moment and make changes. It had focussed on pre-COVID activities but shown that the continuation of empowerment was needed even more so.

RG advised that it had been good, as a board member, to have been kept updated on the challenges of the past few days and looked forward to expressing thanks. RG asked how the long term factors related to population affected demand calculations and future modelling and whether the Temporary Service Changes (TSC) had contributed to the challenges. DL advised all long term modelling included demographic forecasts produced by the local authority. She went on to say that the impact of the TSC would be assessed at the end of August and whilst it

		ACTION
	would easy to say the changes cause the issues, the reality was that performance had improved in the 8 weeks following the changes and in reality they helped manage the challenges which were activity driven. The detailed review at the end of August would help ascertain whether the August activity levels were a "blip" or part of a trend. RDC further assured the Board that the Trust looked at six-week rolling averages and that the System had commenced modelling ahead of winter. The Board noted that no one could predict the recent patient behaviours; how they presented and the slightly higher acuity of their conditions.	
	CF queried whether there was still reluctance from patients to come into hospital and whether everything was being done to encourage this in terms of public information. RDC confirmed the demand had shown patients were presenting for non-elective care and that different messaging was being applied for planned and cancer care. There had been both generic system communications and specific reach outs by the teams i.e. oncologists made a video expressing need for early presentations and assure that suites were safe. DL added that it was not evident from the data that patients had shifted from primary care as those colleagues and Minor Injuries Units were also experiencing increased attendances.	
	AM reflected on the phrasing of "same storm, different boat" and the work that was underway to tackle and address health inequalities and requested more details about equality impact on cover sheets of board reports and papers. DL updated that she was discussing a trust lead for inequality with SH as part of work to bring this into everything we do. The Board also discussed the importance of prioritising resources to tackle inequalities in the county such as rural and urban deprivation in the Forest of Dean and Gloucester city over more affluent areas.	**All**
	The Chair felt the report and discussions captured the culture of compassionate leadership that the Trust was building and expressed thanks on behalf of the Board and the public it serves, to DL, the Executive and all staff delivering care to patients.	
	RESOLVED: The Board NOTED the Chief Executive Officer's report.	
134/20	**TRUST RISK REGISTER**	
	In the absence of EW, DL presented the report and advised one new risk had been added and eight risks had been downgraded.	
	The new addition (**C3224COOCOVID**) "Risks to safety and quality of care for patients with increased waiting in relation to the services that were suspended or which remain reduced" had been scored differently for Safety and Quality and DL highlighted the importance and need for clear communication to patients on how long they might have to wait. DL added that it would be difficult to determine the future routine waiting times until the recovery funding was resolved. There would be a need for a different approach away from the standard complaints route to ensure proper communication and liaison with those waiting.	
	AM was pleased to see the evidence of the maturity within the Trust	

Risk Register (TRR) and asked how the "long tail of COVID" covering long term cardiac and renal support issues were reflected in the new risk. DL advised it was acknowledged that the Trust was not stating an amount of activity to clear, as this would still continue to increase and also warned there were unknown patients who hadn't presented as yet who would enter the system too. MP explained there were deeper complexities due to the differing impact of COVID on different pathways, capacity issues and health inequalities as well as the unknown long-term impact of COVID.

AM challenged whether the System had the courage to think about doing things differently in their response and DL responded that she believed it did and whilst this would not necessarily be characterised by bold decisions, the level of ambition provided a positive start point.

RESOLVED: The Board NOTED the Trust Risk Register as a source of assurance and information and APPROVED the addition on the new risk and downgrading of eight risks as set out in the report.

135/20 DIGITAL REPORT

MH presented the report and highlighted that despite organisational pressures, work had continued to progress the order communications (requests and results) in the Electronic Patient Record (EPR) by the end of the month. MP added there had been good uptake of training amongst junior doctors and consultants.

MP reported work to assess the quality and financial benefits of EPR showed a return of £10 per £1 invested which he hoped would focus future investment and progress. The Chair commended the work and quality of the paper.

RESOLVED: The Board NOTED the Digital Report as a source of assurance and information.

136/20 FINANCE REPORT

KJ presented the report outlining the Month 3 (M3) position and confirmed the current funding regime had been extended to the end of M6 although it was unclear what would happen beyond this with more known at the end of August (linked to the COVID Phase 3 recovery letter).

The M3 position had deteriorated when compared to the first two months and would require top up funding through the "true up" mechanism. M1 and M2 had seen £1.7m received via true up with the M3 request submitted for £3.8m with the increase in spend predominately around non pay and believed to be activity driven. The Trust had been notified this had been accepted and expected to receive payment in mid-August to support increased elective activity in line with national pressure to get ahead of the curve before winter. KJ advised that true up for M4, M5 and M6 were likely to be similar to or higher than M3.

The payment of suppliers had improved significantly to maintain flow in

line with one of the main instructions related to COVID.

The Trust had been successful in achieving a £2.67m bid for new capital monies to reduce critical infrastructure risks. This was in addition to the existing capital allocation and great achievement for the System. GMS were prioritising the spend against the known risks.

RESOLVED: The Board RECEIVED the contents of the report as a source of assurance that the financial position was understood and under control.

137/20 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Finance and Digital Committee.

There was a ten minute break from 13:47 to 13:57.

138/20 QUALITY AND PERFORMANCE REPORT

SH, RDC and MP presented the report which had been previously reviewed at QPC.

SH advised the Effective domain would be added into the iteration of the report and highlighted the Safe domain in the report. Safeguarding activity post-pandemic had been high with good levels of reporting and there had been low levels of healthcare COVID transmission.

RdC highlighted the Trust had maintained cancer performance throughout the pandemic with Two Week Waits at 98% in June 2020 (highest in the South West) following nine months of consistent delivery. Improvements were being made in other areas with a reduction in the number of patients waiting 104 days which was at the lowest level in two years. The recent cancer survey had produced its best results ever for the Trust with 39/52 indicators better than the national average and focused attention on those that weren't.

Planned care was the area most drastically affected by COVID and the team were looking at how improvements could continue to be made including improving in-list productivity and better use of private hospital capacity.

The Unscheduled and Emergency Care report showed an improvement in the quality metrics for ED performance in July 2020 compared to July 2019.

In relation to the backlog MP assured that whilst the Trust was doing well, the Executive team wanted better. He highlighted the dangers of comparing performance in a league table and that the reality related to available capacity, especially when activity levels were returning to pre-COVID levels or higher.

The Board were informed that harm review processes were in place and waiting lists were being reviewed to focus on and prioritise the most clinically at risk patients, recognising this came at a cost to those patients with lower impact outcomes from waiting including psychological health, long term conditions and chronic pain having to wait longer than those whose wait would result in permanent harm, disability or death, which was not a trade-off that would be easily made.

The Chair sought views from the Tri on how they felt the Trust would perform in 12-18 months when there may be COVID in the background, backlogs and a cessation or reduction in the flow of funding to address this. MP explained the situation would be complex and require a multifactorial approach across the System to agree, understand and share the risks. There would be also be a need to manage expectations, being open and transparent on what could (and could not) be achieved and what it meant for elective care. RdC assured the system approach was already being applied with the System Recovery Cell continuing to have a weekly call and modelling on elective activity, beds and workforce linked to Phase III planning.

MN queried whether 800k outpatients per annum referenced in the Quality Account was pre-COVID. RdC advised the overall figure was based on pre-COVID levels and added the Trust had delivered 31k outpatients in June 2020 (through a combination of face-to-face, virtual and telephone appointments). The actual level of activity fluctuated each week but was up to 95% of the previous year in the current week.

MN followed up to ask if the virtual approach could be used to address the backlog. RdC explained that clinicians had no less time with their patients on a virtual consultation so productivity was no better and there would still be conversions and admissions to other pathways for patients. DL added that more consultants had been working in outpatients due to some types of surgery being paused but this was no longer the case. On virtual outpatients, she noted whilst it didn't necessarily enable more care to be delivered there were other important benefits and many patients appeared to prefer it due to not having to drive to hospital and pay for parking; she also noted its contribution to our "green" agenda.

RG wished to record the quality and quantity of information received repeatedly by the Board through this report and commended the scrutiny and assurance from QPC. RG questioned whether it was possible to determine a common denominator for overall activity to aid comparison and RdC agreed to consult with the Business Intelligence team and feedback. **RdC**

RESOLVED: The Trust Board RECEIVED the Report as assurance that the Executive team and Divisions fully understand the current levels of non-delivery against performance standards and have action plans to improve the position, alongside the plans to clinically prioritise those patients that need treatment planned or un-planned during the pandemic.

139/20 QUALITY ACCOUNT

SH presented the report and thanked KPR and Suzie Cro, Deputy Director of Quality for their work on this. The Quality Account supported the Annual Report and Accounts and had been approved by the QPC. The reported demonstrates the breadth of quality performance and received positive comments from Healthwatch, the CCG and HOSC. The Chair commended a fantastic report and the positive feedback from stakeholders.

RESOLVED: The Board ENDORSED the Quality Account, for design and publication to NHS Choices as approved by the Quality and Performance Committee.

140/20 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Quality and Performance Committee.

141/20 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Estates and Facilities Committee.

142/20 ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the Audit and Assurance Committee.

143/20 ANNUAL MEDICAL REVALIDATION AND APPRAISAL REPORT

MP presented the report and described the Trust's and his own responsibilities (as the named Responsible Officer) to the General Medical Council (GMC) relating to revalidation of consultants. Due to the pandemic, doctors were permitted to miss one appraisal in the year from April 2020 by the GMC, but the Trust only paused appraisal in May and June and consultants not wanting to wait were being encouraged to keep to the original schedule.

AM asked if the increase in the number of doctors to be revalidated by 30 was usual. MP assured this was within normal variation and explained the Trust was the host body for the GP trainees across the South West region, as well as some temporary staff which resulted in a larger cohort of doctors for validation.

EWa queried the process if a doctor did not engage with appraisal. MP explained a series of escalation steps which are followed up to the point of a letter being issued from himself and then the GMC. However by and large failures to engage were due to specific personal or professional

circumstances. He added that the Trust no longer had doctors in the GMC's process for overdue appraisal.

The Board heard that it was the individuals' responsibility to be revalidated and that people were sometimes stressed by the process and felt vulnerable, particularly if they fell behind on appraisal, so the Trust had a supportive, responsive system with good administration to support them.

In response to a question from MN on appraisal outcomes, MP explained they were formative rather than summative and confidential to the appraisee and their appraiser, who was independent of their line manager. The appraisal provided an opportunity to discuss complaints or other performance issues and there was an opportunity for the doctor's supervisor / manager to provide feedback. The appraiser was not required to make a judgement and revalidation was delinked from the line management process.

MP confirmed there were no cases where a doctor was not revalidated and felt this would be a failure of the Trust's process if it were to happen and, although there was no guarantee this would not happen, he and the team would seek to try and prevent it as action ought to have been taken before such an outcome was necessary

RESOLVED: The Board RECEIVED the report as a source of assurance regarding the quality of medical appraisal and revalidation throughout the Trust.

144/20 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

SP joined the meeting for this item and presented the report for the period from 1 April to 30 June 2020. Eight exception reports were logged and none of them linked to immediate safety concerns. No fines were levied in this period. Junior doctor vacancies were about the same as previously but locum spend had increased.

SP confirmed that the trajectory of exception reporting had been added to the report as per the Board's request and this showed a broadly stable trend of 150-170 reports per quarter.

EWa asked if it would be preferred that junior doctors had kept on reporting during the peak of the COVID and whether in hindsight anything differently would have been done. SP acknowledged the challenge and explained the junior doctors had been fully aware of the situation they were working within and they were not following their usual schedules but that in the event of a future rise in cases he would request via the Junior Doctor Forum that they keep reporting. MP gave credit to the junior doctors who, like all staff, had worked throughout the pandemic on "three days on, three days off" cycles in teams that had not changed and this had suited a number of the junior doctors. He said that feedback from juniors about their working experience during the pandemic had been very positive.

In response to a question from DL on what the COVID survey had

shown junior doctors valued, SP advised these included the rest facilities, the 2020 Hub, refurbished accommodation and the "too tired to drive scheme". MP added that follow up discussions would take place with Russell Peek, Director of Medical Education to ensure links to the Medical Education Board for feedback on specifics.

RESOLVED: The Board NOTED the Guardian report on safer working hours for doctors and dentists in training for the period from April to July 2020.

SP left the meeting.

145/20 GOVERNOR QUESTIONS AND COMMENTS

The Chair invited Alan Thomas (AT), public governor for Cheltenham and lead governor to comment and raise questions on behalf of governors.

AT welcomed the reference to the National Voices work in the CEO report and reflected on the reference to the "same storm but different boats" to inequalities related to mental health. AT also asked how the governors could be assured that the Trust and System consultation process related to FFtF considered and address issues of "digital poverty" for those without online access or capabilities and requested greater emphasis included with the papers and cover sheets. DL updated the engagement team's focus on this.

AT advised that following comments at the last meeting on patients being informed where they were on their pathways, he had personally been contacted about two of his four pathways and welcomed the progress made but stressed more needed to be done.

AT advised that there had been good engagement with governors on FFtF but that media reports on ED at GRH were making it increasingly difficult to articulate why there was only an ED in Gloucester as whilst governors and staff understood the rationale, the public did not. AT felt that DL had articulated very well the reasons in her recent letter which Governors could use as a source of information. He said he was content that governors would be supported at the consultation stage.

145/20 NEW RISKS IDENTIFIED

There were none.

146/20 ANY OTHER BUSINESS

There were none.

[Meeting closed at 14:41]

Date of the next meeting: Thursday 10 September 2020 at 12:30 via Microsoft Teams.

Signed as a true and accurate record:

Chair
10 September 2020

Public Trust Board – Matters Arising – September 2020

Minute	Action	Owner	Target Date	Update	Status
13 AUGUST 2020					
133/20	**CHIEF EXECUTIVE OFFICER'S REPORT:**				
	More details about equality impact on cover sheets of board reports and papers.	All	September 2020	Corporate Governance team have issued a reminder to Executives and authors on this and will do a secondary check as part of producing meeting papers.	**CLOSED**
138/20	**QUALITY AND PERFORMANCE REPORT**				
	Consult with the Business Intelligence team and feedback on possibility of a common denominator for overall activity to aid comparison.	RdC	September 2020	The update is this has been asked of BI but it is challenging as a number of technical definitions / counting and coding changes that are still in negotiation with NHSI / E. Closed and Committee will receive updates progress against Phase 3 planning commitments once agreed.	**CLOSED**

BOARD – 11 JUNE 2020

Report Title							
UPDATE FROM THE CHAIR							
Sponsor and Author(s)							
Author: Sim Foreman, Trust Secretary Sponsor: Peter Lachecki, Trust Chair							
Executive Summary							
The Trust moved to virtual meetings for Board, Committee and Governor meetings from April 2020. The paper reconfirms the current arrangements and proposes their continuation to the end of the calendar year.							
Recommendations							
The Board is asked to APPROVE that Board, Committee and Governor meetings continue to be held virtually until 31 December 2020.							
Impact Upon Strategic Objectives							
There is no impact on the strategic objectives from this paper.							
Impact Upon Corporate Risks							
There is no impact on corporate risks from this paper.							
Regulatory and/or Legal Implications							
Decisions and actions must still be taken in a manner that is legal and compliant with regulation although it is recognised that there may be changes to statute and regulatory frameworks due to the pandemic. The proposed arrangements provide for the continuation of Trust governance processes.							
Equality & Patient Impact							
There are no direct implications on equality and patient impact.							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval	**X**	For Information	

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

BOARD – SEPTEMBER 2020

UPDATE FROM THE CHAIR

1. Purpose

1.1. To update on the arrangements related to Board, Committee and Governor meetings and seeks APPROVAL for these to be continued until 31 December 2020.

2. Executive Summary

2.1 The Board has previously received two papers (April and June 2020) to update on the Trust's governance arrangements in in response to the global COVID-19 pandemic.

3. Board and Committee meetings

3.1. Board and Board Committee meetings have been held remotely using MS teams since April 2020 with shortened agendas to focus on key business and assurance items.

3.2. The Board AGREED in June 2020 that the length of Board, committee and governor meetings would be extended to allow more business to be transacted and that meetings would continue to be held remotely until the end of September 2020. It had been hoped that physical attendance by some board members would be introduced when and if considered safe and practicable to do so, but sadly this has not been possible and continues to be the case in accordance with COVID guidance.

3.3. The advice and guidance has not changed and it is proposed that the Trust continues to convene Board, Committee and Governor meeting virtually until 31 December 2020.

3.4. It is noted that the use of virtual meetings has also meant that meetings have been more accessible due to the removal of the need to travel and the Trust has noted an increase in the number of external observers, especially governors, at the meetings.

3.5. A review will take place in early December so an update can be provided at the Board meeting on 10 December 2020.

4. Recommendation

4.1. The Board is asked to APPROVE that Board, Committee and Governor meetings continue to be held virtually until 31 December 2020.

Author: Sim Foreman, Trust Secretary
Presenter: Peter Lachecki, Trust Chair

PUBLIC BOARD SEPTEMBER 2020

REPORT OF THE CHIEF EXECUTIVE

1 Operational Context

1.1 The operational context for the Trust remains largely unchanged from last month with the exception of increasing levels of emergency activity which now mirror pre-COVID levels on occasions. Given the ongoing challenges associated with delivery of safe emergency care, consistent with the requirements of a COVID secure environment, A&E waiting times have been adversely impacted and every effort is being made to address this with some recent improvements in performance. An external review by Dr Matthew Cooke, former National Clinical Director for Urgent and Emergency Care has identified further improvement opportunities and new ways of working are being piloted.

1.2 Positively, patients with confirmed COVID-19 remain very low in number and whilst there are signs of an increase in cases elsewhere, Gloucestershire as a whole remains in a relatively positive place although increases are now being observed in the 18-30 age group. The national picture serves to remind us of the importance of being prepared for the winter ahead and possible spikes as “lockdown” measures are eased. The recent re-opening of schools and other educational establishments is a key event with respect to the risk of increased transmission – particularly secondary and higher educational institutions. The successful delivery of the national *Test, Trace and Isolate* programme will be key to the mitigation of this risk and it is evident that this is not yet where it needs to be. As host to a university, the county council and its partners are working closely with the University of Gloucestershire to mitigate any enhanced risks associated with the return of students later this month.

1.3 Our focus on recovery and the re-establishment of services paused or reduced during the pandemic continues and month on month we are seeing some very positive signs of planned activity levels increasing. Outpatient activity is now at c84% of pre-COVID levels, elective activity 64% and very positively, we are one of the strongest performers regionally and nationally for diagnostic recovery at 85% of previous activity levels of CT and MRI imaging delivered in the most recent week. The impact of measures to prevent the spread of COVID transmission impact most significantly in endoscopy and day case where in these areas activity is at around 54% of former levels but with a significant focus to improve performance in these areas – recent changes to infection control practice will be an enabler to this.

2 Key Highlights

2.1 Without doubt one of this month’s (year’s!) most significant highlights is confirmation of delivery of the 62 week cancer waiting standard for the month of July. The jury is still out on when the Trust last achieved this standard but certainly not during my 4 + year tenure with the current favourite being June 2014 – the archives are being trawled….. Positively, many specialities have been achieving the 62 day standard for a year or more but Trust level performance has eluded us due to challenges in urology pathways which have been the focus of work for many years. However, under the leadership of Rachael De Caux, Chief Operating Officer a complete review and redesign of high volume pathways such as prostate cancer, involving colleagues from

surgery, imaging, pathology and beyond has finally paid dividends. This now positions the Trust as one of the strongest performers regionally, and indeed nationally, against the suite of cancer waiting standards. Thanks go to many, many staff both clinical and non-clinical but of note Felicity Taylor Drew, Director of Planned Care and James Curtis, Cancer Services Manager have been instrumental in delivering these improvements.

2.2 Another significant milestone during August was the mobilisation of the next phase of our Electronic Patient Record deployment. On the 26th August many, many months of work behind the scenes from our Digital Care Team and clinical leaders came to fruition with the very successful go-live of our electronic ordering and receipting system for blood tests (pathology) and images (radiology). August has focussed on roll out out across all of our adult inpatient wards with our emergency departments and outpatients to follow later this month and next. This is a huge fete at any time but the additional complications of a team working remotely for much of the preparation phase, makes this an even more noteworthy in my view. Huge thanks to Mark Hutchinson, his team and all those front lien colleagues who embraced yet another step in our digital future.

2.3 Although we are still in the midst of summer, attention has turned to the development of our preparations for winter. Most commentators are predicting an increase in the numbers of patients who contract coronavirus and our plans are being developed with this as the context alongside a range of other scenarios. NHS England have signalled an extended flu vaccination programme and Trusts have also been asked to prepare for the delivery of a COVID-19 vaccination programme to NHS staff and other vulnerable groups, for the time when a vaccine becomes available. Importantly, we will be reviewing the impact of the recent temporary service changes which were established to enable us to continue to deliver as much of our "usual" care as possible in the scenario whereby we have a spike or second surge in COVID. Further extensions to the temporary changes are incorporated within the Winter Plan and will be formally considered at this month's A&E Delivery Board and the September meeting of the Health Overview and Scrutiny Committee.

2.4 The long awaited financial regime and funding envelopes for months 8-12 of the remaining year are still outstanding at the current time and therefore we continue to develop our Phase Three Recovery Plan in the context of a number of financial scenarios rather than funding certainty. The Board will consider the most recent iteration of the plan at this month's meeting ahead of submission later this month.

2.5 Last month we took a significant step in our One Gloucestershire *Fit For The Future* programme with the consideration of the Pre Consultation Business Case (PCBC) by the Trust and Regional Clinical Senate; earlier this month the PCBC was formally considered by NHS England and NHS improvement against the "five tests" required of any business case. As a result of these assurance reviews, a further iteration of the case is now underway paving the way for final approval next month and presentation to the Health Overview and Scrutiny Committee in October ahead of public consultation later in the month. Both Regional Senate and NHSE / I commended the Trust and systems partners on the rigour of the PCBC and in particular the strength of clinical engagement and the quality of the approach to public engagement and consultation – both particularly noteworthy given the challenges and competing priorities of the last six months.

2.6 Following the publication of the NHS People Plan, each of the NHSE / I regions are required to establish a People Board to oversee delivery of the plan throughout their

region. The Board's focus will include providing assurance to the Chief Executive of the NHS that the South West is making progress on the plan's objectives, to provide support and development to systems and to share best practice across the region. I am delighted to have been invited to join the Regional Board and to have been given the opportunity to Chair a sub-group of the Board overseeing the *staff engagement* pillar of the strategy.

2.7 Unsurprisingly, a key strand of the NHS People Plan is centred on ensuring diverse and inclusive workplaces and our own work in this area continues to make progress. As a system we have now partnered with Val Simms, Diverse City lead and a group of eight community advocates from Gloucestershire's Black, Asian and Minority Ethnic (BAME) communities. Entitled *Operation Better Outcomes*, the focus is on addressing the existing and recently compounded inequalities experienced by BAME people through improved understanding of the issues and perspectives affecting the NHS locally and BAME communities. Two initial parallel work streams have been proposed – *Walk In My Shoes (WIMS) Engagement Group* and *WIMS Two Way Mentoring Programme* – the former aimed at improving outcomes by identifying opportunities for change in the delivery of healthcare and health related information and the second a pairing of eight NHS directors from across Gloucestershire with eight advocates from our local BAME communities aimed at enhancing each person's understanding of the issues affecting them, their organisations and the communities they represent; importantly, building sustainable relationships is a key ambition of this aspect of the programme. Thanks go to Bren McInerney who was the driver behind the initla idea and continues to lend his support and considerable experience in this area.

2.8 Alongside this, the Trust has now agreed the scope and terms of reference for what is being referred to as our *Widening Participation Review.* We are now actively seeking a partner to work with us on delivering this programme of work and hope to appoint and commence the review no later than November. The aim of the approach is to seek an independent review of the issues which contribute to colleague perception that the employment experience of BMAE colleagues is less positive than that of their non-BAME counterparts in key areas such as career progression and discrimination in the workplace. The aim being to identify the things that are working well which we should build upon and those areas where further, significant action is required. The Board's People Committee will oversee this work, led by Emma Wood, Director of People and Organisational Development with a steering group comprising a range of Board members, Diversity Network members and front line colleagues.

2.9 There have been a number of successes in the past month reflecting the work of colleagues throughout the organisation. Firstly, the revalidation of the Trust's Gold Award as part of the Ministry of Defence's Employer Recognition Scheme (ERS); one of just 14 Trusts nationally to have achieved this. Secondly, the Trust has had four entries shortlisted in this year's national patient experience awards #PENNA including the nomination of the fabulous Jean Tucker as PALS Manager of the Year. Other entries include the work led by Betty Ten Stewart supporting dads of premature babies – SHED; the work led by Shona Duffy to develop guidelines for staff to better support our homeless patients and the work of our patient experience team on "closing the loop – from concern to change".

2.10 Numerous discussions have taken place regarding our own approach to recognition, thanks giving and also commemoration of those who died or lost loved ones as a result of the pandemic. Recognising the huge amount of work that had already taken place before the pandemic struck, and the numerous "business as usual" initiatives and efforts that continued throughout the pandemic, we have decided to retain our

usual approach to the annual staff awards but defer these to early summer next year – nominations will be invited as per our usual approach and we very much hope to be able to celebrate in the traditional manner at the "Manor" but time will tell. In respect of recognising the efforts of colleagues throughout the pandemic, the Board feels that we should adopt as inclusive approach as possible and in doing so not single out individuals or teams given the tremendous collective effort that characterised our response to COVID-19; the form this collective recognition will take will be developed through a staff engagement group to ensure it reflects what colleagues want.

2.11 With respect to commemorative activities, proposals are being developed amongst Integrated Care System (ICS) partners with a view to marking this occasion in mid-April next year, reflecting the one year anniversary of the peak of the pandemic in Gloucestershire; numerous themes are being considered including the development of commemorative gardens and spaces around our sites and the award of a "service medal" or similar for all those who worked in ICS organisations during the pandemic. Closer, we will be joining in a national minutes silence on Wednesday 9th September to pay respects to all those working in emergency services who lost their lives through the pandemic and also supporting the County Council in their *Gloucestershire Day* activities planned for the 21st September 2020 which is being organised to publicly thank the staff who went above and beyond their normal work duties in Gloucestershire during the Covid-19 pandemic. The day will also be an opportunity to celebrate the spirit and strength of our communities and to nominate members of the public who live or work in the county and stood out for their contribution during the pandemic. A link to the *COVID-19 Heroes* website can be found here https://www.gloucestershire.gov.uk/covid-19-information-and-advice/gloucestershire-day/covid-19-community-heroes/

2.12 Governor elections are now firmly under way with a record number of both public and staff nominations being received. The final outcome of the elections will be announced at the Annual Members Meeting on the 8 October 2020 but I am very confident that once again we will move forward with an exceptional cadre of individuals in our Council of Governors.

2.13 The Trust is also actively recruiting to fill two non-executive vacancies on the Board – one Associate and one substantive - and is continuing with its ambition to develop as diverse and inclusive a Board as possible with both general and targeted recruitment. Interviews are schedule to take place next month and, as per our constitution, appointments are the responsibility of the Council of Governors.

2.14 Finally, on a very positive note the Trust has just been advised of a further allocation from the NHS COVID-19 Charitable Fund which we anticipate will be in the order of £175,000. We can bid as a single organisation or as a system and the focus for investment remains in line with earlier waves of funding in the areas of staff health and wellbeing, mental health services, addressing diversity, inclusion and resulting health inequalities. Emma Wood, working with our own Charitable Trustee, will lead our submission.

2.15 Phew – quite a lot going on!

Deborah Lee
Chief Executive Officer

5 September 2020

TRUST BOARD – SEPTEMBER 2020

Report Title			
TRUST RISK REGISTER			
Sponsor and Author(s)			
Author: Lee Troake, Corporate Risk, Health & Safety Sponsor: Emma Wood, Director of P&OD			
Executive Summary			
Purpose The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. **Key issues to note** • A new risk escalation process is now in place through the Risk Management Group (RMG), effective from 2 September 2020 • There were no changes made to the Trust Risk Register at RMG on 2 September 2020			
Recommendations			
To note this report.			
Impact Upon Risk – known or new			
The RMG / TRR identifies the risks which may impact on the achievement of the strategic objectives			
Equality & Patient Impact			
Potential impact on patient care, as described under individual risks on the register.			
Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees		
Divisional Board	**Trust Leadership Team Sub-group**	**Other (Specify)**
		Risk Management Group 2 September 2020
Outcome of discussion when presented to previous Committees **To accept changes recommended**		
Proposed new TRR risks to be referred to lead Executive before re-submitting to the RMG.		

TRUST BOARD – SEPTEMBER 2020

Trust Risk Register

1. Revised Risk Escalation Process

The Risk Management Group (RMG) has now been formally established as the eight group under the Trust Leadership Team and will act as both the corporate divisional board and the decision-making group for risks escalated to the Trust Risk Register. The membership of the RMG has been broadened to ensure that all divisions contribute to this process with an enhanced focus on good risk management. RMG has agreed a new Terms of Reference to take account of its responsibilities and broader membership.

Divisions will be held to account through the RMG in relation to their governance and management of risk. This will include work to align risks to the 10 organisational objectives and Board Assurance Framework.

The Board will shortly review the organisational Risk Appetite and Risk Tolerances which will support the effective management of risks at the most appropriate level of the organisation. This will provide a robust and transparent platform for risk escalation and will facilitate greater consistency in risk scoring. The outcome of this work will re-shape the profile of the Trust Risk Register in line with our organisational strategy.

2. Trust Risk Register Overview

There are 21 risks on the Trust Risk Register. These are predominantly safety-related risks, with a small number of risks relating to quality, statutory and environment.

3. Trust Risk Register Changes

- No new risks were accepted onto the Trust Risk Register
- The scores on existing risks remain the same
- No risks were downgraded or removed from the Trust Risk Register

4. Conclusion & Assurance to the Board

The Board is asked to take assurance from this report that the Trust Risk Management process continues to operate dynamically for all risks and risks are effectively identified and managed as part of our business as usual.

Ref	Inherent Risk	Controls in place	Division	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead title	Date Risk to be reviewed by	Approval status
C3089COOEFD	Risk of failure to achieve the Trust's performance standard for domestic cleaning services due to performance standards not being met by service partner.	1. Domestic Cleaning Services are currently provided by the Service Partner with defined performance standards/KPIs for functional areas in the clinical & non-clinical environment. (NB. Performance Standards/KPIs are agreed Trust standards that marginally deviate from guideline document 'The National Specifications for Cleanliness in the NHS – April 2007'); 2. Cleaning Services are periodically measured via self-audit process and performance is reported against the agreed Performance Standards/KPIs to the Contract Management Group (bi-monthly, every two months); 3. Scope of Cleaning Service currently agreed with the Service Partner includes – Scheduled & Reactive Cleaning, Planned Cleaning, Barrier Cleaning, Deep Cleaning and other Domestic Duties; 4. Provision of an Ad-hoc cleaning service is provided by the Service Partner with defined rectification times for the functional areas; 5. Cleaning activities and schedules are noted as being agreed at local levels (e.g. departmental/ward level) between Trust and Service Partner representatives.	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	03/09/2020	Trust Risk Register
C2817COO	Tower block ward ducts / vents have built up dust and debris over recent years.	Funding for cleaning now secured; Schedule for cleaning drawn up to be undertaken in the summer months where wards can be decanted to day surgery areas, allowing cleaning to take place at weekends.	Corporate, Gloucestershire Managed Services	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Chief Operating officer	30/09/2020	Trust Risk Register
C2970COOEFD	Risk of harm or injury to staff and public due to dilapidation and/or structural failure of external elevations of Centre Block and Hazelton Ward Ceiling – resulting in loose, blown or spalled render/masonry to external & internal areas.	1) Snapshot' visual survey undertaken from ground level to establish the scope of the loose, blown or spalled render and masonry to the external elevations of the building & any loose material removed (frequency TBC); 2) Heras fencing has been put up to isolate persons from the areas of immediate concern; 3) Areas of concern being monitored (frequency TBC). (All Controls to be reviewed and confirmed as active & appropriate).	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Chief Operating Officer	02/10/2020	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	30/09/2020	Trust Risk Register

		Committee and the Quality and Performance Committee 8. Falls management training package									
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings, as a consequence of the Trust's inability to generate and borrow sufficient capital.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation; 8. Prioritisation of Capital managed through intolerable risk process 2019-20 – Complete 30/4/19 and revisited periodically through Capital contingency funds; 9. On-going escalation to NHSI for Capital Investment requirements – Trust recently awarded Capital Investment for replacement of diagnostic imaging equipment (MR, CT and mammography) in October 2019, SOC for £39.5 million Strategic Site Development on GRH and CGH sites approved September 2019, Trust recently rewarded emergency Capital of £5million for 19/20 from NHSI.	Corporate, Gloucestershire Managed Services	Environmenta l	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating officer	02/10/2020	Trust Risk Register
C3253PODCOVID	Risk to the health of staff working in the healthcare setting who are extremely clinically vulnerable, clinically vulnerable or BAME and are at increased risk of developing a more serious or fatal COVID-19 infection.	1. Risk assessment templates provided to managers to support a personal risk assessment for each member of staff within these groups 2. Managers will be asked to confirm with the hub that the assessment has been completed 3. Assessments will be kept on personal files 4. Extremely clinically vulnerable staff to work from home 5. Clinically vulnerable staff to work from home or a suitable low risk environment 6 IT resources provided to enable remote working 7. DSE equipment available to work from home 8. Home working policy 9 Social distancing guidelines and toolkit developed 10. Risk assessment templates provided to support social distancing risk assessment	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Safety	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	Deputy CEO and director of People	30/09/2020	Trust Risk Register

C3224COOCOVID	Risks to safety and quality of care for patients with increased waiting in relation to the services that were suspended or which remain reduced	• RAG rating of patients in clinical priorisation & Clinical Harm Reviews • Movement of the acute take from CGH to GRH (see issues outlined in gaps below) ED dept at CGH will operate as a minor injuries unit, all emergency patients are managed through GRH. This will enable CGH to manage planned patients who have tested negative to COVID. • All emergency surgery will move to GRH. Vascular emergency patients will move from CGH to GRH. 50% of benign Gynaecology elective day cases will transfer from GRH to CGH. Some Upper GI urgent activity may also move to CGH (Hot laparoscopic Cholecystectomy), if additional theatre capacity is required.	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Operating Officer	30/09/2020	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Platinum level service agreement on Room 3 - with 24 hour call out. Tube replacement has taken place in Room 3 which has corrected dosing issues however image quality remains poor. Cost analysis carried out and procurement of mobile lab to take place should either lab fail permanently prior to a build solution. Regular Dosimeter checking and radiation reporting. Service Line fully compliant with IRMER regulations as per CQC review Jan 20.	Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	25/09/2020	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Diagnostics and Specialties	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	30/09/2020	Trust Risk Register

C1850NSafe	The risk of safety to patients, staff and visitors in the event of any adolescent 12-18yrs presenting with significant mental health, behavioural, emotional and social difficulties, with potentially self harming and violent behaviour whilst on the ward. Patient's stay at GHT is prolonged whilst waiting assessment and a place of safety with an Adolescent Mental Health (Tier 4) facility or foster care placement.	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC\commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff available - decompression sessions can be given to support staff after difficult incidents 6. Designated social work allocated by CCG	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2020	Trust Risk Register
C2719COO	The risk of inefficient evacuation of the tower block in the event of fire, where training and equipment is not in place.	All divisions now taking accountability to ensure fire training and evacuation being undertaken and evidence; Records kept at local level as per fire safety standards to includes: fire warden training, e-learning, fire drills and location of fire safety equipment: Fire safety committee now established; Training needs and equipment are identified; Training programs launched to include drills using an apprenticeship model: see one, do one, teach, one for matrons (to be distributed out to staffing); Education standardisation documentation established for all areas; Localised walkabouts arranged with fire officer (Site team prioritised); Consistent messaging cascaded at the site meeting for training and compliance.	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Chief Operating O fficer	28/08/2020	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19 8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties 9. Review of % over breach report with validated administratively and clinically the values 10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	Medical, Surgical	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	30/09/2020	Trust Risk Register

C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	30/10/2020	Trust Risk Register
C3084P&OD	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	01/10/2020	Trust Risk Register

C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards.	The RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concern Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to implement. Reporting through Theatre Collaborative and PCDG. 7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	30/09/2020	Trust Risk Register
S2917CC	The risk of patient and staff harm and loss of life as a result of an inability to horizontally evacuate patients from critical care	Presence of fire escape staircase Hover-jack to aid evacuation of level 3 patient Fire extinguisher training for staff	Gloucestershire Managed Services, Surgical	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Chief Operating Officer	19/10/2020	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients.	Medical, Surgical	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of Quality and Chief Nurse	14/09/2020	Trust Risk Register

C2989COOEFD	The risk of patient, staff, public safety due to fragility of single glazed windows. Risk of person falling from window and sustaining serious injury or life threatening injuries. Serious injury from contact with broken glass / shattered windows. Glass shards may be used as a weapon against staff, other patients or visitors. Risk of distress to other patients / visitors and staff if person falls	1. All faults are logged on Backtraq via the Estates Helpdesk either on-line or via the 6800 number and reports are available as necessary; 2. Many windows have a protective film to prevent shards of glass fragmenting and causing harm; 3. Patient Risk Assessments are in place by the Trust for vulnerable patients to ensure that controls are in place locally to minimise and/or mitigating patient contact with windows/glass; 4. Window Restrictors are fitted to all windows which require them and are maintained on an annual PPM schedule by Gloucestershire Managed Services; 5. Window Restrictor Policy in place which is reviewed and updated on a three yearly basis or as required; 6. If a window is broken or damaged it is replaced with a window which has toughened glass and complies with all current legislative requirements (e.g. 6.4mm laminate safety glass tested to provide class 2 level of protection to BS EN 12600, manufactured to BS EN 14449 and/or BS EN ISO 12543-2); 7. Money is made available in the Capital budget for replacement of windows (Note for AM: Accuracy of control/mitigation action to be confirmed).	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	Chief Operating Officer	02/10/2020	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/08/2020	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times).	Diagnostics and Specialties	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	12/09/2020	Trust Risk Register
	The risk of moderate to severe harm	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at	Diagnostics and Specialties,						Director of		

C1945NTVN	due to insufficient pressure ulcer prevention controls	higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Quality and Chief Nurse	31/08/2020	Trust Risk Register

TRUST BOARD – SEPTEMBER 2020
Microsoft Teams

Report Title

BOARD ASSURANCE FRAMEWORK

Sponsor and Author(s)

Author: Sim Foreman, Trust Secretary
Sponsor: Emma Wood, Deputy CEO and Director of People and OD

Executive Summary

Purpose

To present the Board Assurance Framework (BAF) as at the end of Q1 2020/21.

The principal risks to the Strategic Objectives set out in "Our Journey to outstanding 2019 – 2024" have been reviewed by the Lead Executives and reviewed by the respective board committee which has oversight of the risk.

The review process has seen a reduction in the number of principal risks within the BAF from 38 down to 28. This has been as a result of some risks being closed, merged or managed within programme risks and no longer considered strategic.

The Board should review the controls and assurances in place for the principal risk for which it has been allocated oversight (4.1, 4.2, 5.1, 5.3, 6.1 and 6.2) to assure itself that these are adequate.

Recommendations

The Board is asked to:

a) **REVIEW** the controls and assurances in place for those principal risks allocated to the Board and assure itself that these are adequate;
b) **APPROVE** the BAF and NOTE the updates and assurance ratings for Q1 2020/21.
c) **AGREE** and **ASK** Committees to further reduce principal risks as appropriate as per Audit and Assurance committee recommendation

Impact Upon Strategic Objectives

The BAF is an assurance framework relating to the delivery of all Strategic Objectives.

Impact Upon Corporate Risks

Related risks from the Trusts Risk Register have been identified and mapped to each principal risk.

Regulatory and/or Legal Implications

As a Foundation Trust it is important that the BAF works as a tool to support the Board's assurances in terms of self-certification on compliance with its Terms of Authorisation.
The Care Quality Commission (CQC) well-led domain requires a robust management of risk and assurance framework of all good and outstanding Trusts.

Equality & Patient Impact

The management of risk and assurance that the Trust is being managed effectively to deliver the strategic objectives will positively impact upon patient safety and experience and the equitable provision of services.

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

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
22 Jul 2020	30 Jul 2020	28 Jul 2020	25 Aug 2020			
Outcome of discussion when presented to previous Committees						
Committees NOTED the updates to the principal risks assigned to them and APROVED the addition of new risks and/or closure or merging of other risks. The Committees AGREED the proposed assurance ratings for each Strategic Objective.						

Board Assurance Framework

1. Introduction

The Board Assurance Framework (BAF) provides a means by which the organisation can focus on the principal risks which might compromise achieving its Strategic Objectives. The BAF identifies the key controls in place to manage and mitigate risks and also enables the Board to gain assurance about the effectiveness of these controls.

The BAF describes the principal risks to achieving the ten strategic objectives as set out in 'Our Journey to Outstanding 2019–2024 and is a tool to enable effective scrutiny and challenge. It is a structured means of identifying the main sources of risk, assurance and controls in a coordinated way to enable discussion and challenge to take place at Board level.

This quarterly report is designed to provide the Board with a regular overview of the BAF management and reporting process. It aims to highlight any particular points that need to be brought to the Board's attention.

Committees scrutinise the BAF risks within their remit in detail to seek assurance, on the Board's behalf, that appropriate controls and mitigating actions are in place and managed effectively.

The Board has allocated oversight of a number of principal risks (4.1, 4.2, 5.1, 5.3, 6.1 and 6.2) and should assure itself of the adequacy of the controls and assurances pertaining to these.

The Board last reviewed the whole BAF in September 2019.

2. Key Points to note

Following the Executive review process during Q1 2020/21 there were 38 principal risks on the BAF although a number were proposed for closure due to either being managed via programme risk registers (and therefore no longer considered strategic risks) or as a result of the risk score being reduced to be equal or lower than the target score.

Some risks were merged into new risks (where there was duplication or commonality) and these are highlighted.

Each Committee, with the exception of Estates and Facilities Committee (who will receive its BAF update at the next meeting), has received a report on the BAF risks for which it has allocated oversight. The Committees have reviewed the BAF and approved the amendments and assurance levels proposed.

The Audit and Assurance Committee considered the whole BAF and discussed the appropriateness of the Board having oversight of the principal risks or whether these should re-allocated to other committees. The Audit and Assurance Committee was clear that it should not "own" any risks itself in order to maintain and hold an independent assurance position. Discussions will take place with Executive Leads and Committee Chairs as part of the Q2 review process to identify principal risks should be re-allocated from the Board to them with a recommendation presented within the next BAF update.

Subject to the Board review and approval, this would result in the BAF containing 28 principal risks to the strategic objectives. It is expected that the ongoing review and risk management processes will result in a further reduction in the number of principal risks, as well as new risks emerging. The Audit and Assurance Committee recommended that the Committees be the appropriate fora to reduce principal risks as appropriate.

Board Assurance Framework

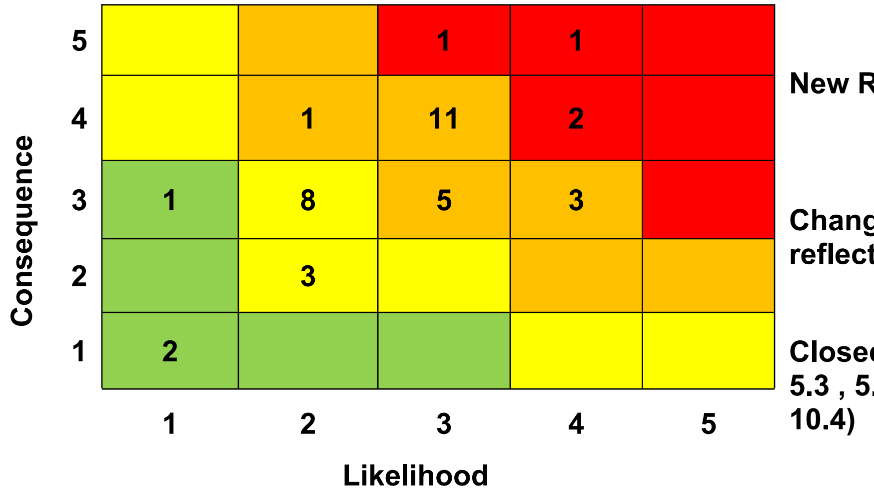
3. BAF Summary

The BAF summary (appendix 1) provides an analysis of the risks which may threaten the achievement of the strategic objectives. As it is an iterative document these risks may change in the forthcoming months; they may be removed or new ones added.

Table 1 shows the risk profile for Q1 2020/21 and provides a summary of any changes made to the BAF affecting the risk profile.

Table 1: BAF Risk Profile Q1 2020/21

Total number of risks by score:



Highlights of recent changes:

New Risks: Two (5.5 & 10.5)

Changes in Score: Zero (changes reflected in closed/merged risks)

Closed Risks: Ten (2.3, 5.1, 5.2, 5.3 , 5.4, 6.1, 6.2, 6.3, 10.3 and 10.4)

4. Recommendation

The Board is asked to

a) **REVIEW** the controls and assurances in place for those principal risks allocated to the Board and assure itself that these are adequate;
b) **APPROVE** the BAF and NOTE the updates and assurance ratings for Q1 2020/21.
c) **AGREE** and **ASK** Committees to further reduce principal risks as appropriate as per Audit and Assurance Committee recommendation.

Appendices

1) Summary of the BAF risk and assurance ratings for 2020/21
2) Risk and Assurance Ratings
3) Principal Risks and Quarterly Progress update

Appendix 1 – Summary of the BAF risk and assurance ratings for 2020/21

Strategic Objectives		Principal risk													
		ID	Executive Lead	Assuring Committee	Risk rating					Assurance rating				Comments
					Q1	Q2	Q3	Q4	Target	Q1	Q2	Q3	Q4	
1	**Outstanding Care** We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	1.1	Director of Quality and Chief Nurse	QPC	12				4	G				
		1.2			9				3					
		1.3			8				1					
		1.4			12				4					
2	**Compassionate Workforce** We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people	2.1	Director of People & OD	PODC	6				4	G				
		2.2			6				4					
		2.3			1				1					**CLOSED: Risk score achieved – See 2.3**
		2.4			6				4					
3	**Quality improvement** Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other	3.1	Director of Safety and Medical Director	QPC	12				6	A				
		3.2			12				6					
4	**Care without boundaries** We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners	4.1	Chief Operating Officer	**Board**	6				4	A				
		4.2			9				4					
5	**Involved People** Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services	5.1	Director of Strategy and Transformation	PODC	6				3	G				**CLOSED – Merged into new risk 5.5**
		5.2			12				4					
		5.3			6				3					
		5.4			12				4					
		5.5			12				4					**NEW RISK**
6	**Centres of Excellence** We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county	6.1	Director of Strategy and Transformation	**Board**	12				8	A				**CLOSED: On Programme Risk Register**
		6.2			9				6					**CLOSED: On Programme Risk Register**
		6.3			1				1					**CLOSED: Risk score achieved – see 6.3**
7	**Financial Balance** We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources	7.1	Director of Finance	FDC	15				6	A				
		7.2			6				1					
		7.3			20				12					
		7.4			16				4					
		7.5			6				3					
		7.6			9				4					
8	**Effective Estate** We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact	8.1	Director of Strategy and Transformation / Director of Finance / Chief Operating Officer	EFC	16				8	A				
		8.2			3				6					**CLOSED: Risk score achieved – see 8.2**
		8.3			12				6					
9	**Digital Future** We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care	9.1	Chief Information Officer	FDC	9				6	A				
		9.2			4				4					**CLOSED: Target score reached. See PR9.2**
		9.3			6				3					
		9.4			4				2					
10	**Driving Research** We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK	10.1	Director of Strategy and Transformation	PODC	4				4	A				
		10.2			8				4					
		10.3			12				8					**CLOSED – Merged into new risk 10.5**
		10.4			12				8					
		10.5			12				12					**NEW RISK**

Appendix 3 – Principal Risks and Quarterly Progress Update

Assurance Ratings

Assurance Ratings – Source: BDO		
Level of Assurance	**Design Opinion**	**Effectiveness Opinion**
Substantial	Appropriate procedures and controls in place to mitigate the key risks.	No, or only minor, exceptions found in testing of the procedures and controls.
Moderate	In the main, there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fully effective.	A small number of exceptions found in testing of the procedures and controls.
Limited	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.
No	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.

Risk Ratings

Risk ratings						
Score		**Likelihood of risk occurring**				
		1 Rare	**2** Unlikely	**3** Possible	**4** Likely	**5** Almost certain
Consequence of risk occurring	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

Risk Meanings		
Colour	**Score**	**Meaning**
Green	(1-3)	Low risk
Yellow	(4-6)	Moderate risk
Orange	(8-14)	High risk
Red	(15-25)	Extreme risk

QUARTERLY UPDATE AND REVIEW OF OBJECTIVES TEMPLATE

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework? Are the assurances effective?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
The overarching **Quality Strategy** was endorsed by Board (Dec 2019). The impact of pandemic COVID-19 has caused lots of changes to be made to services and the delivery of services and this has delayed the delivery of some aspects of the Quality Strategy. The Implementation Plan has also required a refresh, to check the strategy will deliver the necessary components to achieve an "outstanding' rating, as we are now operating in very different ways. An additional programme of work "Pathway to Excellence" has also been introduced and some aspects of this programme will be aligned to be delivered within this strategy. The **Delivery Group review has been now been completed and the new structure** implemented (June 2020). QDG terms of reference have been updated to reflect that this Group has operational responsibility for the delivery of Quality strategy. The **Divisional Governance Review** is now underway and this review will enable the information flow to be clear from ward to board. The Digital Strategy was endorsed by Board in Jan 2020 and now **information flows for quality** from ward to board will be reviewed as we now have improved access to quality data via the electronic patient record and electronic observations digital systems.	The implementation plan for the Experience and Safety domains were due in April 2020 for review at **QDG** but this was delayed due to COVID. The plan will be reviewed with the new Quality Strategy dashboard at August's QDG meeting. Delivery plans for the national access targets are reviewed by **Planned Care, Urgent Care and Cancer Delivery Groups**. The Quality Delivery Group now no longer receives Quality Reports from the Divisions as quality is now reviewed at Divisional level via the Executive Review process. The Quality Delivery Groups main function now is to monitor the progress of the delivery of the Quality Strategy and the **horizontal improvement programmes**. QDG has agreed the horizontal improvement programmes and are just 'refreshing' the governance and reporting arrangements for each of the improvement groups.	**GREEN**	An agreed rating will be sought within the committee

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

Principal Risk ID	**1.1**	Risk that we fail to identify quality and safety risks to the delivery of excellent care leading to avoidable harm, poor patient experience and reputational damage			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	4 x 1	**Current Score (C x L)**	4 x 3
Risk Owner (Executive Director)		Director of Quality and Chief Nurse		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Risk Management Strategy, system and process	1a. Annual Internal Audit on Risk Management 1b. Risk Management Group Report to Trust Audit and Assurance committee 1c. Trust Risk Register report to Board and Board Sub committees 1d. Risk & Serious Incident Reports to Board and Q&PC
2. Quality Strategy, systems and processes	2a. QPR report 2b. Exception reports from delivery groups to Sub Board Committees (Planned, Cancer, Emergency & Quality) 2c. Specialist committee reports to Q&PC (Infection PC, Hospital Mortality RG, Safeguarding) 2d. Quality account indicators and priorities 2e. CQC inspections, ratings and improvement plans
3. Health & Safety Systems and processes	3a. H&S reports to Board Sub-committees (P&ODC) 3b. Risk Management Group Report to Trust Audit and Assurance committee 3c. Freedom to Speak Up reports to Board Sub-committees (P&ODC)

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality strategy implementation plan	Strategy implementation plan being developed	SH	Q4 2019/20 New due date Q2 2020/21	Document in draft – due to Covid there was a delay in production. Patient Experience plan complete and being implemented. Patient Experience Annual Report includes an update to be received by Q&P in July. Safety plan completed and being implemented – 2 sections need to be drawn together and will

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

				be reviewed by QDG. Terms of reference for QDG refreshed to demonstrate that this Group is responsible for the delivery of the Quality and Safety aspects of the Strategy.
Quality Framework Quality and risk function capacity, capability and structure	Strengthening, centralisation, co-ordination and development of corporate and divisional risk resources	EW & AS	Q4 2019/20	Quality Framework co-design workshops paused due to Covid and to recommence in Q2 2020/21. Divisional Governance Review programme has commenced.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Consistency of Executive Division reviews	Establish and implement Corporate 'divisional Board' risk review/escalation process	Executives	Q4 2019/20	Divisional Governance Review commenced.
Consistent & effective governance arrangements for Divisions and specialty committees reporting to Board sub Committees	Implement consistent governance reporting and escalation from Specialist committees (e.g. Radiation\Transfusion) to Board Committees	DL EW/AS/SH/SC	Q4 2019/20 Q1 2020/21	Specialist Committee review to be established in Q3 2020/21.

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards	4 x 4
C1798COO	The risk of delayed follow up care due to outpatient capacity constraints all specialities. (Orthodontics; ENT; Urology; Oral Surgery; Diabetic Medicine; Paediatric Urology; Endocrinology; Cardiology; Paediatric Surgery; Neurology; Colorectal and GI Surgery) Risk to both quality of care through patient experience impact (15) and safety risk associated with delays to treatment (4)	3 x 5
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	3 x 5
C2667NIC	The risk of poor patient experience and/or outcomes as a result of hospital acquired C.Diff infection	4 x 3
C2669N	The risk of harm to patients as a results of falls	4 x 3
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	3 x 4

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

S2568Anaes	The risk to patient safety of failure of anaesthetic equipment during an operation with currently very few spares to provide a reliable back up	5 x 1
S2775CC	The risk to patient safety of respiratory or/and cardiovascular instability and even death in the event of either an electrical or mechanical failure or as a result of needing to change over to a different mechanical ventilator	5 x 1

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

Principal Risk ID	**1.2**	Risk that there is a lack of access to performance information, intelligence and insight and/or failure of assurance processes that inhibits our ability to make timely decisions			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3 x 1	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)		Director of Quality and Chief Nurse		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Quality & Performance reporting systems	1a. QPR report 1b. Exception reports from delivery groups to Sub Board Committees (Planned, Cancer, Emergency & Quality) 1c. Specialist committee reports to Q&PC (Infection PC, Hospital Mortality RG, Safeguarding)

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality strategy implementation plan	Strategy developed Implementation plan being finalised	SH	Q4 2019/20 New date Q2 2020/21	Strategy endorsed at Dec Board. Implementation plan was due to be reviewed at QDG in March 2020 but this was delayed due to COVID. There are current safety and experience improvement plans but these need to be drawn together into one overarching document.
Lack of digital strategy & governance capability to support a culture to improve quality outcomes and performance	Establish improvement actions in Digital strategy to move to real time ward to Board and predictive data	MH\SH\RDC\MP	Q4 2019/20 New date Q2 2020/21	Digital Strategy developed and approved by Board. Work on quality data reports has commenced and an Information Management Plan is due to be presented at QDG in August 2020.

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Real time and predictive reporting in assurance and improvement reports	Develop Ward to Board digital real time and predictive reporting capability	MH\SH\RDC\MP	Q3 2020/21	Ward reporting developed via EPR and available for Divisions to use. Work is ongoing engaging ward managers in their use. Executive Division Reviews performance reporting approved at Q&P October 2019 and new system commenced.

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

<table>
<tr><td>Principal Risk ID</td><td>1.3</td><td colspan="5">Risk that we fail to deliver the Trust's enabling Quality Strategy</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>1 x 1</td><td colspan="2">Current Score
(C x L)</td><td>4 x 2</td></tr>
<tr><td colspan="2">Risk Owner
(Executive Director)</td><td colspan="2">Director of Quality and Chief Nurse</td><td colspan="2">Oversight/Assurance Committee</td><td>Quality and Performance</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="4">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. Quality Strategy Performance reporting systems</td><td colspan="4">1a. QPR report
1b. Exception reports from delivery groups to Sub Board Committees (Planned, Cancer, Emergency & Quality)
1c. Specialist committee reports to Q&PC (Infection PC, Hospital Mortality RG, Safeguarding)
1d Quality Strategy key milestones report</td></tr>
<tr><td colspan="2">Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td colspan="2">Update</td></tr>
<tr><td colspan="2">Quality strategy developed and now implementation plan to be drawn up.</td><td>Strategy developed</td><td>SH</td><td>Q4 2019/20

New date Q2 2020/21</td><td colspan="2">Strategy endorsed at Board.
Implementation plan to go to March QDG and then April Q&P. Experience improvement plan developed and being implemented. Safety Plan developed and being implemented. The two documents need to be combined and reviewed at QDG. Overarching strategy dashboard developed and populated with baseline and year 1 data.</td></tr>
<tr><td colspan="2">Approved plan and Governance mechanism to track progress of implementation of Quality Strategy</td><td>Establish a delivery plan & governance and reporting approach</td><td>SH\RDC\MP</td><td>Q2 2020/21

New date Q2 2020/21</td><td colspan="2">Indicators from strategy for six monthly reporting to Q&P charting progress. Report developed to be reviewed by QDG August 2020.</td></tr>
</table>

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
None noted				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges

Principal Risk ID	**1.4**	Risk that we breach CQC regulations or other quality related regulatory standards			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	4 x 1	**Current Score (C x L)**	4 x 3
Risk Owner (Executive Director)		Director of Quality and Chief Nurse		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1.Quality Strategy, systems and processes	1a. QPR report 1b. Exception reports from delivery groups to Sub Board Committees (Planned, Cancer, Emergency & Quality) 1c. Specialist committee reports to Q&PC (Infection PC, Hospital Mortality RG, Safeguarding) 1d. Quality account indicators and priorities 1e. CQC inspections, ratings and improvement plans
2. Health & Safety Systems and processes	2a. H&S reports to Board Sub-committees (P&ODC) 2b. Risk Management Group Report to Trust Audit and Assurance committee 2c. Freedom to Speak Up reports to Board Sub-committees (P&ODC)

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality strategy implementation plan	Strategy developed and now implementation plan to be approved by QDG	SH	Q4 2019/20 New date Q2 2020/21	Strategy endorsed at Dec Board. Implementation plan to be approved by QDG delayed due to COVID. Safety plan and experience plan being implemented. Dashboard developed to be reviewed by QDG in August 2020.
Consistency of Executive Division reviews	Establish and implement Corporate 'Divisional Board' risk review/escalation process	DL	Q4 2019/20	Divisional Governance Review complete and new system being tested. New Delivery Group structure was delayed due to COVID and was implemented in June 2020.
Consistent & effective governance arrangements for	Implement consistent governance reporting and	DL	Q4 2019/20	Divisional Governance Review complete new structure being implemented.

<table>
<tr><td>Divisions and specialty committees reporting to Board sub Committees</td><td>escalation from Specialist committees (e.g. Radiation\Transfusion) to Board Committees</td><td>EW\AS\SC</td><td>Q1 2020/21

New Q2 2020/21</td><td>Specialist Committee review delayed due to COVID will be established in August 2020.</td></tr>
<tr><th>Gaps in Assurances
Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective</th><th>Actions for gaps</th><th>Owner</th><th>Date</th><th>Update</th></tr>
<tr><td>Quality Account delayed due to COVID.</td><td>Report to be completed.</td><td>SH</td><td>Q3 2020/21</td><td>Quality Account delayed due to COVID. Assurance reports now received from HOSC, CCG, Healthwatch. Account now complete to be endorsed by Board.</td></tr>
</table>

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
C2628COO	The risk of regulatory intervention (including fines) and poor patient experience resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards	4 x 4

QUARTERLY UPDATE AND REVIEW OF OBJECTIVES TEMPLATE

Strategic Objective 2 : We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people.

<table>
<tr><th colspan="4">Quarterly Progress report</th></tr>
<tr><th rowspan="2">Current assurances (positive and negative)
What is known about the effectiveness of the controls from the assurance framework? Are the assurances effective?</th><th rowspan="2">General update
E.g. milestones reached</th><th colspan="2">Assurance Rating</th></tr>
<tr><th>Proposed</th><th>Agreed</th></tr>
<tr><td>During Q1 the People and OD Committee have received specific COVID 19 response reports, detailing our response priorities, alongside our approach to the management of emergent risks.

The People and OD Committee received a report in April 2020, detailing progress against the People and OD strategy. This assurance report demonstrated that the People and OD teams have made satisfactory progress against the P&OD Strategy and that the assurance mechanisms in place (including detailed assurance mapping for committee reports, against the P&OD strategy) are providing an appropriate level of detail regarding risk management, progress and the management of priority work streams. The BAF will return to the P&OD Committee in August 2020 and at this point it is proposed that the principle risk 2.3 ; The Risk that we fail to deliver the Trusts enabling People and OD Strategy, is closed

All reports to the People and OD Committee have been mapped for assurance purposes against the People and OD Strategy in the committees ‘assurance mapping’ document.</td><td>Junes People and Organisational Development Committee were assured that sufficient controls exist to monitor performance against key workforce priorities as articulated in the People and OD Strategy. Where operational improvements are required, actions are fed into the appropriate work streams, monitored by the People and OD Delivery Group. Where Divisional exceptions are highlighted this is challenged and monitored through the Executive Review process.

Turnover and Retention
• Registered Nurse Retention rates remain consistently higher than Model Hospital Peers, at 88- 89%
• Annual turnover rate for non-registered nursing is 2% lower, at 16.22%, compared to the same period in 2019.

Sickness Absence
• Excluding COVID-19 the Trust ‘normal’ annual sickness absence rate is relatively stable at 3.82%
• April 2020 saw an additional 7% rise in sickness absence associated with COVID
• Initial May 2020 information indicates a reduction in COVID sickness absence to 3-4% (in addition to normal sickness absence)</td><td>GREEN

Meeting the key milestones as identified in the P&OD Strategy AND responding proactively and flexibly to meet COVID 19 demands.</td><td>An agreed rating will be sought within the committee</td></tr>
</table>

	Vacancy levels • As we work to consolidate establishment data with the finance general ledger, the Trust overall vacancy rate currently sits at 5.88%. • Medical staffing vacancies remain below target (0.93%) • **Staff Nurse and ODP vacancy rate is at 10.39%,** Medicine has a 19.3% Vacancy rate and accounts for 68% of the vacancies (93.52fte.) • **Non-registered Nurse vacancy rate is above the 10% target, at 12.39%** now excludes staff who were previously included due to their Finance account code, (we can now distinguish between HCAs and Play Specialists etc.) This is an improved position on our reporting period of February 2020 where the vacancy rate was 17.06%. • These figures include HCAs, TNAs, NAs, Apprentice HCA and paid Y2 students. There have been seven priority People &OD work streams during Q1, supporting the Trusts COVID 19 response: **Colleague wellbeing** • After an extended period of seven day working, we surveyed staff of the wellbeing offer provided. Following this survey, we have continued to open with extended hours between mon-frit • Charitable funding is supporting the recruitment or an interim psychological link worker and a one year secondment BAME Engagement/ Equality Diversity Inclusion (EDI) Lead role.		

	• All 'at risk' staff (i.e. Over 70, BAME, and Shielding) is being risk assessed with full compliance expected by the end of July 2020. **Education** • We have worked closely with our Universities, ICS partners and Health Education England to welcome, support and retain students on paid placement. • Significant induction and refresher activity has been completed, to support rapid induction and deployment (over 70 sessions). • Work has commenced to further increase the use of virtual and digital technology as we develop new delivery methods for education. **Deployment** • We supported the redeployment of individuals into interim roles throughout the COVID-19 response (internally and across the ICS) **Resourcing** • The Medical Staffing team have now received all rotations from Health Education England for our August rotations and are in the process of undertaking pre-employment checks/on-boarding. 154 GP Trainees and 201 trainees will be joining the Trust on 5 August. • Early indications tell us that approximately 89% of Healthcare Assistants (HCA) engaged through rapid recruitment continue to work via the Bank • The increased number of available Bank workers has seen a positive impact on Bank fill rates particularly with Healthcare Assistants. Based on percentage fill of total hours requested, Bank RN fill increased from 58% in March to 69% in May. Healthcare Assistant fill increased from 67% in March to 91% in May. The		

	percentage fill provided by agency remained steady at 25% March and 24% May, the number of hours covered reduced significantly 16,260 March to 8,614 in May. • International recruitment remains paused due to considerable travel and visa restrictions. **Childcare** • We worked closely with the County department of Education to support our staff, who are parents, with childcare. • A 'Thank you' letter on behalf of 'One Gloucestershire' has been sent to all schools, nurseries and childminders across the county. • Keyworker children 'thank you postcards' – have been developed, to enable staff to apply for their children to get a postcard sent to their home to thank them for having a 'hero' parent. • A summer holidays childcare questionnaire has been publicised to staff across the ICS, to identify the demand for the six weeks holidays and whether any trends/patterns/hotspots we need to be aware of. **Infrastructure** • COVID absence has been recorded and reported on daily, linking to the countywide testing pathway. This absence has now reduced. In total 2,248 colleagues (or line managers) have submitted an online form to confirm a COVID-19 related absence from work (equates to 30 % of total employees).Of these, 2,081 colleagues have since returned to work (27% of total employees). • Over 7000 staff was tested for antibodies, with approximately 19% testing as positive. • 267 staff were supported with temporary		

	accommodation. • A revised draft of the Trust Homeworking policy has been circulated for approval, along with additional guidance and a homeworking checklist. • P&OD and Finance colleagues have collaborated to revisit the ESR establishment project and are developing new information pathways to support a move to ESR establishment control. • The May Freedom to Speak Up Pulse Survey from the National Guardians Office, results showed an increase in speaking up in May, with people reporting mixed views on the impact of COVID 19 on people's likeliness of speaking up. Locally we have seen no increase in reporting due to COVID-19.		

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

<table>
<tr><td>Principal Risk ID</td><td>2.1</td><td colspan="4">Risk that we are unable to match recruitment needs (due to national and local shortages) with suitably qualified clinical colleagues.

People & OD risk C1437P&OD: The risk of being unable to match recruitment needs with suitably qualified clinical staff (including: AHP's, Nursing and Medical), impacting on the delivery of the Trusts strategic objectives.
C908P&OD The risk of potential staff shortages associated with the development of the PCNs as part of the NHS LTP across; physio, pharmacy and Physician Associates. Extent of impact unknown at present.</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>Principal risk assessment for BAF: 2 x 2

2 x 2 C1437P&OD
1 x 1 C908P&OD</td><td>Current Score (C x L)</td><td>Principal risk assessment for BAF: 3 x 2

2 x 4 C1437P&OD
1 x 1 C908P&OD</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of People and Organisational Development (OD)</td><td>Oversight/Assurance Committee</td><td>People and OD</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. People and OD Strategy- workforce sustainability and colleague experience pillar initiatives such as: Embed a strong unique employer brand to attract the best talent and embed, Develop new roles and career pathways, Understand supply changes and demands and analyse current and future needs, Develop and implement new workforce models within the Trust and with partners, Placement capacity and student experience and equity for all</td><td colspan="3">1. People and OD Committee review of Strategic Outcome measures, including:
People and OD Dashboard
Quarterly Sustainable Workforce Report
Annual Education Learning and Development Report
ICS Update
Operational exception report
International recruitment plans and education processes in place
Staffing reports – temporary and permanent
Safer staffing reports and processes
Work force plans – Five year and ICS</td></tr>
</table>

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

2. People and OD Delivery Group and monitoring progress of delivery groups and work streams focussed on sustainable workforce including (but not limited to): Recruitment and Retention Staff and Patient Experience Group Strategic Sustainable Workforce and Education Group Medical Education Board Workforce Planning Review business cases for payment of RRP and other initiatives inclusive of bank rates	2. People and OD Delivery Group escalation report to Trust Leadership Team and Divisional Executive Reviews – opportunities to challenge recruitment and retention priority plans and to consider vacancies, turnover and divisional recruitment needs (new operational measures)
3. Projects to maximise intake capacity of Deanery students, nurse, midwifery and AHP student placements – and to improve the experience of students whilst on placement in GHFT (and aligned to the National Nurse Standards changes).	3. Medical Education Board and Education, Learning and Development group review placements alongside HEE feedback which is escalation to People and OD Delivery Group and TLT (as necessary)
4. The management of talent and succession planning, including projects to attract future workforce and boost retention such as: Apprenticeship growth, Advanced Development Pool, Itchy feet transfer windows, Keep in touch events, career clinics, , the national RePAIR programme, and the Professional Advocates programme	4. People and OD Delivery Group, prior to inclusion into the escalation report to Trust Leadership Team People and OD Committee Quarterly Sustainable Workforce Report Education, learning and development report Executive Review of delivery of Divisional Workforce Plans
5. ICS Workforce Plan Collaboration Central workforce planning for the system is overseen by the ICS Workforce Steering Group and 'One Place' project team	5. LWAB oversight and ICS reports to People and OD Committee TLT oversight of ICS programmes of work inclusive of People impacts

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Development of Integrated workforce plans with consideration of PCN impact	To participate in ICS development of PCN offer.	Deputy Director of People and OD	September 2019	There is a known 30% PCN funding gap for new roles. Divisional five year workforce plans have created and annual workforce plans are being developed as part of the annual operating plan cycle. In response to concerns raised at the LWAB, it has been agreed to create a governance pathway, reporting to the LWAB, to oversee the work of numerous PCN task and

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

				finish groups [Pharmacists, Physiotherapists, Physicians Associates, Paramedics & Social Prescribing). A GHT HR Business Partner has been nominated to attend each group and Ali Koeltgen, will be the GHT representative on the new Integrated Roles Steering Group – reporting into the LWAB. In is anticipated that the first steering group meeting will take place in March 2020.
Divisional Business plans (inc. workforce) do not currently extend beyond annual operating plan to support long term projections.	Creation of five year workforce plans integrated with ICS and long term plan drivers.	Deputy Director of People and OD	October 2019	Initial five year plans (integrated ICS plans) submitted. Workforce plan development is now focussed on the annual plans and measures within, to support the annual operating plan development.
Dedicated Recruitment and Retention Lead (Nursing)	Recruit to post	Director of Quality and Chief Nurse	July 2019	Fran Wilson commenced August 2019. First draft of retention plan (NHSI cohort 5) 'person centred careers' submitted with the development of a wider retention methodology and plan in progress.
Lack of established link between Temporary Staffing, E Rostering and Transactional Recruitment and Retention Services	Expand role of MM to incorporate transactional recruitment services	Deputy Director of People and OD	July 2019	MM commenced role as Associate Director for Resourcing mid-July 2019. Benefits of this integration are already being realised, with the review of the recruitment steering groups activity and MM assuming the lead role for the ICS recruitment and retention group (from November 2019).
Recruitment takes too long to support emergency response	Rapid Recruitment pathway	Associate Director of Resourcing	March 2020	Pathway established for rapid bank and substantive recruitment. COVID rapid recruitment learnings are part of a wider review
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
NONE				
Related Risks from the Trust Risk Register				

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

Code	Risk description	C x L Score (Domain)
S3164CC	The risk to sustainability of medical, nursing and AHP workforce due to patients remaining inappropriately on Critical Care	3 x 4 (workforce)
C3125COOEFD	Risk of dispute between the Service Partner and Trade Unions leading to Industrial Action against the Service Partner.	4 X 3 (workforce & reputational)
S3053	The risk to patient safety and staff health and wellbeing due to the inability to recruit and retain nursing staff within the surgical division.	5 x 3 (workforce)
S3035	A risk to safe service provision caused by an inability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction in trainee allocation impacting further on workforce and safety of care	5 x 3 (workforce)
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	5 x 3 (workforce)
S2999Th	The risk to workforce in theatres of unfilled vacancies and inability to meet AFPP guidance for safer staffing levels	3 x 4 (workforce)
S2901Anaes	Inadequate workforce to provide an adequate vascular access service to manage the current demand.	4 X 3 (workforce)
M2434Emer	The risk of reduced safety, patient experience and quality of care due to inability to recruit and retain qualified nursing staff across Unscheduled Care	4 X 3 (workforce)
D&S2051Rad	Risk of a reduced radiology service due to increase in vacancy and turnover rate of skilled Radiographic staff	3 x 4 (workforce)

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

<table>
<tr><td>Principal Risk ID</td><td>2.2</td><td colspan="4">Risk that continued poor levels of staff engagement measured by national and local surveys may negatively impact upon retention, attraction and patient experience

People and OD risks C2803P&OD the risk that disengaged employees are physically present but may not be mentally invested in the workplace; impacting our safety culture, workforce harmony, efficiency and effectiveness</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>Principal risk assessment for BAF: 2 x 2

3 x 1 C2803P&OD</td><td>Current Score (C x L)</td><td>Principal risk assessment for BAF: 3 x 2

3 x 3 C2804P&OD</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of People and OD</td><td>Oversight/Assurance Committee</td><td>People and OD</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. People and OD Strategy specifically initiatives under the colleague experience and transformation pillars including Develop a culture where our values are well embedded in all our practices and policy, Secure equity for all, Remove violence and aggression, bullying and harassment from colleagues' working lives, Promote health, safety and wellbeing, Embed new leadership and management practice, Deliver the best professional education, learning and development. A trajectory of staff survey result improvement has been published within the strategy</td><td colspan="3">1. Reports to People and OD Committee regarding staff survey action plans, exception reports from divisions on colleague engagement, Equality data (WRED, WDES, Gender Pay Gap audit), Freedom to speak up trends, Health and Safety reports and triangulation of staff experience in the performance dashboard</td></tr>
<tr><td colspan="3">2. Senior People and OD leaders are involved in programmes of work which may impact upon colleague engagement such as centres of excellence and strategic site delivery to ensure the staff voice is heard
Staff side are involved in strategic and operational change</td><td colspan="3">2. Scrutiny of employee issues at People and OD Delivery Group, Directors Operational Group and TLT</td></tr>
<tr><td colspan="3">3. Sickness management policies and implementation (D)</td><td colspan="3">3. People and OD Dashboard in People and OD Report (to Executive divisional reviews, People and OD Committee and Board)</td></tr>
</table>

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

4. Staff Patient Experience and Improvement Group identifying areas for action and overseeing projects including but not limited to: Exit Interviews HCA Turnover Staff Survey Action Plans Equality and diversity plans		4. People and OD Delivery Group, prior to inclusion into the escalation report to Trust Leadership Team People and OD Committee Staff Engagement and Staff Survey Reports		
5. People and OD Delivery Group and monitoring progress of delivery groups and work streams focussed on sustainable workforce including (but not limited to): Recruitment and Retention Staff and Patient Experience Group Strategic Sustainable Workforce and Education Group Medical Education Board Equality, Diversity, Inclusion and Human Rights Freedom to Speak Up		6. People and OD Delivery Group escalation report to Trust Leadership Team 7. People metric are scrutinised at executive review		
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Engagement and Involvement Strategy	Strategy under development	Director of Strategy & Transformation	tbc	Strategy currently in circulation.
Triangulation of data relating to staff experience	SPEIG to create and manage triangulation dashboard to support prioritisation of activity	Head of Leadership and OD	June 2020	SPEIG has restarted meetings in June 2020 following the Covid pandemic. Attempts to create a live dashboard to support data triangulation proved challenging to develop, coordinate and maintain. As such, this approach was deemed unsustainable and therefore key staff experience metrics now appear at monthly Divisional Executive Review meetings, led by HRBPs with support from the Staff Experience Coordinator to undertake high-level triangulation and analysis.

				SPEIG continues to develop, deliver and monitor the Trust-wide and divisional Staff Survey Action plans. It also commissions and reviews outputs and actions from ad hoc pulse surveys, and delivers a number of projects aimed at improving staff experience. Triangulation of data will occur on a specified basis whenever new staff experience issues/projects come to light, and this will be carried out during the scoping/commissioning, implementation and subsequent evaluation phases
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
The need to deliver the engagement strategy as noted above	Strategy under development	Director of Strategy & Transformation	24/06/20	Strategy in development, informed through the 'Community Conversations' work with the VCS by Helen England (external facilitator) and Anna Rarity (Patient and Public Involvement Manager).

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
C2803P&OD	The risk that disengaged employees are physically present but may not be mentally invested in the workplace; impacting our safety culture, workforce harmony, efficiency and effectiveness	Workforce (3x3)

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

Principal Risk ID	**2.3**	Risk that we fail to deliver the Trust's enabling People and Organisational Development Strategy			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	Principal risk assessment for BAF:1x1 No entry on risk register relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF: 1 x 1 No entry on risk register relating to this principal risk
Risk Owner (Executive Director)		Director of People and OD		**Oversight/Assurance Committee**	People and OD
Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*			**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*		
1. Delivery teams in People and OD are familiar with the strategy and have team plans to deliver the milestones set as year 1-2, 3-4 and 5. Team and individual activity linked to appraisals are built around delivery of the strategy Delivery teams are building frameworks and reporting mechanisms to enable transparency of progress against strategic measures			1. People and OD Dashboard in People and OD Report (to People and OD Committee and Board) Sustainable workforce report to People and OD Committee		
2. P&OD Senior leadership team and directorate wide meetings to review progress and interdependencies, alongside Succession planning of People and OD teams link to delivery of the strategy			2. Reports to the People and OD Committee, including but not limited to: Staff survey action plan Equality and diversity Freedom to Speak Up Staff friends and family quarterly survey results Annual health and wellbeing report Operational Dashboard		
3. Divisions are held to account in the Executive review process for delivery of the operational measures **(D)**			2. Scrutiny of employee issues at People and OD Delivery Group, Directors Operational Group and TLT Monitoring of sickness, absence, recruitment and retention – HR Advisory Team review data monthly and included in People and OD dashboard		

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

4. Delivery and assurance structures including People and OD Delivery Group, Health and Wellbeing Committee and People and People and OD Committee		4. People and OD Delivery Group escalation to TLT. Reports to the People and OD Committee, including but not limited to: Staff survey action plan Equality and diversity Freedom to Speak Up Staff friends and family quarterly survey results Annual health and wellbeing report Operational Dashboard Board and Divisional Executive Review escalation report		
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Divisional Business plans (inc. workforce) do not currently extend beyond annual operating plan to support long term projections.	Creation of five year workforce plans, integrated with ICS and long term plan drivers.	Deputy Director of People and OD	October 2019	Initial five year plans (integrated ICS plans) in place, Workforce plan development is now focussed on the annual plans and measures within, to support the annual operating plan development.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Design of operational dashboard required to ensure it captures outcomes aligned to P&OD Strategy and team reporting needs are clarified and delivered	Review of Operational Dashboard through P&OD groups, delivery teams, and Executive Review	Deputy Director of People and OD	October 2019	Complete
Design of exception reports following executive review of matters pertaining to assurance process of P&OD committee to be devised	A template to be designed once the dashboard is finalised	Deputy Director of People and OD	End October 2019	Complete

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

P&OD committee oversight of summary performance against entire P&OD strategy	Summary report	Executive Director of People and OD	April 2020	Complete – no gaps in assurance

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE	*As we believe this is not a principal risk to the BAF it is recommended it is closed*	

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

<table>
<tr><td>Principal Risk ID</td><td>2.4</td><td colspan="4">Risk that we fail to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve

People and OD risks C2803P&OD the risk that disengaged employees are physically present but may not be mentally invested in the workplace; impacting our safety culture, workforce harmony, efficiency and effectiveness
People & OD risk C1437P&OD: The risk of being unable to match recruitment needs with suitably qualified clinical staff (including: AHPs, Nursing and Medical), impacting on the delivery of the Trusts strategic objectives.</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>Principal risk assessment for BAF: 2 x 2

3 x 1 C2803P&OD
2 x 2 C1437P&OD</td><td>Current Score (C x L)</td><td>Principal risk assessment for BAF: 3 x 2

3 x 3 C2803P&OD
2 x 4 C1437P&OD</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of People and OD</td><td>Oversight/Assurance Committee</td><td>People and OD</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. People and OD strategy embeds EDI in all pillars and strategic and operational measures to improve diversity are in place.
Objectives include to: Significantly strengthen the support provided to staff with disabilities and support/education offered to line managers who work with disabled colleagues. Improve the support and reporting mechanisms for colleagues when they experience or witness bullying, abuse, harassment or violence. Eliminate unfair discrimination.
. Our key measures of success and metrics include National reports will show that the experience gap between colleagues with single or multiple protected characteristics have been eliminated. Staff survey reports will show that colleagues are treated fairly, unfair discrimination is eliminated and BAME staff are not disproportionately subject to disciplinary or grievance processes.</td><td colspan="3">1. Reports to People and OD Committee and Board:
WRES and WDES standards
Equality report (and progress against EDI aspirations)
EDS2 Objectives
Gender Pay gap annual report
Staff Survey report and updates
Executive review process – key people metrics and those relating to POD strategy are reviewed monthly including EDI measures
Bi annual Employee Relations report
Freedom to speak up report and analysis
Performance dashboard including recruitment and retention data against model hospital data
Education and learning report (including progress for apprentices)
NHS Employers EDI Partners networking application successful
Board report and action plan on improving the experiences of BAME colleagues (July 2020). Monitoring of agreed plans by People and OD committee</td></tr>
</table>

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

2 Freedom to speak up guardians in place and allow for speaking out	2. Freedom to speak up reports to People and OD Committee and Board
3 Numerous engagement forums including: The Trust Equality and Diversity Network Governors' strategy and engagement group Staff side meetings (LNC and JSCC) Project specific engagement events	3. SPEIG reports to the People and OD Delivery Group and on to People and OD Committee
4 Embedding Equality, Diversity and Inclusion into the operations of the Trust, such as: Equality, Diversity and Inclusion Action plan Equality and diversity consideration on cover sheets for Board, Committees and TLT Unconscious Bias Training for recruiting managers Retention and recruitment plans Board champions and visible leadership in issues facing staff with protected characteristics	4. Progress made against People and OD strategy and the EDI aspirations, as reported to People and OD Delivery Group, TLT and the People and OD Committee and Board.

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Easily accessible list / contact details of BAME interview panellists is required to ensure we fully utilise the support available and adhere to our commitments as outlined in the Trust Equality action plan.	Mel Murrell and Lucy Morris to ensure that the systems in place enable us to fulfil the promise outlined in our plan, via an easy to access system for assigning BAME panellists to interview processes.	MM/LM	December 2019	BAME panellist, action closed at February 2020 PODDG. June 2020 – Whole policy and process review commenced , reviewing the Trust recruitment and selection protocols. Multi-disciplinary task and finish group appointed to review. Deadline Sept 2020.
No current dedicated resource to progress work at pace as part of the Equality, Diversity and Inclusion agenda.	Scope job profile for potential shared workforce and patient EDI resource. of	AK/ AH	April 2020	Post has now been recruited to , with Coral Boston in post as Trust EDI Lead and BAME Freedom to Speak Up Guardian , from 13 July 2020

Strategic Objective 2: We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
NONE				

Related Risks from the People and OD Risk Register		
Code	Risk description	C x L Score (Domain)
C3195PODCOVID	*Risk that reduced training provisions (mandatory and statutory) could impact on workforce safety and quality and on statutory compliance.*	3 x 2 (statutory)
C3256PODCOVID	*The risk of delayed staff immunisation clearance (predominantly hep B) due to restrictions to Occupational Health services during Covid 19.*	3 x 2 (safety)
C3189PODCOVID	*The risk of recruitment process (temp and perm), being too slow to respond to additional offers of support from the community and new candidates.*	3 x 2 (workforce)
C3252PODCOVID	*The risk of a compromised employment and education experience of approximately 170 paid student Nurses placed within our Trust as part of the covid pandemic response.*	3 x 3 (workforce)
C3253PODCOVID	*Risk to the health of staff working in the healthcare setting who are extremely clinically vulnerable, clinically vulnerable or BAME and are at increased risk of developing a more serious or fatal COVID-19 infection.*	5 x 2 (workforce)
C3253PODCOVID	*Risk to the health of staff working in the healthcare setting who are extremely clinically vulnerable or clinically vulnerable and are at increased risk of developing a more serious or fatal COVID-19 infection.*	Risk Rating 10

QUARTERLY UPDATE AND REVIEW OF OBJECTIVES TEMPLATE

Strategic Objective 3: Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework? Are the assurances effective?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
		GREEN	An agreed rating will be sought within the committee

Strategic Objective 3: Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other

<table>
<tr><td>**Principal Risk ID**</td><td>**3.1**</td><td colspan="4">Risk of failure to deliver the Quality Framework and associated distributed quality leadership. This would delay the development of an empowered workforce close to the patient and prevent the required cultural change/embedding of quality improvement.</td></tr>
<tr><td colspan="2">**Principal risk to Achievement of the Objective**
Including target and current risk score</td><td>**Target score (C x L)**</td><td>2 x 3</td><td>**Current Score (C x L)**</td><td>3 x 4</td></tr>
<tr><td colspan="2">**Risk Owner (Executive Director)**</td><td colspan="2">Executive Director of Safety and Medical Director</td><td>**Oversight/Assurance Committee**</td><td>Quality and Performance</td></tr>
<tr><td colspan="3">**Key Controls**
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">**Sources of assurances on Controls**
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. Quality Strategy, systems and processes</td><td colspan="3">1a. Exception reports from delivery groups to Sub Board Committees (Planned, Cancer, Emergency & Quality) reflecting quality framework approach
1c. Specialist committee reports to Q&PC (Infection PC, Hospital Mortality RG, Safeguarding) reflecting quality framework
1d. Quality account indicators and priorities
1e. CQC inspections, ratings and improvement plans
1f. NHS Staff Survey, annually reported to People and OD Committee and Board. Staff survey action plan also reported to People and OD Committee.
1g Well Led CQC & Board self-assessments</td></tr>
<tr><td colspan="2">**Gaps in Controls**
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>**Actions for gaps**</td><td>**Owner**</td><td>**Date**</td><td>**Update**</td></tr>
<tr><td colspan="2">Quality strategy, to include a section on the quality framework and the associated distributed quality leadership</td><td>Strategy developed</td><td>SH/MP/RD</td><td>Q4 2019/20</td><td>Implementation plan for approval at March QDG and April Q&P.
- Approved
- Delivery Plan to go to QDG September 2020</td></tr>
<tr><td colspan="2">Review of divisional governance</td><td>Part of the divisional review being led by DL</td><td>DL</td><td>Q4 2019/20</td><td>Q4 2019/20 new system and reporting being tested.
Underway again after COVID delay</td></tr>
<tr><td colspan="2">Quality framework support structures not (fully) implemented</td><td>Implementation of support structures</td><td>AS</td><td>Q4 2019/20</td><td>In progress and plan for implementation in place.
Risk teams centralised, awaiting some redesign and sign off of roles. New structure to be</td></tr>
</table>

Strategic Objective 3: Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other

				consulted on within safety team.
Success/ effectiveness measures to be developed	Development of success/effectiveness measures	SH/MP/RD	Q1 2020/21	To be approved by Q&P with delivery plan Part of Delivery Plan
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Divisional performance framework	To be developed following divisional governance review	RD'C	Q4 2020/21	Completed and now for testing.
			Q1 20/21	Implemented

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 3: Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other

Principal Risk ID	**3.2**	Risk that we fail to deliver the Trust's enabling Quality Strategy and implement the Quality Framework		
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	2 x 3	**Current Score (C x L)**	3 x 4
Risk Owner (Executive Director)	Executive Director of Safety and Medical Director		**Oversight/Assurance Committee**	Quality and Performance

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1.Quality Strategy, systems and processes	1a. QPR report 1b. Exception reports from delivery groups to Sub Board Committees (Planned, Cancer, Emergency & Quality) 1c. Specialist committee reports to Q&PC (Infection PC, Hospital Mortality RG, Safeguarding) 1d. Quality account indicators and priorities 1e. CQC inspections, ratings and improvement plans
2. Health & Safety Systems and processes	2a. H&S reports to Board Sub-committees (P&ODC) 2b. Risk Management Group Report to Trust Audit and Assurance committee 2c. Freedom to Speak Up reports to Board Sub-committees (P&ODC)

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Quality strategy implementation plan	Strategy developed and implementation plan being developed	SH	Q4 2019/20	To be approved by QDG and for assurance to Q&P April Q1. I believe this has been approved
Consistency of Executive Division reviews	Establish and implement Corporate 'divisional Board' risk review/escalation process	DL	Q4 2019/20	Divisional Governance Review complete new system being tested. Largely complete
Consistent & effective governance arrangements for Divisions and specialty committees reporting to Board sub Committees	Implement consistent governance reporting and escalation from Specialist committees (e.g. Radiation\Transfusion) to	DL EW\AS\SC	Q4 2019/20 Q1 2020/21	Divisional Governance Review complete new system being tested. Specialist Committee review to be established. Terms of reference and process for the

Strategic Objective 3: Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other

	Board Committees			Radiation Safety Committee have been amended and new schedules and reporting are in place. Patient safety issues to Q&P, Staff issues to People and OD Committee. HSE have agreed actions required as part of the improvement notice relating to staff are closed.

Strategic Objective 4: We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• Reporting on ICS developments to Trust Board and Board Committees	• Trust engagement with ICS • Low level of ICS maturity with many elements (vision, governance, decision-making, risk management, engagement) under development	**AMBER**	

Strategic Objective 4: We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners

Principal Risk ID	**4.1**	Risk that individual organisational priorities and decisions are not aligned, which would result in restriction of the movement of resources (including financial and workforce) leading to an impact upon the scope of integration		
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	2 x 2	**Current Score (C x L)**	3 x 2
Risk Owner (Executive Director)	Chief Operating Officer		**Oversight/Assurance Committee**	Board

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. ICS delivery structures including programmes, ICS Executive and ICS Board 2. Trust Executives' membership of ICS structures 3. ICS operating plan	1. Reporting on ICS developments to Trust Board and Board Committees

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
ICS decision-making mechanisms and key decisions road map	Develop ICS decision-making mechanisms and key decisions road map	COO		Executive ownership across each locality Regular executive meetings to share updates from localities Directors Operational Group to include standing agenda item Quality and Performance Committee to include ICS standing agenda item

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Consistency of ICS reporting to partner organisations' Boards and across Board Committees	Implement consistent ICS reporting to partner organisations' Boards and across Board Committees	COO	Quarterly	
ICS governance arrangements	Being developed	CEX	Quarterly	

Related Risks from the Trust Risk Register

Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 4: We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners

Strategic Objective 4: We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners

Principal Risk ID	**4.2**	Risk that the Primary Care Networks funding model has adverse impact on integration			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	2 x 2	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)		Chief Operating Officer		**Oversight/Assurance Committee**	Board

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. ICS delivery structures including programmes, ICS Executive and ICS Board 2. Trust Executives' membership of ICS structures and Place partnerships/locality networks 1. ICS operating plan 2. ICS and Trust Engagement with Primary Care Networks	1. Reporting on ICS developments to Trust Board and Board Committees 2. Workforce Committee

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Visibility of PCN developments and Trust engagement with PCNs	Engagement with Primary Care Networks (via Place partnerships/locality networks	COO	Quarterly	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Workforce plans – specifically recruitment to posts in primary care	ICS Workforce Planning	Director HR&OD	Quarterly	Trust workforce planning is in train for production Autumn 2019 to feed through to ICS plans

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 5: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

<table>
<tr><td>Principal Risk ID</td><td>5.1</td><td colspan="4">Risk that we are unable to identify or get regular attendance from a cross section of patients and carers that represent our population, which could result in us implementing changes that do not fully address the needs of all our patients</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>3 x 1</td><td>Current Score (C x L)</td><td>3 x 2

(from 3x3)</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Strategy and Transformation</td><td>Oversight/Assurance Committee</td><td>People and OD</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. Silver Quality Improvement projects must involve patients when appropriate and are supported by the Patient Experience Improvement Team
2. Partnerships with existing external organisations in Gloucestershire strengthened through the development of ‘Community Conversations’ with the voluntary and community sector (VCS) in order to inform our Communications and Engagement Strategy e.g. Healthwatch Gloucestershire, Inclusion Gloucestershire, MIND, Gloucestershire Carers Hub and the Gloucestershire Maternity Voices Partnership
3. EDS2 Objectives (aiming to have conversations with the community around protected characteristics and to develop person-centred care charters) and an action plan to deliver them
4. Trust membership events required to be virtual during and following the pandemic. Members now offered more active involvement through strategic projects
5. Governors Strategy and Engagement Group
6. Patient experience stories heard at every Board
7. Board approved Quality Strategy includes patient experience objectives</td><td colspan="3">1. Survey data including: Five surveys from the National Survey Programme related to our services; Friends and Family Test; real time patient surveys; local surveys
2. Biannual Learning from Patient Stories Report
3. Council of Governors
4. Equality report to People and OD and the Board
5. Quarterly patient experience report to Q&P Committee
6. Themes and trends within the Annual Complaints Report
7. ‘Community Conversations’ Report to include a high level strategic stakeholder map, identifying external groups, organisations and communities with whom the Trust is committed to collaborating with. The report will provide an insight into how these future relationships will be shaped to be most effective for all parties
8. Working in partnership on Fit for the Future with Gloucestershire Clinical Commissioning Group and through them The Consultation Institute, running staff and public roadshows, Citizen’s Juries, surveys and workshops.
9. Developing a VCS Involvement Network to refer to on projects such as Strategic Site Development will be an additional outcome of ‘Community Conversations’ Report</td></tr>
<tr><td colspan="2">Gaps in Controls</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
</table>

Strategic Objective 5: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

The control is not in place or not effective, due to the design of the control or the likelihood of it being effective				
Fit for the Future public consultation	Consultation plan/ approach being developed	Simon Lanceley, Ellen Rule	24/06/20	Strategy and implementation underway. Consultation during and following a pandemic is a completely new area for consideration. Consultation to take place between September and November 2020. During and following the pandemic inevitably there will be a need for increased virtual engagement. There are plans to use the newly launched CCG virtual engagement HQ, as well as other virtual tools. There will also need to be non-digital ways to consult. Those who are digitally excluded are a new group that we will need to work hard to find new ways to reach. Particular focus will also be needed on reaching out to BAME and those who are impacted by health inequalities.
Engagement, Involvement & Communication Strategy	Strategy under development	Simon Lanceley	24/06/20	Strategy in development, informed through the 'Community Conversations' work with the VCS by Helen England (external facilitator)and Anna Rarity (Patient and Public Involvement Manager).
New post of Director of Engagement, Involvement & Communication	Appointment made	Simon Lanceley	24/06/20	James Brown, appointed, due in post from September 2020
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)

QUARTERLY UPDATE AND REVIEW OF OBJECTIVES TEMPLATE

Strategic Objective 5: Involved People: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services.

<table>
<tr><th colspan="4">Quarterly Progress report</th></tr>
<tr><th rowspan="2">Current assurances (positive and negative)
What is known about the effectiveness of the controls from the assurance framework? Are the assurances effective?</th><th rowspan="2">General update
E.g. milestones reached</th><th colspan="2">Assurance Rating</th></tr>
<tr><th>Proposed</th><th>Agreed</th></tr>
<tr><td>New Engagement, Involvement & Communication Strategy</td><td>Strategy in development, informed through the ‘Community Conversations’ work with the VCS by Helen England (external facilitator)and Anna Rarity (Patient and Public Involvement Manager).</td><td rowspan="3">GREEN</td><td rowspan="3">An agreed rating will be sought within the committee.</td></tr>
<tr><td>Trust Engagement & Involvement capacity & capability</td><td>• Appointment made to new Director of Engagement, Involvement & Communication post – James Brown will be in post from September
• Improved stakeholder communication and management with key groups following appointment of Strategy Patient and Public Engagement Involvement Manager</td></tr>
<tr><td>Programme specific</td><td>Fit for the Future – public consultation planned for Sept to November, to include increased use of digital engagement tools
Strategic Site Development – planning application submitted 22/06, Local residents and partners aware beforehand</td></tr>
</table>

Strategic Objective 5: Involved People: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

<table>
<tr><td>Principal Risk ID</td><td>5.2</td><td colspan="4">Risk that operational delivery pressures prevent staff from contributing to co-design sessions resulting in staff feeling change is being implemented without their input</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>Principal risk assessment for BAF: 4 x 1
No entry on risk register relating to this principle risk</td><td>Current Score (C x L)</td><td>Principal risk assessment for BAF: 4 x 3

(from 4x4)
No entry on risk register relating to this principle risk</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Strategy and Transformation</td><td>Oversight/Assurance Committee</td><td>People and OD</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. Programme boards for major programmes include Senior members of the People and OD and Communication team to ensure staff have a voice, monitor delivery and include staff engagement and internal communication plans (D)</td><td colspan="3">1. Programme Boards report to one of seven Delivery Groups and onto TLT.</td></tr>
<tr><td colspan="3">2. All major change is managed by the People and OD team to ensure published staff engagement and consultation protocols are followed adequately.</td><td colspan="3">2. People and OD assurance framework enable escalation of issues to Trust Leadership Team. In addition the Trade Union Joint Staff Side constitution provides clear routes of escalation and a forum from which to debate and receive feedback on the management of change (attended by the CEO).</td></tr>
<tr><td colspan="3">3. Focussed effort to increase and improve level of staff engagement through a range of methods:
• GSQIA (supported by the Patient Experience Team)
• Objectives defined in Quality Improvement Strategy
• Programme specific events e.g. Centres of Excellence staff engagement sessions; engagement sessions on the new Trust Strategy and EDS2 Objectives
• Staff surveys for co-design purposes
• J2O Executive Team visits</td><td colspan="3">3. Staff Survey – reported to People and OD Delivery Group and Committee provides a thematic view of where colleagues feel involved or not. Further engagement information is captured via J2O executive visits feedback, Executive reviews and the Freedom to Speak Up Guardian (reporting into the People and OD Committee and the Quality Delivery Group).</td></tr>
<tr><td colspan="3"></td><td colspan="3">4. Identify local stakeholders (objective EDS) – work taking place to build stronger community partnerships, including the development of an Involvement Network for Strategic Projects.</td></tr>
</table>

Strategic Objective 5: Involved People: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

		5. Patient Experience Improvement Training is now part of both the Silver and Gold QI programmes, teaching teams different tools and approaches for involving and engaging patients in QI projects		
		6. Reports on' conversations with communities' (EDS2 objective) through Staff and Patient Experience Improvement Group and Equality Diversity and Inclusion Steering Group		
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Engagement, Involvement & Communication Strategy	Strategy under development	Simon Lanceley	24/06/20	Strategy in development, informed through the 'Community Conversations' work with the VCS by Helen England (external facilitator)and Anna Rarity (Patient and Public Involvement Manager).
New post of Director of Engagement, Involvement & Communication	Appointment made	Simon Lanceley	24/06/20	James Brown, appointed, due in post from September 2020
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 5: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

Principal Risk ID	**5.3**	Risk that as a result of some feedback through engagement and consultation not being not taken up, patients, the public and staff feel 'not listened to'			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3X1	**Current Score (C x L)**	3X2
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	Board

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Silver Quality Improvement projects must involve patients when appropriate and are supported by the Patient Experience Improvement Team 2. Partnerships with existing external organisations in Gloucestershire strengthened through the development of 'Community Conversations' with the voluntary and community sector (VCS) in order to inform our Communications and Engagement Strategy e.g. Healthwatch Gloucestershire, Inclusion Gloucestershire, MIND, Gloucestershire Carers Hub and the Gloucestershire Maternity Voices Partnership 3. EDS2 Objectives (aiming to have conversations with the community around protected characteristics and to develop person-centred care charters) and an action plan to deliver them 4. Trust membership events required to be virtual during and following the pandemic. Members now offered more active involvement through strategic projects 5. Governors Strategy and Engagement Group 6. Patient experience stories heard at every Board 7. Board approved Quality Strategy includes patient experience objectives	1. Friends and family test 2. Staff survey 3. Annual Members meeting required to be virtual due to the pandemic 4. Engagement and consultation events, through the Fit for the Future Programme and Strategic Site Development 5. 'Community Conversations' led by Helen England (external facilitator) with the VCS will support the ''listening approach' being taken 6. Survey data including: Five surveys from the National Survey Programme related to our services; Friends and Family Test; real time patient surveys; local surveys 7. Biannual Learning from Patient Stories Report 8. Council of Governors 9. Equality report to People and OD and the Board 10. Quarterly patient experience report to Q&P Committee 11. Themes and trends within the Annual Complaints Report 12. 'Community Conversations' Report to include a high level strategic stakeholder map, identifying external groups, organisations and communities with whom the Trust is committed to collaborating with. The report will provide an insight into how these future relationships will be shaped to be most effective for all parties 13. Developing a VCS Involvement Network to refer to on projects such as Strategic Site Development will be an additional outcome of 'Community Conversations' Report

Strategic Objective 5: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Fit for the Future public consultation	Consultation plan/ approach being developed	Simon Lanceley, Ellen Rule	24/06/20	Strategy and implementation underway. Consultation during and following a pandemic is a completely new area for consideration. Consultation to take place between September and November 2020. During and following the pandemic inevitably there will be a need for increased virtual engagement. There are plans to use the newly launched CCG virtual engagement HQ, as well as other virtual tools. There will also need to be non-digital ways to consult. Those who are digitally excluded are a new group that we will need to work hard to find new ways to reach. Particular focus will also be needed on reaching out to BAME and those who are impacted by health inequalities.
Engagement, Involvement & Communication Strategy	Strategy under development	Simon Lanceley	24/06/20	Strategy in development, informed through the ‘Community Conversations’ work with the VCS by Helen England (external facilitator)and Anna Rarity (Patient and Public Involvement Manager).
New post of Director of Engagement, Involvement & Communication	Appointment made	Simon Lanceley	24/06/20	James Brown, appointed, due in post from September 2020
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 5: Involved People: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

<table>
<tr><td>Principal Risk ID</td><td>5.4</td><td colspan="5">Risk that the staff morale is adversely affected, should the Centres of Excellence vision and/or estates development get delayed and the expected patient and staff benefits do not get realised as/when expected</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>Principle risk assessment for BAF: 2 x 2

No entry on risk register relating to this principle risk</td><td colspan="2">Current Score (C x L)</td><td>Principle risk assessment for BAF: 3 x4

No entry on risk register relating to this principle risk</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Strategy and Transformation</td><td colspan="2">Oversight/Assurance Committee</td><td>People and OD</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="4">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. Programme boards for initiatives include Senior members of the People and OD to ensure staff have a voice, monitor delivery and include staff engagement and internal communication plans</td><td colspan="4">1. Programme board initiatives report into DOG and TLT.</td></tr>
<tr><td colspan="3">2. Clear and open communication , staff survey action plans and engagement through 100 Leaders, Engagement sessions, Extended Leadership Network, CEO Weekly blog, Involve</td><td colspan="4">2. People and OD dashboard reported to People and OD Committee and Board will provide a view of any issues relating to staff morale and centres of excellence. In addition Freedom to Speak Up Guardian reporting into the People and OD Committee and the Quality Delivery Group will highlight potential areas of concern.</td></tr>
<tr><td colspan="3">3. Centres of Excellence and One Place Pre-Consultation Business Case , engagement sessions and implementation plan</td><td colspan="4">3. Centres of Excellence and Fit for the Future business cases reported to Board in addition to this the NHS Staff Survey reports could enable an overview of specific issues for staff relating to centres of excellence in qualitative narrative.</td></tr>
<tr><td colspan="3">4. People and OD strategy initiatives within colleague experience will assist with ensuring open communication is maintained to staff, whilst the Freedom to Speak Up Guardian provides further support.</td><td colspan="4">4. People and OD dashboard reported to People and OD Committee and Board will provide a view of any issues relating to staff morale and centres of excellence. In addition Freedom to Speak Up Guardian reporting into the People and OD Committee and the Quality Delivery Group will highlight potential areas of concern.</td></tr>
<tr><td colspan="3">2. Proposals to engage staff which require release are subject to Director Operational Review and Trust Leadership Team approval</td><td colspan="4">5. Programme board initiatives report into DOG, TLT. High level communication managed in agreement with Trust Board</td></tr>
<tr><td colspan="2">Gaps in Controls
The control is not in place or not effective,</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td colspan="2">Update</td></tr>
</table>

Strategic Objective 5: Involved People: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

due to the design of the control or the likelihood of it being effective				
Engagement and Involvement Strategy	Strategy under development	Director of Strategy	TBA	Draft in circulation but requires further development
Estates strategy	Strategy under development	Director of Strategy and Transformation	Complete	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
The need to deliver the strategies as noted above				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 5: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

<table>
<tr><td>Principal Risk ID</td><td>5.5</td><td colspan="4">Risk that poor engagement (with/ from patients, staff, stakeholders and the public) leads to inadequate representation and low overall involvement meaning a wide range of views are not incorporated into design and decision making</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>4
(4 x 1)</td><td>Current Score (C x L)</td><td>12
(4 x 3)</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Strategy and Transformation</td><td>Oversight/Assurance Committee</td><td>People and OD Committee (PODC)</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. Silver Quality Improvement projects must involve patients when appropriate and are supported by the Patient Experience Improvement Team
2. Partnerships with existing external organisations in Gloucestershire strengthened through the development of ‘Community Conversations’ with the voluntary and community sector (VCS) in order to inform our Communications and Engagement Strategy e.g. Healthwatch Gloucestershire, Inclusion Gloucestershire, MIND, Gloucestershire Carers Hub and the Gloucestershire Maternity Voices Partnership
3. EDS2 Objectives (aiming to have conversations with the community around protected characteristics and to develop person-centred care charters) and an action plan to deliver them
4. Trust membership events required to be virtual during and following the pandemic. Members now offered more active involvement through strategic projects
5. Governors Strategy and Engagement Group
6. Patient experience stories heard at every Board
7. Board approved Quality Strategy includes patient experience objectives
8. Programme boards for major programmes include Senior members of the People and OD and Communication team</td><td colspan="3">1. Friends and family test
2. Staff survey
3. Annual Members meeting required to be virtual due to the pandemic
4. Engagement and consultation events, through the Fit for the Future Programme and Strategic Site Development
5. ‘Community Conversations’ led by Helen England (external facilitator) with the VCS will support the ’’listening approach’ being taken
6. Survey data including: Five surveys from the National Survey Programme related to our services; Friends and Family Test; real time patient surveys; local surveys
7. Biannual Learning from Patient Stories Report
8. Council of Governors
9. Equality report to People and OD and the Board
10. Quarterly patient experience report to Q&P Committee
11. Themes and trends within the Annual Complaints Report
12. ‘Community Conversations’ Report to include a high level strategic stakeholder map, identifying external groups, organisations and communities with whom the Trust is committed to collaborating with. The report will provide an insight into how these future relationships will be shaped to be most effective for all parties
13. Developing a VCS Involvement Network to refer to on projects such as Strategic Site Development will be an additional outcome of ‘Community Conversations’ Report
14. Programme Boards report to one of seven Delivery Groups and onto TLT.
15. People and OD assurance framework enable escalation of issues to Trust Leadership Team. In addition the Trade Union Joint Staff Side constitution provides</td></tr>
</table>

<table>
<tr>
<td colspan="2">to ensure staff have a voice, monitor delivery and include staff engagement and internal communication plans (D)
9. All major change is managed by the People and OD team to ensure published staff engagement and consultation protocols are followed adequately.
10. Focussed effort to increase and improve level of staff engagement through a range of methods:
• GSQIA (supported by the Patient Experience Team)
• Objectives defined in Quality Improvement Strategy
• Programme specific events e.g. Centres of Excellence staff engagement sessions; engagement sessions on the new Trust Strategy and EDS2 Objectives
• Staff surveys for co-design purposes
• J2O Executive Team visits</td>
<td colspan="3">clear routes of escalation and a forum from which to debate and receive feedback on the management of change (attended by the CEO).
16. Staff Survey – reported to People and OD Delivery Group and Committee provides a thematic view of where colleagues feel involved or not. Further engagement information is captured via J2O executive visits feedback, Executive reviews and the Freedom to Speak Up Guardian (reporting into the People and OD Committee and the Quality Delivery Group).
17. Identify local stakeholders (objective EDS) – work taking place to build stronger community partnerships, including the development of an Involvement Network for Strategic Projects.
18. Patient Experience Improvement Training is now part of both the Silver and Gold QI programmes, teaching teams different tools and approaches for involving and engaging patients in QI projects
19. Reports on' conversations with communities' (EDS2 objective) through Staff and Patient Experience Improvement Group and Equality Diversity and Inclusion Steering Group</td>
</tr>
<tr>
<th>Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</th>
<th>Actions for gaps</th>
<th>Owner</th>
<th>Date</th>
<th>Update</th>
</tr>
<tr>
<td>Fit for the Future public consultation</td>
<td>Consultation plan/ approach being developed</td>
<td>Simon Lanceley, Ellen Rule</td>
<td>24/06/20</td>
<td>Strategy and implementation underway. Consultation during and following a pandemic is a completely new area for consideration. Consultation to take place between September and November 2020. During and following the pandemic inevitably there will be a need for increased virtual engagement. There are plans to use the newly launched CCG virtual engagement HQ, as well as other virtual tools. There will also need to be non-digital ways to consult. Those who are digitally excluded are a new group that we will need to work hard to find new ways to reach. Particular focus will also be needed on reaching out to BAME and those who are impacted by health inequalities.</td>
</tr>
</table>

Strategic Objective 5: Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services

Engagement, Involvement & Communication Strategy	Strategy under development	Simon Lanceley	24/06/20	Strategy in development, informed through the 'Community Conversations' work with the VCS by Helen England (external facilitator)and Anna Rarity (Patient and Public Involvement Manager).
New post of Director of Engagement, Involvement & Communication	Appointment made	Simon Lanceley	24/06/20	James Brown, appointed, due in post from September 2020
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)

QUARTERLY UPDATE AND REVIEW OF OBJECTIVES TEMPLATE

Strategic Objective 6: We have established Centres of Excellence that provide urgent , planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within county.

<table>
<tr><th colspan="4">Quarterly Progress Report</th></tr>
<tr><th rowspan="2">Current assurances (positive and negative)
What is known about the effectiveness of the controls from the assurance framework? Are the assurances effective?</th><th rowspan="2">General update
E.g. milestones reached</th><th colspan="2">Assurance Rating</th></tr>
<tr><th>Proposed</th><th>Agreed</th></tr>
<tr><td>Pre-Consultation Business Case (PCBC) 80% complete and describes four shortlisted options informed by staff, patient and public engagement.

Centres of Excellence Strategy aligned to NHS Long Term Plan e.g. separation of emergency and planned care.</td><td>Fit for the Future programme re-started in June.
Key milestones:
• PCBC complete – July 2020
• GHFT PCBC approval – 13th August 2020
• SW Clinical Senate – 20th August
• NHS England Stage 2 Assurance – 3rd September
• Public consultation – Sept to December
• Decision making – Jan/Feb 2021
• Implementation – from Feb 2021

Risk that any second surge in COVID-19 impacts this timeline, particularly public consultation.</td><td>Amber</td><td>An agreed rating will be sought within the Committee</td></tr>
</table>

Strategic Objective 6: We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county

<table>
<tr><td>Principal Risk ID</td><td>6.1</td><td colspan="4">Risk that proposals to establish our Centres of Excellence model get delayed due to public opposition and/or legal challenge, delaying the realisation of patient benefits</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>4 x 2</td><td>Current Score (C x L)</td><td>4 x 3</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Strategy and Transformation</td><td>Oversight/Assurance Committee</td><td>Board</td></tr>
</table>

<table>
<tr><td colspan="2">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="2">1. Fit for the Future Pre-Consultation Business Case (PCBC), that includes our Centres of Excellence (CoEx) PCBC, includes a clear, evidence based case for change that aligns to NHS E guidance (separation of planned and emergency care)
2. Public consultation has been preceded by 3-month public engagement stage designed and supported by The Consultation Institute (TCI)
3. Lessons learned from recent threat of legal action incorporated into engagement and consultation plan
4. Legal support in place to inform decision making and approach (Capsticks)
5. Improved stakeholder communication and management with key groups following appointment of Strategy Patient and Public Engagement Involvement Manager</td><td colspan="3">1. Centres of Excellence Co-ordination Group managing development of final PCBC reports into Strategy & Transformation Delivery Group
2. S&T Delivery Group monthly reporting to Trust Leadership Team & GHFT Board
3. FFtF reporting to ICS Executives
4. GHFT Board to approve final version of FFtF Business Case in August 2020 ahead of public consultation September to November.</td></tr>
<tr><td>Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
<tr><td>Need to design a legally compliant consultation process that takes into account social distancing rules</td><td>Work in progress with TCI to design consultation approach</td><td>GCCG</td><td>June 2020</td><td></td></tr>
<tr><td>Gaps in Assurances
Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
</table>

Strategic Objective 6: We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 6: We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county

Principal Risk ID	**6.2**	Risk that the phased approach to implementation of our Centre of Excellence model is extended beyond reasonable timescales due to a range of dependencies e.g. estate, capital, workforce, technology delaying the realisation of patient benefits			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3 x 2	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)		Director of Strategy and Transformation		**Oversight/Assurance Committee**	Board

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Pre-Consultation business case to include phased implementation plan 2. Board approved Estates Strategy articulates priorities, including SSDP 3. Board approach People & OD Strategy 4. Board approved Digital Strategy 5. Development of 5-year Capital Plan to improve planning and alignment to strategic and operational priorities	1. Centres of Excellence & SSDP Co-ordination Group managing development of final PCBC reports into Strategy & Transformation Delivery Group 2. S&T Delivery Group monthly reporting to Trust Leadership Team & GHFT Board 3. Oversight of development of enabling strategies by relevant committee and then Board approval

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Uncertainty around long-term capital funding route	Awaiting national guidance	Director of Finance	June/ July	
Capital is now allocated at ICS level and PDC limits set	Explore what this means for sourcing capital from other routes e.g. University, County Council, Private organisations	Director of Finance and Director of Strategy & Engagement	July/ August	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)

Strategic Objective 6: We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county

	Not applicable	

Strategic Objective 6: We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county

Principal Risk ID	**6.3**	Risk that the Strategic Site Development Programme fails to take account of the new roles/ways of working set out in the People and OD strategy, leading to suboptimal estate		
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	Principal risk assessment for BAF: 1 x 1 No entry on risk register relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF: 1 x 1 No entry on risk register relating to this principal risk
Risk Owner (Executive Director)	Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1 People and OD Strategy maps new roles and ways of working under the workforce sustainability and transformation pillar including Develop and implement new workforce models within the Trust and with partners, develop new roles and career pathways, Deliver digital and technological efficiencies for people processes	1. Progress made against People and OD strategy reported on a 6 monthly basis to People and OD Committee
2 Oversight of strategic site development business cases at, Strategy Delivery Group, TLT, Finance and Digital Committee and Trust Main Board.	2. Strategic site development programme OBC and FBC oversight at Board
3 Robust development of operational plan, including workforce plan,	3. Board oversight
4 Programme risks managed at SSD Programme Board and escalated through committee, TLT and Board within monthly progress reports	4. Board oversight

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Estates Strategy	Strategy approved by TLT and Estates & Facilities	Director of Strategy and Transformation	Complete	Estates strategy to Trust Main Board December 2019

Strategic Objective 6: We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county

Digital Strategy	Strategy under development	CIO	Complete	New Digital strategy
Strategic site development programme OBC	Business case under development	Director of Strategy and Transformation	Complete	OBC to Trust Main Board February 2020
Strategic Site Development FBC	Business case under development	Director of Strategy and Transformation	December 2020	FBC in development and to seek approval in November 2020
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
The need to receive the strategies noted above and FBC by the timeline noted		Director of Strategy and Transformation		

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• NHSI current UoR rating of 'Requires Improvement' • Trust is within Segment 3 of the NHSI Single Oversight Framework	• Whilst there had been previous NHSI agreement to financial plan for 2019/20, the coronavirus pandemic has meant trusts are working within block contract arrangements until end of March 2021. • Annual report and accounts 2019/20 had qualified opinion from external auditor due inability to complete stocktake due to the pandemic however they did confirm the Trust delivers value for money. This affected a number of trusts across the country and could also impact on 2020/21 audits due to inability to verify opening balances.	Amber (Moderate)	

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

<table>
<tr><td>Principal Risk ID</td><td>7.1</td><td colspan="4">Risk that we lack the capacity and capability needed to identify and/or deliver transformational, sustainable savings schemes</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>3 x 2</td><td>Current Score (C x L)</td><td>5 x 3</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Finance</td><td>Oversight/Assurance Committee</td><td>Finance and Digital</td></tr>
</table>

<table>
<tr><td colspan="2">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="2">1. Operational plan
2. Cost Improvement Programme
3. Engagement on CIP through Involve, CEO weekly blog, 100 Leaders, Extended Leadership Network
4. Improved engagement with budget holders on budget setting process
5. Capability development (Count Me In programme; PMO support to divisions)</td><td colspan="3">1. Monthly CIP update to Finance and Digital Committee
2. Programme Management Office record and monitor the CIP progress
3. Financial Sustainability Delivery Group scrutiny of CIP delivery
4. Executive reviews with divisions include focus on financial recovery and CIP delivery
5. Audit reports</td></tr>
<tr><td>Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
<tr><td>Finance strategy</td><td>Strategy under development</td><td>KJ</td><td>September 2020</td><td>Strategy publication date amended to allow stabilisation of senior finance function.
On progress</td></tr>
<tr><td>Appetite to generate transformational ideas</td><td>To promote and encourage the generation of transformational ideas across the Trust, and within Divisions in particular</td><td>Execs/SL</td><td>September 2020</td><td>KJ identified need to establish where ideas coming are from and to encourage other areas to engage and submit proposals.
A positive outcome of the pandemic has been the speed in which we have implemented change, some of the change is transformational and is being picked up by the Silver lining documentation</td></tr>
<tr><td>Organisational culture re: financial sustainable improvement not fully</td><td>Strengthen organisational awareness to the need for financial sustainability</td><td>KJ</td><td>June 2020</td><td>Build on the Count Me In programme to ensure more staff become aware and engaged in the need to ensure the Trust is financially</td></tr>
</table>

embedded.				sustainable Senior finance team now in place and the focus is understanding the drivers of our deficit/spend Implementing a budget management statement due to be rolled out in August.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
F2927	*Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20*	*5 x 3*

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

<table>
<tr><td>Principal Risk ID</td><td>7.2</td><td colspan="4">Risk of expenditure exceeding budgets, resulting in worsening of Trust's underlying financial position.</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>1 x 1</td><td>Current Score (C x L)</td><td>3 x 2</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Finance</td><td>Oversight/Assurance Committee</td><td>Finance and Digital</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
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<tr><td colspan="3">1. Operational plan
2. Cost Improvement Programme
3. Engagement on CIP through Involve, CEO weekly blog, 100 Leaders, Extended Leadership Network
4. Improved engagement with budget holders on budget setting process
5. Capital plan</td><td colspan="3">1. Financial Sustainability Delivery Group reports
2. Monthly CIP update to Finance and Digital Committee
3. Monthly financial performance report to Finance and Digital Committee and to Board for assurance
4. Budgets remaining stable and position improved for year end 2019/20.</td></tr>
<tr><td colspan="2">Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
<tr><td colspan="2">Degree of ownership of solutions</td><td>Training and communications to encourage and focus on a shift towards the development and implementation of solutions to identified issues</td><td>Execs</td><td>June 2020</td><td>Organisation is good at articulating and identifying issues but more can be done to generate solutions to close the gap.
Due to the pandemic the financial framework is different to what we had assumed at the start of the year. The first four months had very little financial structure, beyond month 4 financial scrutiny will restart and accountability to delivery within an overall financial envelope will be re-instated. The value is not yet known.
Depending on the value there may or may not be a requirement to make efficiencies.</td></tr>
<tr><td colspan="2">Finance strategy</td><td>Strategy under development</td><td>KJ</td><td>September 2020</td><td>Strategy publication date amended to allow stabilisation of senior finance function.</td></tr>
</table>

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
F2335	*The risk of agency spend in clinical and non-clinical areas exceeding planned levels due to ongoing high vacancy levels, with resulting impact of delivery of FY20 CIP programme*	*4 x 4*
F2928	*Risk that the Trust's expenditure exceeds the budgets set resulting in failure to deliver the FY20 Financial Plan*	*4 x 3*
F2927	*Risk that the Trust does not achieve the required cost improvement resulting in failure to deliver the Financial Recovery Plan for FY20*	*5 x 3*

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

<table>
<tr><td>Principal Risk ID</td><td>7.3</td><td colspan="4">Risk that the commissioner funding does not address structural funding deficit over the strategic period</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>4 x 3</td><td colspan="2">Current Score (C x L)</td><td>5 x 4</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Finance</td><td colspan="2">Oversight/Assurance Committee</td><td>Finance and Digital</td></tr>
<tr><td colspan="3">Key Controls
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<tr><td colspan="3">1. Contract negotiations with commissioners informed by 'drivers of deficit' report</td><td colspan="4">1. Financial performance report to Finance and Digital Committee and to Board
2. ICS Board</td></tr>
<tr><td colspan="2">Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td colspan="2">Update</td></tr>
<tr><td colspan="2">Finance strategy</td><td>Strategy under development</td><td>KJ</td><td>September 2020</td><td colspan="2">Strategy publication date amended to allow stabilisation of senior finance function.
Progress being made and still working towards the Sept deadline.</td></tr>
<tr><td colspan="2">Limited influence over commissioner funding</td><td>Work with the ICS to develop new approaches to contracting and a sustainable funding settlement</td><td>KJ</td><td></td><td colspan="2">Contract envelope agreed for 20/21, where growth is managed across the system. Risk share approach needs to be agreed.
This has been superseded by the change in the financial framework due to COVID-19.</td></tr>
<tr><td colspan="2">Limited influence over commissioner funding</td><td>Five year system planning</td><td>RDC/SL/KJ</td><td></td><td colspan="2">The Trust has no influence over the level of funding the commissioner receives however it will have some influence as part of the ICS about how that funding is apportioned out across the provider sector.</td></tr>
<tr><td colspan="2">Ability to explain the structural deficit in a clear way</td><td></td><td>KJ</td><td></td><td colspan="2">This has been presented to F&D for discussion however the pandemic took priority. A further discussion will be needed.</td></tr>
<tr><td colspan="2">Funding for 2020/21 unknown</td><td>Regular ICS discussion about how we collectively get an understanding about what</td><td>KJ</td><td>August 2020</td><td colspan="2">The current funding arrangement will cease from 31 July. New arrangements in place by 1 August.</td></tr>
</table>

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

	drives spend across the system. To proactively engagement with regional colleagues to keep up to date on national changes			Work ongoing around the drivers of our costs across the system. This becomes more challenging for the Trust and a significant call on resources as we have limited service line reporting.
Future funding arrangements for 2021 and beyond not clear	ICS Finance group already established to understand the new guidance when it is published. To proactively engagement with regional colleagues to keep up to date on national changes	KJ		Although the issue is being raised nationally, no guidance or indication on what next year looks like has been shared. Regular regional conference calls are in place to keep abreast of current and future plans.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
ICS – Strengthening				

Related Risks from the Trust Risk Register

Code	Risk description	C x L Score (Domain)
F2723	*Risk that FY20 income recovery will be reduced as a result of being unable to submit accurate data to commissioner to support payment, arising from issues associated with TrakCare implementation* ***Sim – I'm not sure this is relevant now???? The risk may have to change. Can you discuss with Johanna to see what risk we have on the risk register that we can use to support this risk.*** ***For me it's about being able to respond promptly to national changes which is made more challenging as the link between finance, demand and workforce is not easily understood. If we don't respond promptly then the financial impact could be significant for the Trust.***	*3 x3*

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

<table>
<tr><td>Principal Risk ID</td><td>7.4</td><td colspan="5">Risk that we do not have sufficient capital funding for transformation including the Centres of Excellence Programme and the Strategic Site Development Programme and/or cash flow risk due to phasing of the programmes</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>2 x 2</td><td colspan="2">Current Score (C x L)</td><td>4 x 4</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Finance</td><td colspan="2">Oversight/Assurance Committee</td><td>Finance and Digital</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="4">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. Capital plan
2. NHSI funding bids
3. Estates Strategy
4. Strategic Site Development Programme Outline Business Case</td><td colspan="4">1. Financial performance report to Finance and Digital Committee and to Board
2. Capital update to Finance and Digital Committee
3. External audit
4. Business cases (for Centres of Excellence Programme and for the Strategic Site Development Programme) presented to Finance and Digital Committee and to Board for approval
5. Oversight of Strategic Site Development Programme at Estates and Facilities Committee</td></tr>
<tr><td colspan="2">Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td colspan="2">Update</td></tr>
<tr><td colspan="2">Strategic capital funding options</td><td>Finance and Digital Committee oversight; Estates and Facilities Committee input</td><td>KJ</td><td>April 2020</td><td colspan="2">Address by April 2020 for Fit For the Future (FFtF)
Due to impact on COVID-19 the allocation of capital has changed. Systems are now given an allocation and they need to live within that. There are not alternative capital pots to be claimed against.</td></tr>
<tr><td colspan="2">Finance strategy</td><td>Strategy under development</td><td>KJ</td><td>September 2020</td><td colspan="2">Strategy publication date amended to allow stabilisation of senior finance function.
On progress</td></tr>
<tr><td colspan="2">Capital backlog maintenance</td><td>Identify and implement plans to address £60m backlog.</td><td>KJ</td><td>June 2020</td><td colspan="2">Confirmed that Trust can’t apply for general loan as in previous years. It has to be through emergency capital. This could slow investment and delay ambition to strategic projects linked</td></tr>
</table>

				to Centres of Excellence. New capital funding regime for 2020/21 that gives an allocation to systems as mentioned above. The Trust is looking at developing a refurbishment programme as the backlog maintenance will continue to be an issue for the Trust.
Equipment asset register may not capture everything	Develop and strengthen full asset register for capital equipment	KJ		No update, no progress to date
No long term capital allocation from the centre.	Review plans to mitigate the impact of no central long term capital allocation.	KJ	October 2020	Hopeful to receive more information from the Autumn Statement.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
F2522	*Risk that available capital is insufficient to support requirements associated with buildings maintenance, equipment renewal and backlog maintenance resulting in major operational impacts and increased costs*	*4 x4*

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

Principal Risk ID	**7.5**	Risk that the Integrated Care System (ICS) model adversely affects the Trust's financial position			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	3 x 1	**Current Score (C x L)**	3 x 2	
Risk Owner (Executive Director)	Director of Finance		**Oversight/Assurance Committee**	Finance and Digital	
Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*		**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*			
1. One Gloucestershire strategy 2. One Place business case 3. ICS operating plan 4. Trust Executives' membership of ICS structures 5. ICS delivery structures including programmes, ICS Executive and ICS Board		1. Financial performance report to Finance and Digital Committee and to Board 2. Integrated Care System Delivery Board 3. STP Memorandum of Understanding 4. Reporting on ICS developments to Trust Board and Board Committees 5. Appointment of Dame Gill Morgan as ICS Chair.			
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**	
Finance strategy	Strategy under development	KJ	September 2020	Strategy publication date amended to allow stabilisation of senior finance function. On progress	
Effectiveness of ICS governance structure		ICS	September 2020	Appointment of Dame Gill Morgan is a positive action and should lead to further development and strengthening of ICS governance. The system worked extremely well together during the pandemic which has pushed a more open approach to improving pathways. Governance structure in place and working well.	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**	
Consistency of ICS reporting to partner organisations' Boards	Implement consistent ICS reporting to partner		June 2020	Still in development We are using our current reporting templates to	

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

and across Board Committees	organisations' Boards and across Board Committees			consolidate into a system position. This has worked well over the last few months.
ICS governance arrangements	Being developed		September 2020	Still in development although Dame Gill Morgan appointed as independent chair. No update

Related Risks from the Trust Risk Register

Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

<table>
<tr><td>**Principal Risk ID**</td><td>**7.6**</td><td colspan="4">Risk of failure to deliver the required return on investment (ROI), especially in digital projects and programmes</td></tr>
<tr><td colspan="2">**Principal risk to Achievement of the Objective**
Including target and current risk score</td><td>**Target score (C x L)**</td><td>2 x 2</td><td>**Current Score (C x L)**</td><td>3 x 3</td></tr>
<tr><td colspan="2">**Risk Owner (Executive Director)**</td><td colspan="2">Director of Finance</td><td>**Oversight/Assurance Committee**</td><td>Finance and Digital</td></tr>
</table>

<table>
<tr><td colspan="2">**Key Controls**
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">**Sources of assurances on Controls**
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="2">1. Service Development Group peer review business cases
2. Recruitment to key roles for delivering the Electronic Patient Record (EPR)
3. Benefits workshop engaging senior colleagues across the Trust to map benefits and opportunities of the EPR
4. Capital plan
5. Theatre improvement and outpatient improvement implementation plans</td><td colspan="3">1. Financial performance report to Finance and Digital Committee and to Board
2. Business Case approval by Finance and Digital Committee (and Board, where required)</td></tr>
<tr><td>**Gaps in Controls**
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>**Actions for gaps**</td><td>**Owner**</td><td>**Date**</td><td>**Update**</td></tr>
<tr><td>Robust benefits identification, delivery and tracking across major projects</td><td></td><td>PMO</td><td></td><td>In progress, report to go to F&D Committee during the Autumn – focus on IT ROI initially.</td></tr>
<tr><td>Clear line of accountability</td><td>Develop Standard Operating Procedures (SOP) / guidance on accountability and ROI related to key projects and investments</td><td>KJ</td><td>September 2020</td><td>Develop as part of Finance Strategy and link to training and awareness of the need for financial sustainability.</td></tr>
<tr><td>Finance strategy</td><td>Strategy under development</td><td>KJ</td><td>September 2020</td><td>Strategy publication date amended to allow stabilisation of senior finance function.</td></tr>
<tr><td>**Gaps in Assurances**
Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective</td><td>**Actions for gaps**</td><td>**Owner**</td><td>**Date**</td><td>**Update**</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 8: We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact

<table>
<tr><th colspan="4">Quarterly Progress report</th></tr>
<tr><th rowspan="2">Current assurances (positive and negative)
What is known about the effectiveness of the controls from the assurance framework?</th><th rowspan="2">General update
E.g. milestones reached</th><th colspan="2">Assurance Rating</th></tr>
<tr><th>Proposed</th><th>Agreed</th></tr>
<tr><td>• Board approved Estates Strategy to support phase 1 - £39.5M
• Phase 2 priorities being worked up with divisions, reporting to Strategy & Transformation Delivery Group and Infrastructure Delivery Group
• Development of 5-year capital plan to address strategic and operational priorities
• Monitor and respond to NHSE/I calls for capital bids
• Oversight of Strategic Site Development Programme at Estates and Facilities Committee and Board
• Oversight of operational plan, including workforce plan, at Board</td><td>• SSDP OBC to NHS Joint Investment Sub-Committee w/c 22nd June
• Update on Phase 2 Estates priorities to S&T Delivery Group 21st July
• 5-year capital plan in development with updates to Infrastructure Delivery Group
• Awaiting confirmation on long term NHS capital plan.
• Risks/ benefits of capital being allocated to ICS with overall PDC limits to be defined</td><td>AMBER</td><td></td></tr>
</table>

Strategic Objective 8: We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact

<table>
<tr><td>Principal Risk ID</td><td>8.1</td><td colspan="4">Risk that the Trust cannot access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings to prevent cumulative degradation.</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>4 x 2</td><td>Current Score (C x L)</td><td>4 x 4</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Finance / Chief Operating Officer</td><td>Oversight/Assurance Committee</td><td>Estates and Facilities</td></tr>
</table>

<table>
<tr><td colspan="2">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="2">1. Capital programme priorities informed by Trust and Divisional risk registers
2. Develop pre-emptive business cases in anticipation of national calls for capital bids
3. Operationalise GHFT Estates Strategy to produce a Development Control Plan
4. Develop Managed Equipment Service (MES) Business Case
5. £39.5M Strategic Site Development Programme (SSDP)
6. Investigate and develop alternative sources of capital funding</td><td colspan="3">1. Capital programme update to Finance and Digital Committee and Trust Board
2. SSDP FBC to Finance and Digital Committee, Estates Committee and Trust Board
3. Progress on operationalising Estates Strategy reported to Estates Committee
4. MES business case to Finance & Digital Committee and Trust Board
5. Monitor and respond to national calls for capital bids
6. Use Estates Strategy and Development Control Plan to prioritise investment
7. All GHFT enabling strategies being approved by appropriate Board committees and then presented to Trust Board for assurance</td></tr>
<tr><td>Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
<tr><td>SSDP Full Business Case</td><td>FBC under development</td><td>Director of Strategy</td><td>FBC – Dec 2020</td><td>SOC – approved by Board in Nov 2018
OBC – approved by Board in Feb 2020</td></tr>
<tr><td>Finance strategy</td><td>Strategy under development</td><td>KJ</td><td>September 2020</td><td>In progress.</td></tr>
<tr><td>Gaps in Assurances
Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings to prevent cumulative degradation, as a consequence of the Trust's inability to generate and	4 x 4

	borrow capital	

Strategic Objective 8: We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact

<table>
<tr><td>Principal Risk ID</td><td>8.2</td><td colspan="4">Risk that investment decisions are taken at organisational level rather than system resulting in inequity in the quality of NHS estate across Gloucestershire.</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>3 x 2</td><td>Current Score (C x L)</td><td>3 x 1</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Strategy and Transformation</td><td>Oversight/Assurance Committee</td><td>Estates and Facilities</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. ICS Estates Strategy rated ‘Good’ by NHSE in Nov 19
2. Capital now allocated at ICS level with PBC limits</td><td colspan="3">1. ICS Executives have oversight of Estates Strategy</td></tr>
<tr><td colspan="2">Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Gaps in Assurances
Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Related Risks from the Trust Risk Register</td></tr>
<tr><td>Code</td><td colspan="4">Risk description</td><td>C x L Score (Domain)</td></tr>
<tr><td></td><td colspan="4">Not applicable</td><td></td></tr>
</table>

Strategic Objective 8: We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact

Principal Risk ID	**8.3**	Risk that the failure to modernise and renew our estates results in adverse environmental impacts.			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	6 (3 x 2)	**Current Score** **(C x L)**	12 (4 x 3)
Risk Owner **(Executive Director)**		Director of Strategy and Transformation		**Oversight/Assurance Committee**	Estates and Facilities

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Environmental impact & site assessments 2. £39.5M Strategic Site Development Programme 3. New Trust Sustainability Strategy 4. GHFT Estates Strategy & Development Control Plan	1. Capital programme update to Finance and Digital Committee and Trust Board 2. SSDP OBC and FBC to Finance and Digital Committee, Estates Committee and Trust Board 3. Progress on operationalising Estates Strategy reported to Estates Committee

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Sustainability Strategy	Current strategy ends in 2020	Steve Hams		
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register

Code	Risk description	C x L Score (Domain)
C2895COO	Risk that patients and staff are exposed to poor quality care or service interruptions arising from failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings to prevent cumulative degradation, as a consequence of the Trust's inability to generate and borrow capital	4 x 4

Strategic Objective 9: We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
• Digital/IM&T assurance structure for EPR and digital programmes has significant representation from Digital leads, senior clinical and operational colleagues and supplier representation – as well as wider Gloucestershire health partners. This has proven effective to date in supporting identifying a preferred solution during procurement, supporting mobilisation readiness activity, and has been effective in managing current suppliers (e.g. Intersystems). • Sunrise EPR deployment continues ahead of progress with go live dates brought forward for all programme components thus far • Additional layer of oversight between specific project boards and Digital Care Delivery Group in the form of EPR Programme Delivery group has proven effective in maintaining effective oversight of EPR dependencies and enablers. Remain ahead of schedule for current EPR programme as we look towards next year and EPMA/ ECDS deployment.	• Continued active engagement with clinical and operational colleagues to understand clinical priorities/requirements to support defining and deploying of solution including benefits mapping session, visioning & guiding principles • Engagement and system demos. • Close working with Digital and Finance teams to develop a sound and proactive method for identifying and tracking benefits • Early delivery of order comms will be first time that all clinical users are using Sunrise EPR • Reporting of all projects is now presented monthly to Digital Care Board • Given the success of Sunrise EPR deployment to date the organisation is now actively seeking more functionality. Whilst this is hugely positive prioritisation based on quality, safety and financial benefits is essential due to resource constraints.	Moderate	

Strategic Objective 9: We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care

Principal Risk ID	**9.1**	**Risk that we fail to identify and embrace relevant innovations in digital technologies**			
Principal risk to Achievement of the Objective *Including target and current risk score*		**Target score (C x L)**	3 x 2	**Current Score (C x L)**	3 x 3
Risk Owner (Executive Director)		Digital and Chief Information Officer		**Oversight/Assurance Committee**	Finance and Digital Committee

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Digital review of business cases 2. EPR business case and implementation programme 3. EPR Delivery Group 4. Digital Care Delivery Group 5. ICS Board for cross Gloucestershire opportunity awareness 6. Digital Strategy (Approved Feb 2020)	1. Digital Care Delivery Group 2. Digital update to Finance and Digital Committee and to Board 3. ICS Digital Execs

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Finance strategy	Strategy under development	KJ	September 2020	Awaiting,? delay due to COVID
Limitations in financial resource to support embracing identified opportunities/enablers	Continuous dialogue at a board level	MH	Ongoing	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 9: We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care

Principal Risk ID	**9.2**	**Risk that the Electronic Patient Record (EPR) programme and other technology programmes do not proceed as set out in the implementation plans, delaying the timeliness and/or scale of benefits expected**		
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	4 x 1	**Current Score (C x L)**	4 x 1
Risk Owner (Executive Director)	Digital and Chief Information Officer		**Oversight/Assurance Committee**	Finance and Digital Committee

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. EPR Delivery Group 2. IM & T leads 3. Trak Optimisation Programme 4. Trak Care Optimisation Delivery Group 5. Digital Care Delivery Group 6. EPR Delivery governance structure has clearly defined internal and supplier side escalation routes, with regular touch points at each level to proactively mitigate potential issues. 7. Supplier representation across EPR delivery governance meetings. 8. EPR delivery team includes technical and PMO colleagues with previous successful Sunrise EPR experience and working with Allscripts. 9. Permanent recruitment into experienced and knowledgeable roles 10. Regular reporting to TLT and senior clinical forums 11. Digital Strategy 12. Medical Director now chairs the Digital Care Board and is therefore aware of all Digital projects and programmes.	1. Digital update to Finance and Digital Committee via Digital Care Delivery Group, IT risk register, EPR Progress summary and Trak Optimisation Board summary 2. EPR delivery group and Trak Optimisation delivery group report into the Digital Care Delivery Group, which reports into the Trust Leadership Team 3. Monthly Digital Care Delivery Group report at both Finance and Digital Committee and Quality and Performance committee detailing the progress of projects that report into the Digital Care Board 4. Delivery of all aspects of the agreed EPR business case early to date, meaning earlier benefits realisation and improvement in patient and staff experience

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Consistent senior	CCIO/CNIO currently	MH/SH	August 2020	During COVID deputy chief nurse and CNIO

clinical/nursing representation across governance structure include of increasing accountability at senior meetings.	engaged from project team to Digital Care Board level, with conversations had to support Deputy Chief Nurse involvement to support capacity and additional senior nursing accountability of appropriate level.			(also infection control lead less present) need to review representation and presence within the programme from nursing
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 9: We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care

<table>
<tr><td>Principal Risk ID</td><td>9.3</td><td colspan="5">Risk that we fail to support leaders and staff to engage with the EPR and other technology programmes as required and the benefits are limited as a result</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>3 x 1</td><td>Current Score (C x L)</td><td colspan="2">3 x 2</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Digital and Chief Information Officer</td><td>Oversight/Assurance Committee</td><td colspan="2">Finance and Digital Committee</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="4">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. EPR Communication and engagement strategy and plan to ensure active, consistent and meaningful involvement of all stakeholders (as appropriate) throughout the programming. This will support and enable local ownership of the EPR, rather than being seen as an IT driven /owned solution.
2. Communications to be delivered through existing and project specific channels including Involve, CEO weekly blog/ vlog, 100 Leaders, Extended Leadership Network and, intranet page and digital inbox hosted by the Digital Transformation team
3. Senior clinical/ business ownership of delivery worktreams.
4. End users/clinicians to have ongoing opportunities to view the solution understand the functionality and benefits it offers through demos and involvement in solution defining, and engagement events through the programme.
5. Clinical staff embedded into EPR team
6. Mixed method training approach
7. EPR Usage reports to highlight gaps in care
8. Exec Review of EPR reports to drive accountability
9. Digital Strategy</td><td colspan="4">1. Digital update to Finance and Digital Committee and to Board
2. Digital Care Delivery Group
3. EPR USage
4. Quality Delivery Group</td></tr>
<tr><td colspan="2">Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td colspan="2">Update</td></tr>
</table>

Strategic Objective 9: We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care

Lack of senior buy in/support to support release of time/involvement in project such as testing, training, design. And ownership of the solution and its benefits at a local level.	Senior clinical project members proactively owning engagement with respective peer groups. Deployment methodology will enable forward planning of engagement points and will require support from leadership team(s) to support release of time.	MH/Execs		Remains challenginig in light of COVID but ongoing escalation of areas that require input to Execs/ Divisional tris has so far managed to maintain a level of delivery.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
	Not applicable	

Strategic Objective 9: We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care

Principal Risk ID	9.4	Risk that the Trust EPR cannot be appropriately linked to systems in primary care, community providers and other remote providers and/or lack of commitment from relevant external parties adversely affecting the ability to create joint health records and deliver best care for everyone

Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	2 x 1	**Current Score (C x L)**	2 x 2
Risk Owner (Executive Director)	Digital and Chief Information Officer		**Oversight/Assurance Committee**	Finance and Digital Committee

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. EPR Procurement of open APIs and FHIR compliant system meaning the EPR will use JUYI to link 2. Joining Up Your Information (JUYI) implemented in partnership with external partners 3. EPR delivery group 4. Digital Care Delivery Group representation includes representatives from Gloucestershire Health Partners. 5. Roll out of access to Sunrise EPR to primary care and some community colleagues 6. Delivery workstreams including clinical/business and IT leads with sufficient seniority and oversight/awareness of wider Gloucestershire strategy and requirements. 7. Digital Strategy	1. ICS Delivery Board 2. LDR Execs 3. Digital Delivery Group- ICS wide 4. Digital Care Delivery Group 5. Digital update and ICS update to Finance and Digital Committee and to Board 6. JUYI Board

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)

Strategic Objective 9: We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care

	Not applicable	

QUARTERLY UPDATE AND REVIEW OF OBJECTIVES TEMPLATE

Strategic Objective 10: We are research active, providing innovative and ground breaking treatments; staff from all disciplines contributes to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK.

Quarterly Progress report			
Current assurances (positive and negative) *What is known about the effectiveness of the controls from the assurance framework? Are the assurances effective?*	**General update** *E.g. milestones reached*	**Assurance Rating**	
		Proposed	**Agreed**
We are monitored externally on a monthly basis by our key funder (NIHR Clinical Research West of England) and expected to have action plans for any research studies not ranking green or any high level objectives falling behind target)	NIHR High Level Objective reporting currently on-hold due to COVID-19 Pandemic. R&D Team is working with NIHR to agree re-start priorities and phasing. Size of R&D team means it will not be possible to maintain COVID-19 trials and potential vaccine studies as well as re-starting all non-COVID-19 trials and studies and a proposed prioritisation will come to Strategy & Transformation Delivery Group in August 2020.	**AMBER**	An agreed rating will be sought within the committee.

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

<table>
<tr><td>Principal Risk ID</td><td>10.1</td><td colspan="4">Risk that we are unable to secure funding to support individuals and teams to dedicate time to research due to competing priorities limiting our ability to extend our research portfolio

C2531S&TR&D Non-recurring nature of research and development funding allocations</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>Principal risk assessment for BAF 4 x1 (same as risk register entry due to similarity of risk)

3 x
2 C2531S&TR&D</td><td>Current Score (C x L)</td><td>Principal risk assessment for BAF 4 x 1 (same as risk register entry due to similarity of risk)

4 x 2 C2531S&TR&D Business Domain</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Strategy and Transformation</td><td>Oversight/Assurance Committee</td><td>People and OD</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system</td><td colspan="3">1. At least quarterly research report to Strategy and Transformation Delivery Group; oversight provided of the research strategy and research portfolio.</td></tr>
<tr><td colspan="3">2. Annual business plan to key funder NIHR CRN – details plans to increase the number of commercial studies, which are a source of income.</td><td colspan="3">2.Progress against all High Level Objectives – defined by the National Institute Health Research (NIHR) – reviewed and reported quarterly internally to Research and Innovation Forum and externally to WE Clinical Research Network
June 2020: Performance against High Level Objectives currently suspended due to COVID-19</td></tr>
<tr><td colspan="3">3. Support for non-NIHR funded studies is provided by the Gloucestershire Research Support Service (GRSS) via an SLA with the NHS research active organisations in the county and including Public Health in Gloucestershire County Council. Statement of intent to work more closely with the University of Gloucestershire signed.</td><td colspan="3">3. Annual business plan submitted to West of England Clinical Research Network (CRN), who provide the main source of income to research through non-recurring, activity-based funding.</td></tr>
</table>

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

4. Board Approved Research Strategy (October 2019)				
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
The need to receive the strategy noted above	To be considered at P& OD committee in August 2019	Director of Strategy and Transformation	Complete	
Knowledge of impact of COVID on commercial income	Currently trying to determine financial impact of COVID (short and longer term) on research	Head of Research and Development	Sept 2020	June 2020: COVID-19 has forced the abrupt diversion of research resources and activities to COVID-19 specific studies. Activity levels have been very high but have been non-commercial. Currently assessing a) the potential impact of lack of commercial impact on R&D income and b) which studies can be reactivated under the restart framework

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

Principal Risk ID	**10.2**	Risk that we do not identify and address relevant skills, capacity and capability gaps to allow us to achieve our research vision			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	Principal risk assessment for BAF 4x1 No risk register entries relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF 4 x 2 No risk register entries relating to this principal risk	
Risk Owner (Executive Director)	Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD	

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Capability and capacity assessments for new studies to maximise workforce utilisation	1. Oversight of the research portfolio by C&C, Delivery Teams and SMT Oversight of the research portfolio by CRN West of England June 2020: All studies suspended to COVID-19 currently being reviewed for restart however COVID-19 studies still take priority. Capacity to take on new additional non-COVID studies extremely limited unless sufficient external funding accompanies it.
2. Review and closure of poor performing studies to release staff with regular review of staffing at relevant meetings.	2. Monthly 1:1's and SMT
3. The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system	3. Oversight of research activity by R&D Forum and People and OD Committee
4. Annual business plan	4. Annual business plan submitted to Clinical Research Network West of England (CRN)
5. Novice researcher placements offered	5. Oversight of research activity by R&D Forum and People and OD Committee
6. Board approved Research Strategy (October 2019)	

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Engagement, Involvement & Communication Strategy	Strategy under development	Simon Lanceley	24/06/20	Strategy in development, informed through the 'Community Conversations' work with the VCS by Helen England (external facilitator)and Anna Rarity (Patient and Public

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

				Involvement Manager).
New post of Director of Engagement, Involvement & Communication	Appointment made	Simon Lanceley	24/06/20	James Brown, appointed, due in post from September 2020
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Awaiting communication and engagement strategy as noted above				

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

Principal Risk ID	**10.3**	Risk that the business case to secure University Hospital status does not demonstrate an acceptable return on investment delaying the realisation of patient and staff benefits			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	Principal risk assessment for BAF: 4 x 2 No risk register entries relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF: 4 x 3 (return and therefore risk is yet undefined) No risk register entries relating to this principal risk	
Risk Owner (Executive Director)	Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD	
Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*		**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*			
1. The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system		1 & 2 Reported to R&D Forum			
2. Statement of intent to work more closely with the University of Gloucestershire signed.					
3. Task and Finish Group for identifying potential benefits and submitting Business Case for University Hospital status		3 & 4 Update reports to People and OD Committee and final business case submission anticipated in September 2020 prior to Board consideration			
4. Final Business case to go through People and OD delivery group and TLT before reaching committee					
5. Board approved Research Strategy (October 2019)		1.			
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**	
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**	
Final Business case to go through People and OD delivery group and	Board strategy session in February 2020 to seek	Director of Strategy and	September 2020	Guidance received from Trust Main Board strategy session in February 2020	

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

TLT before reaching committee – guidance required as to priority & source of investment	guidance	Transformation		
Related Risks from the Trust Risk Register				
Code	Risk description			C x L Score (Domain)
NONE				
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Excess Treatment Savings Report	To be planned and delivered	Head of R&D		To be finalised in February 2020
Related Risks from the Trust Risk Register				
Code	Risk description			C x L Score (Domain)
NONE				

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

Principal Risk ID	**10.4**	Risk that the business case for University Hospital status does not stack up and there is no additional funding to support a net investment in University Hospitals' status.		
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	Principal risk assessment for BAF: 4 x 2 No risk register entries relating to this principal risk	**Current Score (C x L)**	Principal risk assessment for BAF: 4 x 3 (unknown risk as no business case with funding requirements defined) No risk register entries relating to this principal risk
Risk Owner (Executive Director)	Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system	1. Reported to R&D Forum 2. Update reports to People and OD Committee and final business case submission anticipated in September 2019 prior to Board consideration
2. Statement of intent to work more closely with the University of Gloucestershire signed	
3. Board approved Research Strategy (October 2019)	3.

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Excess Treatment Savings	To be planned and delivered	Head of R&D	~~March 2020~~ Sept 2020	Ongoing. June 2020 Update: Work delayed due to COVID-19 activities
Increase commercial offer	To be planned and delivered	Head of R&D	March 2020	December 2019: Ongoing. Developing statement and recommendations for future travel paper. Submitted an outline questionnaire to host one of five national Patient Recruitment Centres for late phase commercial research (jointly with Gloucestershire Health and Care NHS FT)

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

				Unsuccessful In discussions with Gloucestershire Health and Care NHS FT around a joint commercial study. June 2020: COVID-19 has forced the abrupt diversion of research resources and activities to COVID-19 specific studies. Activity levels have been very high but have been non-commercial. Currently assessing a) the potential impact of lack of commercial impact on R&D income and b) which studies can be reactivated under the restart framework
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Excess Treatment Savings Report	To be planned and delivered	Head of R&D		To be finalised in February 2020 June 2020: Delayed due to COVID-19 activities and expected change to system

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
NONE		

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

Principal Risk ID	**10.5**	Risk that the business case to secure University Hospital status does not demonstrate an acceptable return on investment delaying the realisation of patient and staff benefits; or an initial pump-priming funding source cannot be secured to deliver any initial investment that may be required.			
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	4 x 2	**Current Score (C x L)**	4 x 3	
Risk Owner (Executive Director)	Director of Strategy and Transformation		**Oversight/Assurance Committee**	People and OD Committee (PODC)	
Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*		**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*			
1.The Research 4 Gloucestershire initiative is focussing on its role to develop an integrated approach to research across the Gloucestershire Integrated Care system		Reported to R&D Forum			
2. Statement of intent to work more closely with the University of Gloucestershire signed.					
3. Task and Finish Group for identifying potential benefits and submitting Business Case for University Hospital status		Update reports to People and OD Committee and final business case submission anticipated in September 2020 prior to Board consideration			
4. Final Business case to go through People and OD delivery group and TLT before reaching committee					
5. Board approved Research Strategy (October 2019)					
Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**	
Excess Treatment Savings	To be planned and delivered	Head of R&D	~~March 2020~~ Sept 2020	Ongoing. June 2020 Update: Work delayed due to COVID-19 activities	
Increase commercial offer	To be planned and delivered	Head of R&D	March 2020	December 2019: Ongoing. Developing statement and recommendations for future travel paper. Submitted an outline questionnaire to host one of five national Patient Recruitment Centres for late phase commercial research (jointly with Gloucestershire Health and Care	

Strategic Objective 10: We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK

				NHS FT) Unsuccessful In discussions with Gloucestershire Health and Care NHS FT around a joint commercial study. June 2020: COVID-19 has forced the abrupt diversion of research resources and activities to COVID-19 specific studies. Activity levels have been very high but have been non-commercial. Currently assessing a) the potential impact of lack of commercial impact on R&D income and b) which studies can be reactivated under the restart framework
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Final Business case to go through People and OD delivery group and TLT before reaching committee – guidance required as to priority & source of investment	Board strategy session in February 2020 to seek guidance	Director of Strategy and Transformation	September 2020	Guidance received from Trust Main Board strategy session in February 2020
Excess Treatment Savings Report	To be planned and delivered	Head of R&D		To be finalised in February 2020

Related Risks from the Trust Risk Register

Code	Risk description	C x L Score (Domain)

TRUST BOARD – 10 SEPTEMBER 2020
VIA MS TEAMS

Report Title
Staff Survey and Equality Diversity Inclusion Action Plan 2020-22 and WRES 2018/19 Comparison Report
Sponsor and Author(s)
Authors: Abigail Hopewell, Head of Leadership and Organisational Development; Lucy Morris, Staff Experience & Talent Development Coordinator Sponsoring Director: Emma Wood, Deputy CEO and Director of People and Organisational Development
Executive Summary

Purpose
To inform the Board of the Trust's Staff Survey/EDI Action Plan 2020/22.
To inform the Board of how the Trust's Workforce Race Equality Standard (WRES) performance compares to Trusts which have a similar percentage of BAME in the local population (as per 2011 census).

Key issues to note
A combined Staff Survey/EDI action plan has been developed given the overlap of interest and focus of both groups in these areas (Staff Patient Experience Improvement Group – SPEIG, Equality Diversity Inclusion Steering Group – EDISG). Each group will take responsibility for delivery of specific actions. Members of SPEIG and EDISG sit on both groups to ensure duplication is avoided and synergies can be maximised.
The action plan will cover two years to March 2022 – to accommodate delays caused by COVID, and also to allow sufficient time and traction to implement and embed new work streams and improvements.

WRES Comparison report:
1) Figures suggest White staff were only marginally (0.3 points) more likely than BAME staff to be appointed from shortlisting making Gloucestershire NHS Foundation Trust one of three Trusts to report a fair relative likelihood.
2) BAME staff were marginally (0.3 points) more likely than White staff to access non-mandatory training and CPD, making Gloucestershire NHS Foundation Trust one of four Trusts to report a fair relative likelihood.
3) Gloucestershire NHS Foundation Trust ranked highest in relation to Non-Executive BAME members (25%) compared to similar Trusts.
4) Although Gloucestershire NHS Foundation Trust reported low numbers of BAME staff in senior and VSM roles, recent figures suggest 10% of staff in senior to VSM roles are BAME which is more than double the BAME population of Gloucestershire comparatively (4.6% as of 2011).

1) Gloucestershire NHS Foundation Trust reported the greatest percentage difference between BAME and White staff in relation to experiencing discrimination from managers or colleagues compared to similar Trusts.
2) BAME staff were 1.5 times more likely to enter the formal disciplinary process compared to White staff making Gloucestershire NHS Foundation Trust one of ten Trusts that reported a higher likelihood of BAME staff entering the formal disciplinary process compared to White staff.
3) Gloucestershire NHS Foundation Trust reported a high percentage of difference between

BAME and White staff experiencing harassment, bullying or abuse from patients, relatives or the public compared to similar Trusts.

4) High numbers of unknown ethnicities were reported in support roles and senior non-clinical roles compared to similar Trusts.
5) Gloucestershire NHS Foundation Trust reported the third highest percentage difference between BAME staff and White staff believing the Trust provided equal opportunities for career progression or promotion suggesting an area of concern is internal progression of BAME staff.

Next Steps

Staff Survey/EDI Action plan to be delivered and monitored by SPEIG) and the EDISG.

WRES comparison report to go to the EDI Steering Group in September, where recommendations will be considered and additional actions can be identified.
WRES comparison report to go the People and Organisational Development subgroup which is overseeing efforts to improve the experience of BAME colleagues.
WRES comparison report to be shared with the organisation we appoint to conduct the BAME Widening Participation Review.

Recommendations

The Board to be ASSURED of the Trust's plans to improve the experience of colleagues working across our Trust.

The Board to NOTE the WRES Comparison report, and associated next steps.

Impact Upon Strategic Objectives

Compassionate workforce. We have a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people.

Impact Upon Corporate Risks

CP2803P&OD – the risk of continued poor levels of staff engagement is that our staff experience will impact negatively on retention, recruitment and patient experience.

Regulatory and/or Legal Implications

The NHS staff survey is an annual requirement which all Trusts in England must participate in.
Publication of the WRES and WDES is a requirement of NHS England. Compliance is monitored by NHS England, Commissioners and NHSI.

Equality & Patient Impact

Supports delivery of the People and Organisational Development strategy and our two colleague equality objectives:

1. Significantly strengthen the support provided to staff with disabilities and support/education offered to line managers who work with disabled colleagues.
2. Improve the support and mechanisms for colleagues when they experience or witness bullying, abuse, harassment or violence. Eliminate unfair discrimination.

Resource Implications

Finance		Information Management & Technology	
Human Resources	X	Buildings	

Action/Decision Required

For Decision		For Assurance	X	For Approval		For Information	X

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			25 August 2020			People & OD Delivery Group – 11 August 2020 Equality Diversity Inclusion Steering Group (by email)

Outcome of discussion when presented to previous Committees
People & OD Committee 25 August 2020 The Committee commented that the priorities felt open-ended and requested whether hard targets could be placed on these. It was clarified that whilst the priorities are generic statements of intent, the associated actions sitting underneath each priority are SMART and provide a tangible way of measuring our progress against delivery of the priorities. The Committee also requested more time to discuss and understand the detail of the WRES and WDES. As such it was agreed that this will be raised as a higher agenda item in future meetings.

Project	Staff Survey and EDI Action Plan - Trust wide and Divisional 2020-22	Total tasks	21
Lead	Abigail Hopewell	Complete	0
Last updated:	04/09/2020	In progress	14
Project End	31/03/2022	Delayed	0
Days until project end	573	Not started	5

Priority	Trust-wide Action	Start date	End date	Lead	Monitored through EDISG/SPEIG/Division	Quarterly Updates (Oct/Jan/Apr/Jul)	Status
1. Develop and strengthen our compassionate culture	Launch revised values and new compassionate behaviour framework	Sep-20	Nov-20	Abigail Hopewell	Staff Patient experience improvement group		In progress
1. Develop and strengthen our compassionate culture	Design and commence delivery of Compassionate Leadership programme for leaders and managers, which includes a clear section on both giving and seeking feedback on work/changes	Aug-20	Commence delivery Oct-20	Abigail Hopewell/Paul Wain	Staff Patient experience improvement group		In progress
1. Develop and strengthen our compassionate culture	Awareness campaign targeted on improving emotional intelligence and understanding of protected characteristics, specifically BAME, Disability, LGBT+. To be incorporated as part of rollout of values/behaviours and compassionate leadership	Autumn-20	tbc	Abigail Hopewell/Coral Boston/Paul Wain	EDI Steering group		In progress
1. Develop and strengthen our compassionate culture	Introduce regular "colleague story" slot at Trust Board e.g. "What it's like to be…BAME/LGBT+/Disabled"	Autumn-20	tbc	Katie Parker-Roberts	EDI Steering group		Not started
2. Proactively address bullying, harassment and discrimination experienced by colleagues	Finalise design, launch and embed Wellness check-in tool	Jul-20	Launch Sept 20. Embed tbc	Lucy Morris	Staff Patient experience improvement group		In progress
2. Proactively address bullying, harassment and discrimination experienced by colleagues	Incorporate Civility Saves Lives materials into launch of new values/behaviours and Compassionate Leadership programme	Aug-20	Commence delivery Oct-20	Abigail Hopewell/Paul Wain	Staff Patient experience improvement group		In progress
2. Proactively address bullying, harassment and discrimination experienced by colleagues	Extend the support to colleagues around Speaking Up/Raising Concerns	tbc	tbc	Katie Parker-Roberts	Staff Patient experience improvement group		Not started
3. Continue to improve experience of appraisals and access to education and talent development opportunities	Work with SDs on incorporating updated appraisal paperwork and values/behaviours into consultant appraisal	Autumn-20	Q4 20/21	tbc	Staff Patient experience improvement group		In progress
3. Continue to improve experience of appraisals and access to education and talent development opportunities	Plan and design Iaspire/Stepping Up equivalent programme aimed specifically at BAME.	Autumn-20	Nov-20	Abigail Hopewell/Coral Boston	Staff Patient experience improvement group		In progress
3. Continue to improve experience of appraisals and access to education and talent development opportunities	Proactive targeting of leadership opportunities at BAME colleagues	Summer-20	Q4 20/21	Coral Boston	Staff Patient experience improvement group		In progress
3. Continue to improve experience of appraisals and access to education and talent development opportunities	Launch revised Appraisal paperwork (updated following feedback)	Sep-20	Oct-20	Lucy Morris	Staff Patient experience improvement group		In progress
3. Continue to improve experience of appraisals and access to education and talent development opportunities	Expand talent development opportunities (ADP) with explicit focus on under-represented groups including BAME and disabled colleagues	Sep-20	Sep-21	Lucy Morris with divisional leds	Staff Patient experience improvement group		In progress
3. Continue to improve experience of appraisals and access to education and talent development opportunities	Establish BAME Mentoring Scheme	Autumn-20	Q4 20/21	Coral Boston/Paul Wain	EDI Steering group		In progress
4. Continued focus on the safety, health and wellbeing of colleagues	Develop staff health-wellbeing action plan for 2020/22 has been developed, to be monitored by SPEIG and incorporated into this action plan. To include specific activities and support for colleagues and managers around mental health/stress and MSK	Aug-20	Oct-20	Abigail Hopewell/Michele Pashley	Staff Patient experience improvement group		In progress
4. Continued focus on the safety, health and wellbeing of colleagues	Identify the learning and actions taken from the Covid-19 response that we can usefully embed into our daily BAU practice to promote colleague safety and wellbeing	Aug-20	Oct-20	Abigail Hopewell/Michele Pashley	Staff Patient experience improvement group		Not started
4. Continued focus on the safety, health and wellbeing of colleagues	Monitor ongoing feedback relating to Covid experiences, and outputs from Covid Risk Assessments of vulnerable groups, to identify any specific actions which can be taken to support more vulnerable colleagues (esp. shielding and BAME), as required	Ongoing	Ongoing	Coral Boston/Lee Troake	EDI Steering group		In progress
EDI Specific	Improve signage and visual representation of diversity of our workforce in and around hospital grounds (and social/digital media). Include generation of refreshed photo library to represent diverse and current faces/people in our Trust	Launch Autumn-20	Updated quarterly	Kate Jeal	EDI Steering group		Not started
EDI Specific	Delivery of WRES, WDES, Stonewall WEI, Gender Pay Gap report, Equality Report. Resulting in actions, as required	Ongoing	Ongoing	Abigail Hopewell	EDI Steering group		In progress
EDI Specific	Restart campaign (delayed by Covid) to encourage people to update protected characteristic data on ESR	Dec-20	Mar-21	Abigail Hopewell	EDI Steering group		Not started
EDI Specific	Mandate BAME representation on recruitment/selection panels for band 8a+ and Consultant/senior medical job vacancies	Aug-20	Jan-21	Lucy Morris / Julia Evans / Richard Giles	EDI Steering group		In progress
EDI Specific	Where data available, complete divisional versions of WRES and WDES	Aug-20	Sep-20	Lucy Morris	EDI Steering group		Not started

Priority	Specific Actions	Linked to theme/s	Activities undertaken to date
1. Develop and strengthen our compassionate culture	• Launch revised values and new compassionate behaviour framework • Design and deliver Compassionate Leadership programme for leaders and managers, which includes a clear section on both giving and seeking feedback on work/changes **Priority divisions/staff groups:** • D&S • Healthcare Scientists • Medical & Dental • 16-20 and 21-30 year olds	Immediate Managers Team Working Staff Engagement	• Values/behaviours materials almost finalised for this launch, which was scheduled 1st May and now delayed pending step-down/de-escalation of Covid-19 response • LOD team currently developing revised compassionate leadership programme amidst Covid-19 activities
2. Proactively address bullying, harassment and discrimination experienced by colleagues	As above, plus • Embed principles and practice of Civility Saves Lives • Extend the support to colleagues around Speaking Up/Raising Concerns • Launch and embed Reasonable Adjustments passport **Priority divisions/staff groups:** • Medicine • Surgery • Medical & Dental • Nursing & Midwifery • BAME • Disabled • 21-30 year olds • LGBT+	Bullying and Harassment Equality Diversity & Inclusion Safety Culture	• Additional FTSU Guardians identified and trained • Reasonable Adjustments passport almost finalised. Launch delayed pending step-down/de-escalation of Covid-19 response • Civility Saves Lives materials ready to use to support launch of new values/behaviours
3. Continue to improve experience of appraisals and access to education and talent development opportunities	• Launch revised Appraisal paperwork (updated following feedback) • Expand talent development opportunities (ADP) with explicit focus on under-represented groups including BAME and disabled colleagues • Improve experience of medical appraisals **Priority divisions/staff groups:** • Women & Children • Medical & Dental • BAME • Disabled	Quality of Appraisals	• Meeting held earlier in year with SD Forum to explore how to align medical appraisal paperwork with non-medical paperwork • Revised/refreshed paperwork ready to launch. Delayed pending step-down/de-escalation of Covid-19 response • Plans and design in place to deliver IAspire programme aimed specifically at BAME. Delayed pending step-down/de-escalation of Covid-19 response • Proactive targeting of leadership opportunities undertaken, such as coaching certificate at BAME colleagues
4. Continued focus on the safety, health and wellbeing of colleagues	• Extend the support to colleagues around Speaking Up/Raising Concerns • Identify specific activities and support for colleagues and managers around stress/resilience and MSK injuries • Identify the learning and actions taken from the Covid-19 response that we can usefully embed into our daily BAU practice to promote colleague safety and wellbeing **Priority divisions/staff groups:** • Medicine • Surgery • Additional Clinical Services • Nursing & Midwifery • Healthcare Scientists • Medical & Dental • BAME • Disabled • 21-30 year olds • LGBT+	Health and Wellbeing Safety culture Violence	• Staff Health-wellbeing action plan for 2020/21 has been developed. This is on hold pending step-down/de-escalation of Covid-19 response • Additional FTSU Guardians identified and trained

Workforce Race Equality Standard (WRES) 2019

Comparison data

The findings of this report reflect data submitted to NHS England in 2019. Comparisons are made for indicators 1-9 between Gloucestershire Hospitals NHS Foundation Trust and other NHS Trusts which reside in locations with a similar White population as Gloucestershire (Table 1). The total sample comprises 18 Trusts.

	Table 1. Trust name	% white population (location)
1	Worcestershire Acute Hospitals NHS Trust	96%
2	Warrington And Halton Hospitals NHS Foundation Trust	96%
3	South Tyneside NHS Foundation Trust	96%
4	Poole Hospital NHS Foundation Trust	96%
5	Nottingham University Hospitals NHS Trust	96%
6	Northern Lincolnshire And Goole NHS Foundation Trust	96%
7	East Sussex Healthcare NHS Trust	96%
8	City Hospitals Sunderland NHS Foundation Trust	96%
9	West Suffolk NHS Foundation Trust	95%
10	Royal United Hospitals Bath NHS Foundation Trust	95%
11	Northumbria Healthcare NHS Foundation Trust	95%
12	North Tees And Hartlepool NHS Foundation Trust	95%
13	Hampshire Hospitals NHS Foundation Trust	95%
14	**Gloucestershire Hospitals NHS Foundation Trust**	**95%**
15	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	95%
16	York Teaching Hospital NHS Foundation Trust	94%
17	Mid Essex Hospital Services NHS Trust	94%
18	Hull University Teaching Hospitals NHS Trust	94%

Summary of findings

Indicator 1 (page 3) – Gloucestershire Hospitals NHS Foundation Trust reported a high number of BAME colleagues in clinical and non-clinical support roles compared to similar Trusts. In relation to the number of BAME colleagues in senior positions, Gloucestershire Hospitals NHS Foundation Trust fell mid-table compared to similar Trusts, and was one of the majority of Trusts which reported 0% BAME staff in VSM positions.

Indicator 1 (page 3) - Gloucestershire Hospitals NHS Foundation Trust reported a high number of unknown ethnicities in relation to support roles and senior non-clinical roles compared to other Trusts.

Indicator 2 (page 4) - Gloucestershire NHS Foundation Trust was one of three Trusts that reported White staff were marginally more likely to be appointed from shortlisting compared to BAME staff.

Indicator 3 (page 5) - Gloucestershire NHS Foundation Trust was one of ten Trusts to report a greater likelihood of BAME staff entering the formal disciplinary process compared to White staff. The Trust reported a figure 0.44 points lower than Royal United Hospitals Bath NHS Foundation Trust which reported the greatest likelihood of BAME staff entering this process.

Indicator 4 (page 6) - Gloucestershire NHS Foundation Trust was one of eleven Trusts that reported a marginally greater likelihood of BAME staff accessing non-mandatory training and CPD compared to White staff.

Indicator 5 (page 6) - Gloucestershire NHS Foundation Trust ranked 12th out of 17 Trusts in relation to the percentage difference between White responses and BAME responses of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

Indicator 6 (page 7) - Gloucestershire NHS Foundation Trust ranked 6th in relation to the percentage difference between White responses and BAME responses of staff experiencing harassment, bullying or abuse from staff in last 12 months.

Indicator 7 (page 8) - Gloucestershire NHS Foundation Trust ranked 15th in relation to the percentage difference between White responses and BAME responses of staff believing that the Trust provided equal opportunities for career progression or promotion.

Indicator 8 (page 9) - Gloucestershire NHS Foundation Trust reported the greatest percentage difference between White and BAME experiences of discrimination at work from any of the following b) Manager/team leader or other colleagues.

Indicator 9 (page 9) - Gloucestershire NHS Foundation Trust reported that 12% of board members were BAME, the 2nd highest in the sample following a joint first ranking between Doncaster and Bassetlaw Trust, Northumbria Healthcare Trust and Worcestershire Acute Trust (13%). Gloucestershire NHS Foundation Trust was one of eleven Trusts which reported 0% BAME board members with voting membership. Gloucestershire NHS Foundation Trust ranked the highest of other Trusts reporting Non-Executive BAME members (25%).

Positive areas

1) Figures suggest White staff were only marginally (0.3 points) more likely than BAME staff to be appointed from shortlisting making Gloucestershire NHS Foundation Trust one of three Trusts to report a fair relative likelihood.
2) BAME staff were marginally (0.3 points) more likely than White staff to access non-mandatory training and CPD, making Gloucestershire NHS Foundation Trust one of four Trusts to report a fair relative likelihood.
3) Gloucestershire NHS Foundation Trust ranked highest in relation to Non-Executive BAME members (25%) compared to similar Trusts.
4) Although Gloucestershire NHS Foundation Trust reported low numbers of BAME staff in senior and VSM roles, recent figures suggest 10% of staff in senior to VSM roles are BAME which is more than double the BAME population of Gloucestershire comparatively (4.6% as of 2011).

Areas of concern

1) Gloucestershire NHS Foundation Trust reported the greatest percentage difference between BAME and White staff in relation to experiencing discrimination from managers or colleagues compared to similar Trusts.
2) BAME staff were 1.5 times more likely to enter the formal disciplinary process compared to White staff making Gloucestershire NHS Foundation Trust one of ten Trusts that reported a higher likelihood of BAME staff entering the formal disciplinary process compared to White staff.
3) Gloucestershire NHS Foundation Trust reported a high percentage of difference between BAME and White staff experiencing harassment, bullying or abuse from patients, relatives or the public compared to similar Trusts.
4) High numbers of unknown ethnicities were reported in support roles and senior non-clinical roles compared to similar Trusts.
5) Gloucestershire NHS Foundation Trust reported the third highest percentage difference between BAME staff and White staff believing the Trust provided equal opportunities for career progression or promotion suggesting an area of concern is internal progression of BAME staff.

Recommendations

1) Address the gap between BAME and White colleagues' experiences of discrimination and abuse by patients, managers and colleagues by encouraging all colleagues to challenge poor behaviours and model a compassionate culture. Improve the support offered to BAME colleagues through our Freedom to Speak Up Guardians (FTSU).
2) Target interventions to identify particular areas or staff groups in which BAME staff are more likely to enter into the formal disciplinary process compared to White staff and work to address the imbalance through unconscious bias training and targeted HR support.
3) Target retention and progression pathways for BAME colleagues in support roles and ensure that internal recruitment is inclusive and supports BAME staff to develop with the Trust.
4) Engage colleagues whose ethnicities are unknown on ESR to improve the accuracy of our figures, particularly relating to clinical and non-clinical support roles and senior non-clinical roles.
5) Understand the practices of best performing Trusts to inform our own practices, including Nottingham University Hospitals NHS Trust, West Suffolk NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust and Warrington and Halton Hospitals NHS Foundation Trust.

Indicator 1. Non-clinical Workforce Skill Mix by Ethnicity (BAME/White) as of March 2019

Definitions: Support (Bands 1-4), Senior (Bands 8a to 9), VSM -Very Senior Managers. Refer to **Appendix 1** for full rankings tables and analysis.

Table 2.

	Workforce Skill Mix by Ethnicity– **Support** positions		Workforce Skill Mix by Ethnicity– **Senior** positions		Workforce Skill Mix by Ethnicity– **VSM** positions	
	Non-clinical	Clinical	Non-clinical	Clinical	Non-clinical	Clinical
Highest numbers of BAME colleagues	Hampshire Hospitals NHS Foundation Trust (13%)	Nottingham University Hospitals NHS Trust (16%)	Worcestershire Acute Hospitals NHS Trust (9%)	City Hospitals Sunderland NHS Foundation Trust (13%)	Northumbria Healthcare NHS Foundation Trust (7%)	Worcestershire Acute Hospitals NHS Trust (50%)
Lowest numbers of BAME colleagues	South Tyneside NHS Foundation Trust (1%)	South Tyneside NHS Foundation Trust (1%)	York Teaching Hospital NHS Foundation Trust (1%)	Warrington and Halton Hospitals NHS Foundation Trust (2%)	Joint Last With 15 Other Trusts (0%)	Joint Last With 11 Other Trusts (0%)
Gloucestershire NHS Foundation Trust ranking (out of 18)	3rd (10% BAME)	5th (11% BAME)	9th (3% BAME)	9th (7% BAME)		

- Gloucestershire NHS Foundation Trust reported high numbers of BAME colleagues in clinical and non-clinical support roles compared to other Trusts residing in locations with a comparative White population. The Trust ranked 3rd and 5th highest in the table of 18 Trusts respectively.
- Gloucestershire NHS Foundation Trust ranked 4th and 9th highest in relation to number of unknown ethnicities in non-clinical and clinical support roles respectively.
- Gloucestershire NHS Foundation Trust ranked mid-table in relation to number of BAME colleagues in senior clinical and non-clinical positions.
- Whilst Gloucestershire NHS Foundation Trust reported the 2nd lowest number of unknown ethnicities in relation to senior clinical posts, the Trust ranked 7th highest in relation to unknown ethnicities for senior non-clinical posts.
- Gloucestershire NHS Foundation Trust was one of sixteen comparative Trusts that reported no BAME representation at **non-clinical VSM** level and one of twelve comparative Trusts that reported no BAME representation at **clinical VSM** level. In relation to number of unknown

ethnicities, Gloucestershire NHS Foundation Trust reported no unknown for clinical VSM and 14% unknown for non-clinical VSM.

Indicator 2. Relative likelihood of White staff being appointed from shortlisting compared to BAME staff.

Table 3.		
Region	**Org name**	**Relative likelihood of White staff being appointed from shortlisting compared to BAME staff:**
North East and Yorkshire	North Tees And Hartlepool NHS Foundation Trust	0.8
Midlands	Nottingham University Hospitals NHS Trust	0.9
North East and Yorkshire	Hull University Teaching Hospitals NHS Trust	0.9
Midlands	Worcestershire Acute Hospitals NHS Trust	1.0
North East and Yorkshire	South Tyneside NHS Foundation Trust	1.0
South West of England	**Gloucestershire Hospitals NHS Foundation Trust**	1.03
North East and Yorkshire	City Hospitals Sunderland NHS Foundation Trust	1.2
South East of England	Hampshire Hospitals NHS Foundation Trust	1.2
South East of England	East Sussex Healthcare NHS Trust	1.3
East of England	West Suffolk NHS Foundation Trust	1.4
North West	Warrington And Halton Hospitals NHS Foundation Trust	1.5
South West of England	Poole Hospital NHS Foundation Trust	1.5
North East and Yorkshire	Northern Lincolnshire And Goole NHS Foundation Trust	1.5
North East and Yorkshire	York Teaching Hospital NHS Foundation Trust	1.6
East of England	Mid Essex Hospital Services NHS Trust	1.7
South West of England	Royal United Hospitals Bath NHS Foundation Trust	1.7
North East and Yorkshire	Northumbria Healthcare NHS Foundation Trust	1.8
North East and Yorkshire	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	2.4
A figure below 1.0 indicates that BAME staff are more likely to be appointed from shortlisting. A relative likelihood of 1 indicates that there is no difference: i.e. BAME applicants are equally as likely of being appointed from shortlisting as White applicants		

Table 3. demonstrates that Gloucestershire NHS Foundation Trust was one of three Trusts that reported White staff were no more likely than BAME staff to be appointed from shortlisting.

Doncaster and Bassetlaw Trust reported the highest likelihood of White staff being appointed over BAME staff (2.4) and North Tees and Hartlepool Trust reported a greater likelihood of BAME staff being appointed (0.8).

Indicator 3. Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff

Table 4		
Region	**Org name**	**Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:**
North East and Yorkshire	South Tyneside NHS Foundation Trust	0.00
East of England	Mid Essex Hospital Services NHS Trust	0.16
North East and Yorkshire	Northumbria Healthcare NHS Foundation Trust	0.53
East of England	West Suffolk NHS Foundation Trust	0.62
North East and Yorkshire	Hull University Teaching Hospitals NHS Trust	0.69
North East and Yorkshire	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	0.74
North East and Yorkshire	North Tees And Hartlepool NHS Foundation Trust	0.76
Midlands	Nottingham University Hospitals NHS Trust	0.80
North East and Yorkshire	Northern Lincolnshire And Goole NHS Foundation Trust	0.94
North West	Warrington And Halton Hospitals NHS Foundation Trust	1.06
South East of England	Hampshire Hospitals NHS Foundation Trust	1.09
North East and Yorkshire	City Hospitals Sunderland NHS Foundation Trust	1.11
South West of England	Poole Hospital NHS Foundation Trust	1.24
South West of England	**Gloucestershire Hospitals NHS Foundation Trust**	**1.50**
Midlands	Worcestershire Acute Hospitals NHS Trust	1.53
North East and Yorkshire	York Teaching Hospital NHS Foundation Trust	1.60
NORTH	York Teaching Hospital NHS Foundation Trust	1.60
South East of England	East Sussex Healthcare NHS Trust	1.80
South West of England	Royal United Hospitals Bath NHS Foundation Trust	1.94
A figure above 1 indicates that BAME staff are more likely to enter the formal disciplinary process over White staff		

Table 4 demonstrates that Gloucestershire NHS Foundation Trust was one of ten Trusts that reported a greater likelihood of BAME staff entering the formal disciplinary process over White staff. Royal United Bath Trust reported the greatest likelihood of BAME staff entering the formal disciplinary process whilst South Tyneside Trust and Mid Essex Foundation Trust reported greater likelihoods of White staff entering the process.

The two Trusts which demonstrate the most equitable treatment of White and BAME staff in the disciplinary process are North Lincolnshire and Goole NHS Foundation Trust, and Warrington & Halton Hospitals NHS Foundation Trust.

Indicator 4. Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff

Table 5.

Region	Org Name	Relative Likelihood Of White Staff Accessing Non-Mandatory Training And CPD Compared To BME Staff:
East Of England	West Suffolk NHS Foundation Trust	0.57
North East And Yorkshire	North Tees And Hartlepool NHS Foundation Trust	0.67
North East And Yorkshire	York Teaching Hospital NHS Foundation Trust	0.83
Midlands	Worcestershire Acute Hospitals NHS Trust	0.88
North East And Yorkshire	Northumbria Healthcare NHS Foundation Trust	0.90
North East And Yorkshire	Northern Lincolnshire And Goole NHS Foundation Trust	0.93
North East And Yorkshire	Hull University Teaching Hospitals NHS Trust	0.95
South West Of England	**Gloucestershire Hospitals NHS Foundation Trust**	**0.97**
South East Of England	Hampshire Hospitals NHS Foundation Trust	0.97
South West Of England	Royal United Hospitals Bath NHS Foundation Trust	0.99
East Of England	Mid Essex Hospital Services NHS Trust	0.99
North West	Warrington And Halton Hospitals NHS Foundation Trust	1.06
North East And Yorkshire	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	1.08
Midlands	Nottingham University Hospitals NHS Trust	1.16
South East Of England	East Sussex Healthcare NHS Trust	1.33
A figure above 1.0 indicates that White staff are more likely to access non-mandatory training compared to BAME staff.		

For this indicator, four Trusts did not submit data. From the sample of fifteen Trusts, Gloucestershire NHS Foundation Trust was one of eleven Trusts that reported a slightly greater likelihood of BAME staff accessing non-mandatory training and CPD compared to White staff.

West Suffolk Trust reported the greatest likelihood (0.57) of BAME staff accessing non-mandatory training over White staff and East Sussex Trust reported the greatest likelihood of White staff accessing non-mandatory training over BAME staff comparatively (1.33).

Indicator 5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

*Indicators 5-8 are taken from the **2019** Staff Survey results as opposed to the 2018 results which would have been submitted with the 2019 WRES report. Indicators 5-8 are based on 17 Trusts as South Tyneside and Sunderland Trust submitted data as one Trust before it devolved into two separate Trusts.*

Table 6.		
		Difference % between White responses and BAME responses
1	Nottingham University Hospitals NHS Trust	0.2

2	Hull University Teaching Hospitals NHS Trust	0.5
3	Hampshire Hospitals NHS Foundation Trust	1.5
4	Mid Essex Hospital Services NHS Trust	2.1
5	West Suffolk NHS Foundation Trust	2.8
6	York Teaching Hospital NHS Foundation Trust	2.9
7	Royal United Hospitals Bath NHS Foundation Trust	3.4
8	Warrington And Halton Hospitals NHS Foundation Trust	3.4
9	East Sussex Healthcare NHS Trust	3.4
10	Poole Hospital NHS Foundation Trust	4.3
11	Worcestershire Acute Hospitals NHS Trust	4.7
12	**Gloucestershire Hospitals NHS Foundation Trust**	**4.9**
13	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	5.3
14	Northern Lincolnshire And Goole NHS Foundation Trust	8.0
15	South Tyneside NHS Foundation Trust	8.7
16	North Tees And Hartlepool NHS Foundation Trust	14.3
17	Northumbria Healthcare NHS Foundation Trust	20.4

Table 6 demonstrates that Gloucestershire NHS Foundation Trust ranked 12th in relation to the percentage difference between White responses and BAME responses of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. This difference was 0.6 and 1.5 points greater than the two other South West Trusts respectively.

The two Trusts which demonstrated the smallest gap between White and BAME staff in experiencing harassment, bullying and abuse from patients are Hull University Teaching Hospitals NHS Trust and Nottingham University Hospitals NHS Foundation Trust.

Indicator 6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

	Table 7.	
		Difference % between White responses and BAME responses
1	West Suffolk NHS Foundation Trust	0.4
2	Hampshire Hospitals NHS Foundation Trust	3.0
3	Worcestershire Acute Hospitals NHS Trust	3.1
4	Royal United Hospitals Bath NHS Foundation Trust	3.8
5	Hull University Teaching Hospitals NHS Trust	4.3
6	**Gloucestershire Hospitals NHS Foundation Trust**	**4.6**
7	East Sussex Healthcare NHS Trust	4.8
8	Poole Hospital NHS Foundation Trust	5.8
9	York Teaching Hospital NHS Foundation Trust	5.8
10	Nottingham University Hospitals NHS Trust	6.5
11	Northumbria Healthcare NHS Foundation Trust	6.8
12	Warrington And Halton Hospitals NHS Foundation Trust	7.0
13	Northern Lincolnshire And Goole NHS Foundation Trust	8.0
14	South Tyneside NHS Foundation Trust	8.2
15	Mid Essex Hospital Services NHS Trust	8.2

16	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	10.5
17	North Tees And Hartlepool NHS Foundation Trust	15.4

Table 7 demonstrates that Gloucestershire NHS Foundation Trust ranked 6th in relation to the percentage difference between White and BAME staff experiencing harassment, bullying or abuse from staff in last 12 months. This percentage difference was 4.2% greater than West Suffolk NHS Trust which ranked 1st and 0.8% greater than Royal United Hospitals Bath in the South West region.

The Trust which demonstrated the most similar experience between White and BAME staff in experiencing harassment, bullying and abuse from staff was West Suffolk NHS Foundation Trust.

Indicator 7. Percentage believing that trust provides equal opportunities for career progression or promotion.

	Table 8.	
		Difference % between White responses and BAME responses
1	Northumbria Healthcare NHS Foundation Trust	1.1
2	West Suffolk NHS Foundation Trust	4.7
3	Poole Hospital NHS Foundation Trust	6.1
4	Worcestershire Acute Hospitals NHS Trust	8.4
5	East Sussex Healthcare NHS Trust	8.4
6	York Teaching Hospital NHS Foundation Trust	8.8
7	Warrington And Halton Hospitals NHS Foundation Trust	9.1
8	Hull University Teaching Hospitals NHS Trust	9.6
9	Mid Essex Hospital Services NHS Trust	10.2
10	Northern Lincolnshire And Goole NHS Foundation Trust	11
11	North Tees And Hartlepool NHS Foundation Trust	12.8
12	South Tyneside NHS Foundation Trust	13.2
13	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	13.5
14	Hampshire Hospitals NHS Foundation Trust	15.7
15	**Gloucestershire Hospitals NHS Foundation Trust**	**16.6**
16	Nottingham University Hospitals NHS Trust	17.7
17	Royal United Hospitals Bath NHS Foundation Trust	20.3

Table 8 demonstrates that Gloucestershire NHS Foundation Trust reported a high percentage difference between White and BAME staff believing the trust provided equal opportunities for career progression or promotion. This percentage difference was 3.7% less than Royal United Hospitals Bath Trust which ranked 1st in this table and 15.5% greater than the lowest ranking Trust (Northumbria Healthcare). These results seem to conflict with the results of indicator 4 which suggested little-to-no-difference between BAME and White staff accessing non-mandatory training. This may indicate that whilst BAME staff are accessing training opportunities, they do not feel supported to progress further with the Trust.

The Trust which demonstrated the smallest differential gap between White and BAME staff in experiencing equal opportunities for career progression was Northumbria Healthcare NHS Foundation Trust.

Indicator 8. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

	Table 9.	
		Difference % between White responses and BAME responses
1	Northumbria Healthcare NHS Foundation Trust	4.5
2	West Suffolk NHS Foundation Trust	6.2
3	Warrington And Halton Hospitals NHS Foundation Trust	6.2
4	Northern Lincolnshire And Goole NHS Foundation Trust	6.4
5	East Sussex Healthcare NHS Trust	7.0
6	Nottingham University Hospitals NHS Trust	7.4
7	North Tees And Hartlepool NHS Foundation Trust	7.4
8	Royal United Hospitals Bath NHS Foundation Trust	7.7
9	Worcestershire Acute Hospitals NHS Trust	7.9
10	Mid Essex Hospital Services NHS Trust	9.0
11	Hull University Teaching Hospitals NHS Trust	9.0
12	South Tyneside NHS Foundation Trust	9.1
13	York Teaching Hospital NHS Foundation Trust	11.1
14	Hampshire Hospitals NHS Foundation Trust	11.1
15	Poole Hospital NHS Foundation Trust	11.3
16	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	12.4
17	**Gloucestershire Hospitals NHS Foundation Trust**	**12.8**

Table 9 demonstrates that Gloucestershire NHS Foundation Trust reported the greatest percentage difference between White and BAME staff experiencing discrimination at work from managers or colleagues. This was 8.3% greater than Northumbria Healthcare Trust (ranked 17th), 1.5% greater than Poole Hospital and 5.1% greater than Royal United Hospitals Bath.

The Trust which demonstrated the smallest gap between White and BAME staff experiencing discrimination from their manager/team was Northumbria Healthcare NHS Foundation Trust.

Indicator 9. NHS Trust Board Representation by Ethnicity and Executive/ Non Executive membership

From the sample of eighteen Trusts, Gloucestershire NHS Foundation Trust reported that 12% of board members were BAME, the 2nd highest in the sample following a joint first ranking between Doncaster and Bassetlaw Trust, Northumbria Healthcare Trust and Worcestershire Acute Trust (13%). Nine Trusts record no BAME board members.

Gloucestershire NHS Foundation Trust was one of eleven Trusts which reported 0% BAME board members with voting membership. Doncaster and Bassetlaw Trust and Worcestershire Acute Trust both ranked highest, reporting 18% of board members who were BAME had voting membership. All South-based Trusts reported no BAME board members with voting membership.

Gloucestershire NHS Foundation Trust ranked the highest in relation to Non-Executive BAME members (25%). Thirteen out of eighteen Trusts reported no BAME non-executive Board members.

Author:

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July 2020

Appendix 1.

Support roles: non-clinical and clinical

Table 10 demonstrates that Gloucestershire Hospitals ranked 3rd highest in the sample of 18 Trusts, meaning that 15 Trusts reported fewer **BAME** colleagues in **non-clinical support** positions. The two Trusts reporting the highest numbers of BAME colleagues in non-clinical support roles were also in the South.

Table 11 demonstrates that Gloucestershire NHS Foundation Trust reported the 5th highest number of **BAME** colleagues in **clinical support** roles. The Trusts that reported higher numbers of BAME colleagues in clinical support roles were in the Midlands and South East regions, with Nottingham University Trust reporting 16%. South Tyneside Foundation Trust reported the fewest BAME colleagues in clinical support positions (1.2%).

Gloucestershire NHS Foundation Trust had the 3rd fewest numbers of **White** colleagues in **non-clinical support** roles (80%), above Nottingham University Trust (72%) and Hampshire Foundation Trust (70%). Gloucestershire NHS Foundation Trust ranked 4th highest in relation to 'unknown' ethnicity of colleagues in non-clinical support roles (10.5%).

Gloucestershire NHS Foundation Trust ranked 13th in relation to the number of **White** colleagues in **clinical support** roles (86%). Trusts in Northern regions of the UK ranked 1st to 9th highest reporting the most White colleagues in clinical support positions, after which there was an even spread of regions.

The two remaining South West Trusts ranked 10th and 11th reported slightly more **White** colleagues in **clinical support** roles than Gloucestershire NHS Foundation Trust. Overall, the data ranged from 96% (City hospitals Sunderland) to 70% (Hampshire Trust). Gloucestershire NHS Foundation Trust ranked 9th highest in relation to number of **'unknown'** ethnicities (2.8%) in clinical support roles.

	Table 10. Indicator 1. Non-clinical Workforce Skill Mix by Ethnicity as at March 2019 - Support		**Support**
	Region	**Org name**	**BME**
1	South East of England	Hampshire Hospitals NHS Foundation Trust	13.2%
2	South West of England	Royal United Hospitals Bath NHS Foundation Trust	11.8%
3	**South West of England**	**Gloucestershire Hospitals NHS Foundation Trust**	**9.8%**
4	Midlands	Nottingham University Hospitals NHS Trust	9.6%
5	East of England	Mid Essex Hospital Services NHS Trust	5.6%
6	South East of England	East Sussex Healthcare NHS Trust	5.3%
7	East of England	West Suffolk NHS Foundation Trust	4.7%
8	Midlands	Worcestershire Acute Hospitals NHS Trust	4.2%
9	South West of England	Poole Hospital NHS Foundation Trust	3.7%
10	North West	Warrington And Halton Hospitals NHS Foundation Trust	3.2%
11	North East and Yorkshire	York Teaching Hospital NHS Foundation Trust	2.7%
12	North East and Yorkshire	Hull University Teaching Hospitals NHS Trust	2.5%
13	North East and Yorkshire	Northumbria Healthcare NHS Foundation Trust	2.2%
14	North East and Yorkshire	North Tees And Hartlepool NHS Foundation Trust	2.2%

15	North East and Yorkshire	Northern Lincolnshire And Goole NHS Foundation Trust	2.0%
16	North East and Yorkshire	City Hospitals Sunderland NHS Foundation Trust	1.9%
17	North East and Yorkshire	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	1.7%
18	North East and Yorkshire	South Tyneside NHS Foundation Trust	0.9%

	Table 11. Indicator 1. Clinical Workforce Skill Mix by Ethnicity as at March 2019 – Support		
	Region	**Org name**	**BME**
1	Midlands	Nottingham University Hospitals NHS Trust	16.4%
2	South East of England	Hampshire Hospitals NHS Foundation Trust	14.6%
3	South East of England	East Sussex Healthcare NHS Trust	13.7%
4	Midlands	Worcestershire Acute Hospitals NHS Trust	12.7%
5	**South West of England**	**Gloucestershire Hospitals NHS Foundation Trust**	**11.2%**
6	East of England	Mid Essex Hospital Services NHS Trust	11.2%
7	South West of England	Royal United Hospitals Bath NHS Foundation Trust	10.1%
8	South West of England	Poole Hospital NHS Foundation Trust	9.9%
9	East of England	West Suffolk NHS Foundation Trust	9.4%
10	North West	Warrington And Halton Hospitals NHS Foundation Trust	6.2%
11	North East and Yorkshire	York Teaching Hospital NHS Foundation Trust	4.7%
12	North East and Yorkshire	North Tees And Hartlepool NHS Foundation Trust	4.5%
13	North East and Yorkshire	Hull University Teaching Hospitals NHS Trust	4.2%
14	North East and Yorkshire	Northumbria Healthcare NHS Foundation Trust	3.8%
15	North East and Yorkshire	City Hospitals Sunderland NHS Foundation Trust	3.3%
16	North East and Yorkshire	Northern Lincolnshire And Goole NHS Foundation Trust	2.7%
17	North East and Yorkshire	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	2.4%
18	North East and Yorkshire	South Tyneside NHS Foundation Trust	1.2%

Senior roles: non-clinical and clinical

Gloucestershire NHS Foundation Trust ranked 9th in relation to the number of **BAME** colleagues in **senior clinical** and **non-clinical** positions.

Royal United Bath Trust ranked 6th reporting 1.3% more BAME colleagues in non-clinical senior posts compared to Gloucestershire NHS Foundation Trust. However, in relation to clinical senior posts, Royal United Bath Trust and Poole Hospital Trust reported fewer BAME colleagues comparatively.

Warrington and Halton Hospital (North West) reported the fewest **BAME** colleagues in **senior clinical** posts (2.3%) and City Hospitals Sunderland reported the highest numbers of BAME colleagues in clinical senior posts (13%). City Hospitals Sunderland also reported the 2nd highest number of **unknown** ethnicities in **senior clinical** positions (13%) whilst Gloucestershire NHS Foundation Trust reported the 2nd lowest number of **unknown** ethnicities (0.6%) just behind Poole Hospital (0%).

Gloucestershire NHS Foundation Trust ranked 11th in relation to number of **White** colleagues in **senior non-clinical** posts (93%). Royal United Bath Trust reported 2.9% more White colleagues in senior **non-clinical** posts and Poole Hospital Trust reported 5.5% more White colleagues compared to Gloucestershire NHS Foundation Trust. In relation to number of **unknown** ethnicities of colleagues in **senior non-clinical** posts, Gloucestershire NHS Foundation Trust ranked 7th highest at 4.2%.

Gloucestershire NHS Foundation Trust ranked 9th in relation to the number of White colleagues in **senior clinical** posts (93%). Poole Hospital (South West) reported the highest number of White colleagues in senior positions (97%).

	Table 12. Indicator 1. Non-clinical Workforce Skill Mix by Ethnicity as at March 2019 – Senior		**Senior**
	Region	**Org name**	**BME**
1	Midlands	Worcestershire Acute Hospitals NHS Trust	9.3%
2	Midlands	Nottingham University Hospitals NHS Trust	6.8%
3	East of England	Mid Essex Hospital Services NHS Trust	5.9%
4	South East of England	Hampshire Hospitals NHS Foundation Trust	5.5%
5	North East and Yorkshire	North Tees And Hartlepool NHS Foundation Trust	4.5%
6	South West of England	Royal United Hospitals Bath NHS Foundation Trust	4.4%
7	East of England	West Suffolk NHS Foundation Trust	4.2%
8	North East and Yorkshire	Northern Lincolnshire And Goole NHS Foundation Trust	3.4%
9	South West of England	Gloucestershire Hospitals NHS Foundation Trust	3.1%
10	South East of England	East Sussex Healthcare NHS Trust	3.1%
11	North East and Yorkshire	South Tyneside NHS Foundation Trust	2.7%
12	North East and Yorkshire	Northumbria Healthcare NHS Foundation Trust	2.6%
13	North East and Yorkshire	Hull University Teaching Hospitals NHS Trust	2.3%
14	North East and Yorkshire	City Hospitals Sunderland NHS Foundation Trust	1.8%
15	South West of England	Poole Hospital NHS Foundation Trust	1.8%
16	North West	Warrington And Halton Hospitals NHS Foundation Trust	1.3%
17	North East and Yorkshire	York Teaching Hospital NHS Foundation Trust	0.9%

18	North East and Yorkshire	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	0.0%

	Table 13 Indicator 1. Clinical Workforce Skill Mix by Ethnicity as at March 2019 – Senior		
	Region	**Org Name**	**BME**
1	North East And Yorkshire	City Hospitals Sunderland NHS Foundation Trust	13.0%
2	East Of England	Mid Essex Hospital Services NHS Trust	9.8%
3	North East And Yorkshire	Northern Lincolnshire And Goole NHS Foundation Trust	9.3%
4	South East Of England	Hampshire Hospitals NHS Foundation Trust	8.8%
5	South East Of England	East Sussex Healthcare NHS Trust	8.6%
6	Midlands	Worcestershire Acute Hospitals NHS Trust	8.5%
7	North East And Yorkshire	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	8.5%
8	Midlands	Nottingham University Hospitals NHS Trust	7.6%
9	South West Of England	Gloucestershire Hospitals NHS Foundation Trust	6.5%
10	North East And Yorkshire	Hull University Teaching Hospitals NHS Trust	5.3%
11	North East And Yorkshire	North Tees And Hartlepool NHS Foundation Trust	3.9%
12	North East And Yorkshire	South Tyneside NHS Foundation Trust	3.8%
13	East Of England	West Suffolk NHS Foundation Trust	3.5%
14	South West Of England	Poole Hospital NHS Foundation Trust	3.4%
15	North East And Yorkshire	York Teaching Hospital NHS Foundation Trust	3.4%
16	South West Of England	Royal United Hospitals Bath NHS Foundation Trust	3.1%
17	North East And Yorkshire	Northumbria Healthcare NHS Foundation Trust	2.8%
18	North West	Warrington And Halton Hospitals NHS Foundation Trust	2.3%

VSM roles: non-clinical and clinical

Gloucestershire NHS Foundation Trust was one of sixteen Trusts that reported no BAME representation at **non-clinical VSM** level. Gloucestershire NHS Foundation Trust ranked fourteen out of eighteen in relation to number of White colleagues in **non-clinical VSM** positions (85.7%) with 14% unknown ethnicities. Eleven Trusts reported 100% of White colleagues in VSM positions, Northumbria Healthcare Trust reported 93% whilst Nottingham University reported 46%.

In relation to the ethnicity of colleagues in **clinical VSM** positions, four Trusts provided no data and two Trusts reported 100% unknown ethnicities. All other Trusts recorded 0% **BAME** ethnicity in **clinical VSM** positions with the exceptions of Warrington and Halton (North West) and Worcestershire Acute (Midlands) at 10% and 50% respectively. Gloucestershire NHS Foundation Trust ranked joint highest in relation to numbers of **White** colleagues in **clinical VSM positions** (100%). The Trust with fewest White staff at VSM position was Worcestershire Hospital (50%).

PUBLIC BOARD
10 SEPTEMBER 2020 via MS Teams

Report Title

People and Organisational Development Performance Dashboard

Sponsor and Author(s)

Authors: Mel Murrell, Associate Director of Resourcing and Alison Koeltgen, Organisational Director of People and Organisational Development
Sponsoring Director: Emma Wood, Deputy CEO and Director of People and Organisational Development

Executive Summary

Purpose

This Performance dashboard aligns to key metrics identified within the People and Organisational Development Strategy. Key performance indicators detailed within are benchmarked (where appropriate) to Model Hospital Peer rates and University Hospital/ Teaching Peer rate. The indicators include:

- Retention
- Vacancy levels
- Turnover
- Sickness
- Appraisal and Mandatory Training

The People and Organisational Development Committee reviewed the detail of this report on the 25 August 2020. The Board are advised that the report was noted and reviewed.

There are a variety of other strategic and operational measures contained within the People and OD Strategy for which performance is more appropriately measured in narrative/ more detailed report form (i.e. Bullying and Harassment, Equality, Diversity and Inclusion measures, Staff Engagement, Integrated Care System updates). These have been mapped accordingly in the People and Organisational Development Committee Assurance Mapping profile and feature, as part of the overarching People and Organisational Development Committee work plan.

Key issues to note

Turnover and Retention

Non registered nursing turnover is now below 16%, at its lowest level since July 19, however Medicine Division's turnover is 21.7%. In comparison, the Surgical Division employs a similar number of non-registered nursing staff but has a turnover rate of only 11.53%. Whilst medicine has traditionally experienced a higher rate of non-registered turnover, this trend has been reflected in Executive Review discussions in July 2020, consequently work is now underway to benchmark this data with other Trusts medical wards whilst evaluating locally what our staff experience indicators (including exit interview) tell us about the issue.

Registered nurse retention rate is currently 89.2%, the highest it has reached over the last 2 years. Whilst it is challenging to accurately identify the key reasons for this improvement, we do know that our narrative as an organisation has and People and Organisational Development department has reflected the key aims of our People and Organisational Development Strategy, highlighting the correlation between staff and patient experience and

investing considerable effort and resource into improved staff health and wellbeing, education and talent development.

Overall Trust turnover continues to decrease; July reports a rate 10.42% against June 19 11.57%. This continues the downward trend in turnover from April 19. Every Staff Group with the exception of Additional Clinical Services (14.3%, predominantly non registered staff) is below target, as is every division except Medicine (13.49%).

Sickness Absence has been predictably impacted by COVID. The 12 month sickness rate excluding COVID related absence is now 3.77%, which is lower than average reported levels. However, when including COVID related absence, the 12 month rate increases to 4.53%. COVID absence only for the month of June was 2.45%, down from a high of 6.75% in April.

Vacancy levels

The overall Trust vacancy level for July is approaching the target of 5% (now 5.14%). The staff nurse/ODP vacancy rate is 10.10% for July. This represents a shortfall of 130 fte below the funded establishment.
June and July's vacancy rate has been calculated from ESR, which has increased the accuracy when looking at individual groups of staff. 61.8 Nurses awaiting PIN have been identified against staff nurse establishment, and will be expected to commence in Band 5 roles during September. Currently there remains a challenge in accurately identifying vacancies at ward level; this is due to the number of temporary service led moves as part of the COVID response which have not been reflected in the contracted element of the finance ledger or ESR.
Non Registered nursing vacancy is currently 4.86% which includes the 78 fte Year 2 Nursing Students employed by the Trust until the end of July as part of the COVID response. It will be expected that the vacancy rate will increase as the students return to University and active recruitment gets underway.

Appraisal

Appraisals have seen a reduction to 76% since the changes to working practice and service changes for staff (due to COVID) have taken effect. Corporate has the highest proportion of staff who can work from home and the lowest Appraisal rate (67%). As colleagues either adapt to working from home more, or integrate back into work (physically) we expect to see this improve, however appreciate it could take some time to catch up to an acceptable level.

Mandatory Training

Mandatory training is at 90% compliance for the Trust. Compliance levels continue to be supported through the increased uptake of E-Learning and the move toward virtual training packages previously delivered as face to face. Information Governance training is highlighted as an exception due to the decline in compliance to 88%. Efforts continue to promote the importance of this training and to support improved compliance in areas where it is more challenging to reach staff (such as bank services).

Exit Questionnaire Project Update
A brief progress report is annexed to the Dashboard, describing the progress of the Surgery Division pilot – testing a new Exit Questionnaire process. Following the launch of an online 'JISC' questionnaire in November 2019 as a potential alternative to the ESR questionnaire the Division observed that compliance rates rose to a 45% compliance rate**.** This mechanism will be rolled out to other divisions during September and October 2020 (delayed due to COVID) and will sit alongside and in addition to face to face exit interviews, to enable the improved capture of standard exit data.

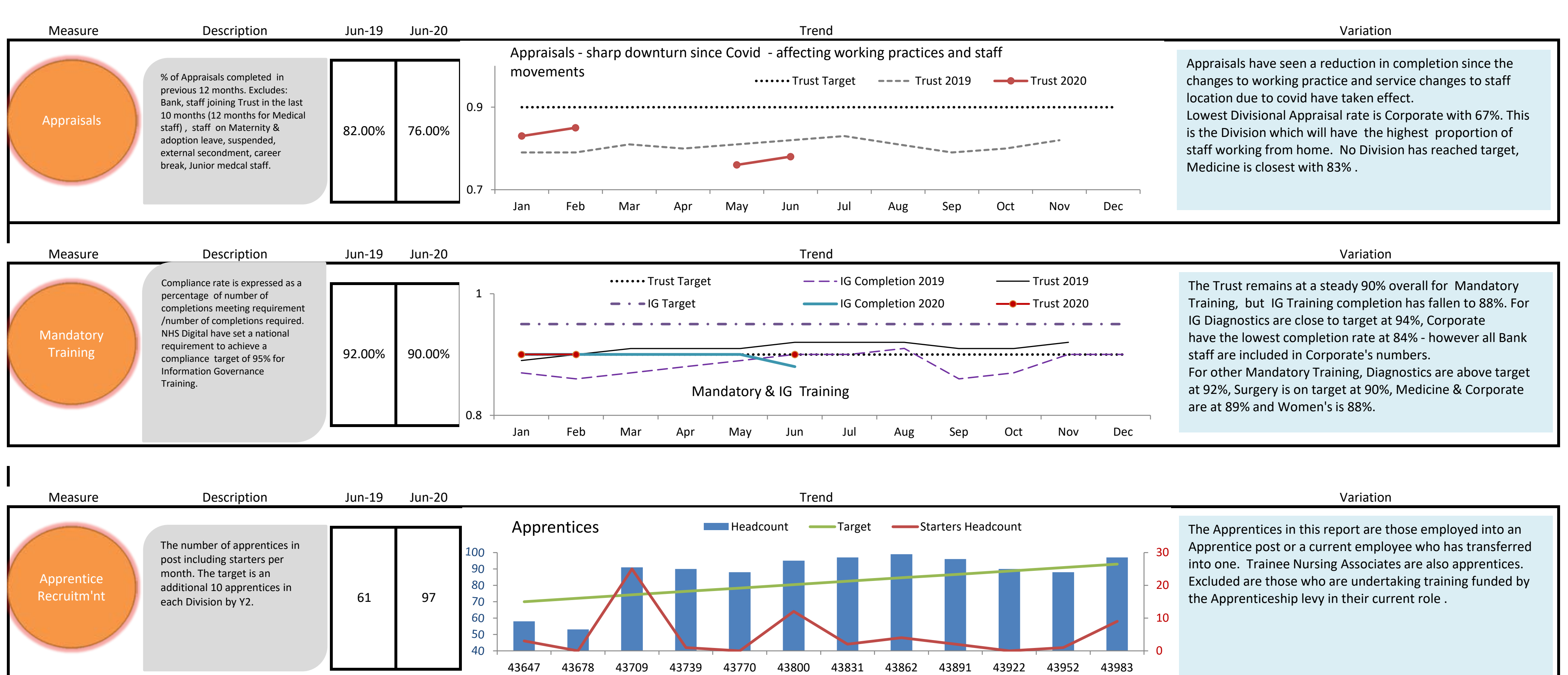
Recommendations
It is recommended that the Board are assured that sufficient controls exist to monitor performance against key workforce priorities as articulated in the People and Organisational Development Strategy. Where operational improvements are required, actions are fed into the appropriate workstreams, monitored by the People and Organisational Development Delivery Group. Where Divisional exceptions are highlighted this is challenged and monitored through the Executive Review process.
Impact Upon Strategic Objectives
Reflects known pressures and priorities relating to the delivery of a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people.
Impact Upon Corporate Risks
Workforce stability is a critical part of our plans to mitigate the risk associated with the limited supply of key occupational groups such as Nurses, AHPs and Medical staff.
Regulatory and/or Legal Implications
The reports proposed in Appendix 2 are designed in such a way to provide assurance that the Trust are operating in accordance with: National reporting requirements associated with Equality, Diversity and Inclusion Freedom to Speak Up best practice NHSI/E requirements Best practice and employment legislation, including the Equality Act.
Equality & Patient Impact
There is a known researched link between employee experience, stability, retention and patient experience. The People and Organisational Development Strategy promotes a culture of ‘caring for those who care’, who in turn will enhance the experience of our patients.

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

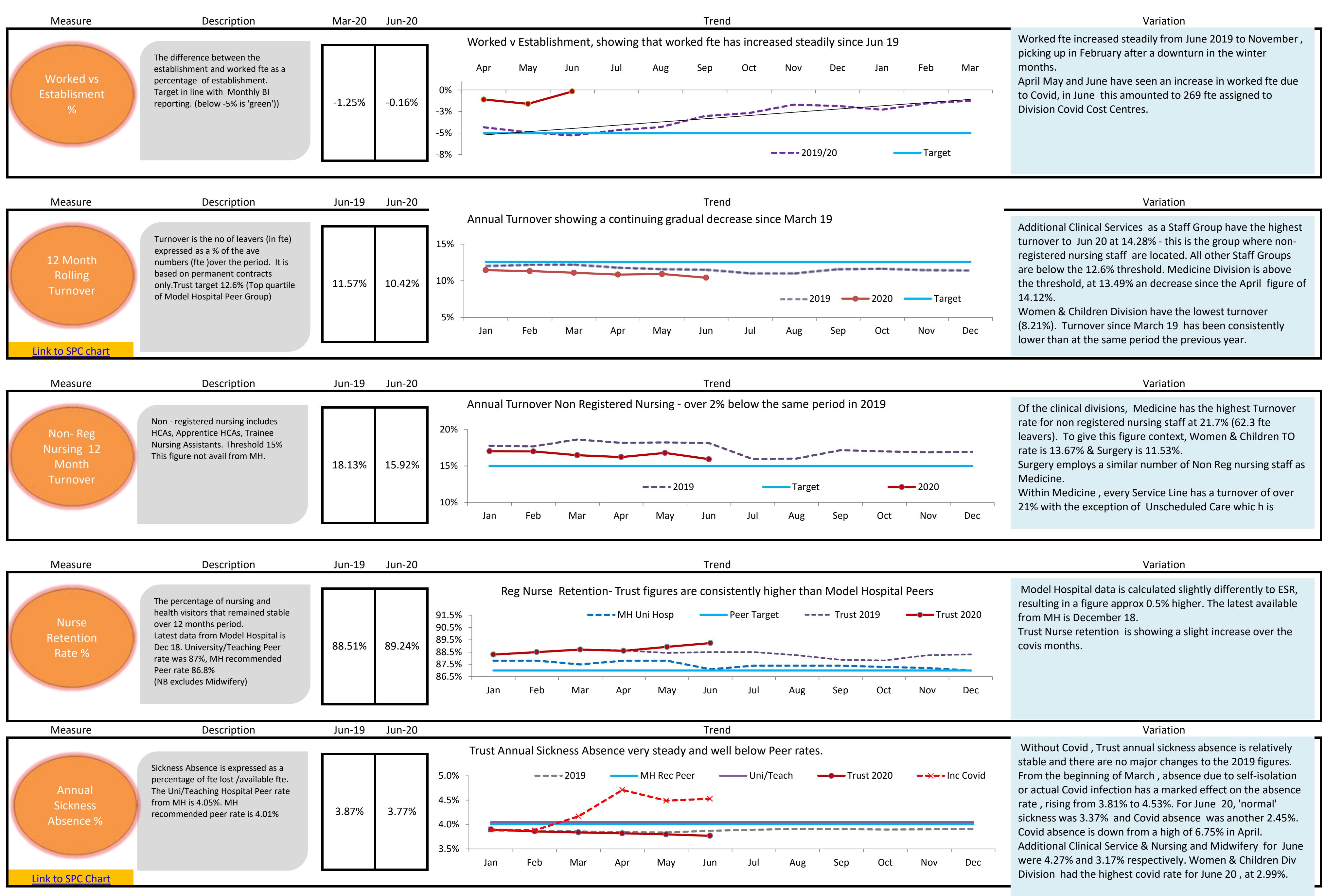
Action/Decision Required							
For Decision		For Assurance	X	For Approval		For Information	X

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
			25 August 2020			
Outcome of discussion when presented to previous Committees						
The Committee were assured by the data provided and noted the improvements made to Trust targets. The improvements required within Medicine Division to reduce their vacancy rates in particular were discussed. An exception report will be provided to outline plans and progress.						

Gloucestershire Hospitals NHS Foundation Trust

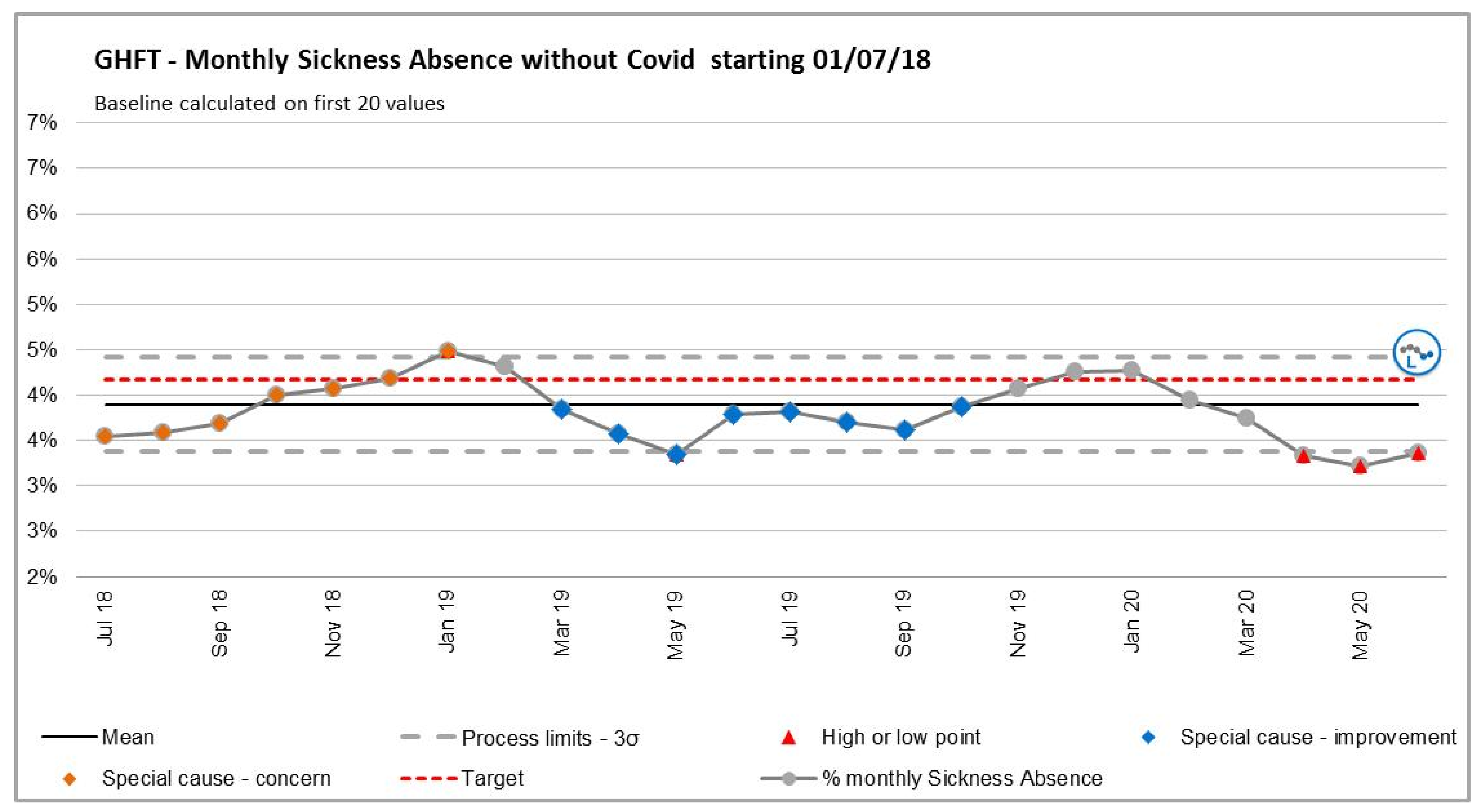


Gloucestershire Hospitals NHS Foundation Trust



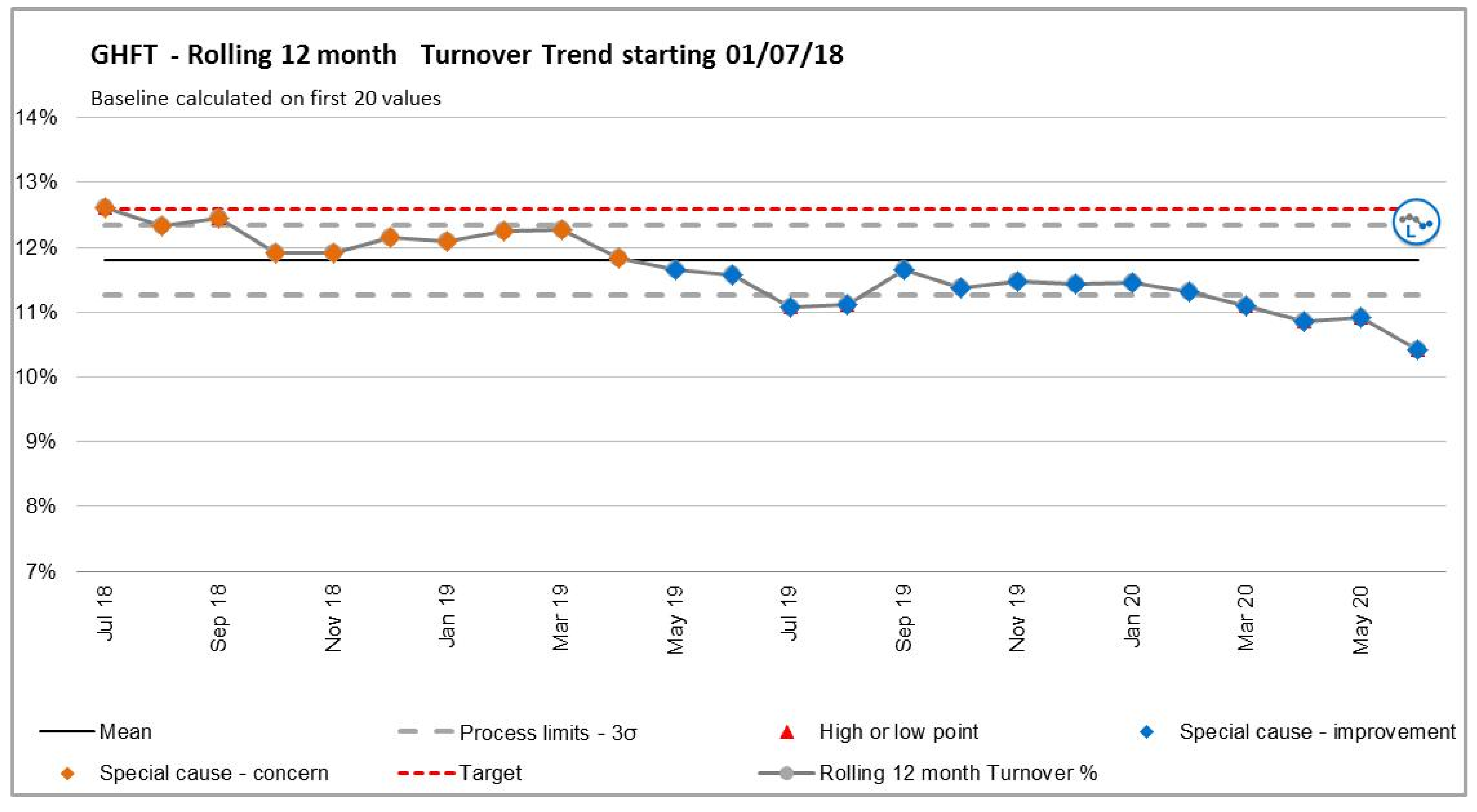
GHFT monthly sickness Absence SPC chart

The SPC chart clearly demonstrates the seasonal variations in sickness absence rate. Although This could be illustrated equally well on a simple run chart, this report will continue with SPC charting to monitor high/low points.

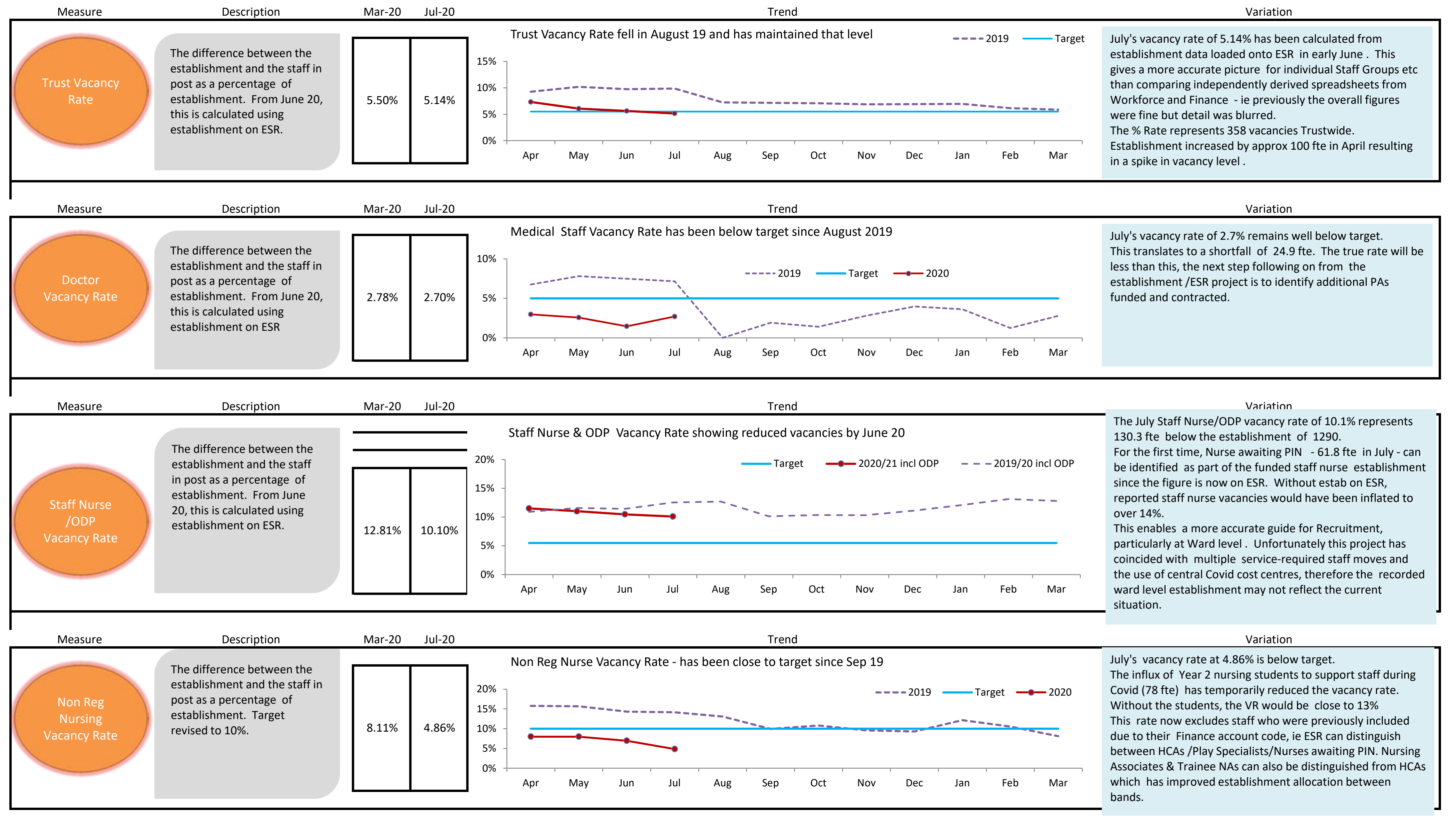


GHFT 12 month rolling turnover SPC chart

There has been a statistically significant reduction in Trust Turnover since April 2019



Gloucestershire Hospitals NHS Foundation Trust



Exit Questionnaire Project - Summary of Progress

The purpose of this summary is to provide the People and Organisational Development Committee with an update on the work to improve Exit Questionnaire compliance. It is recognised that exit questionnaires do not remove the opportunity for face to face discussions, which are still encouraged, however they do provide a mechanism from which to capture clear data relating to the reasons people chose to leave our Trust.

The last report on the Exit Interview project came in October 2019, which detailed the intent and structure of the Silver QI initiative, reporting into the Staff and Patient Experience Group. This report included detail on the challenges relating to the capture of exit information from questionnaires and exit interviews/ conversations and reported a compliance rate that had risen marginally from **28% to 31.52%.** At this time we reported limited divisional engagement.

The project aim ambitiously describes a target of increasing the capture of the exit data to a compliance rate of 60%, to improve reporting of trends and themes, by 31st March 2020.

Surgery Division Pilot

The Surgical Division launched an online 'JISC' questionnaire in November 2019 as a potential alternative to the ESR questionnaire. The study ran this concurrently with the ESR questionnaire over a three month review period. Compliance rates rose to a **45% compliance rate** whilst compliance across the Trust for the ESR questionnaire completion stayed at only 32%**.** An example of the 'JISC' questionnaire can be viewed in fig1.

It should be noted that alongside the Surgery pilot the People and Organisational Development team launched revised policy and action cards for managers to ensure there is a clearly defined process to follow for employees leaving the Trust.

Lessons learnt included:

- Improved questions/ better quality data to understand the intricate reasons for leaving around work/ life balance and relationship with Managers.
- JISC questionnaires can be sent swiftly by the division as soon as an individual resigns, compared to the HR advisory team sending once the individual is processed as a leaver in ESR.
- At the point the Surgery Division assumed responsibility for their own exit questionnaires, compliance rose

Next Steps

The plan to roll out of the JISC questionnaire to the rest of the Trust was scheduled for March 2020, however planned actions were superseded by the Covid response and associated workload. New planned rollout is scheduled take place during September and October 2020.

Bilal Pandore
HR Manager (Exit Questionnaire Project Lead)

Figure 1. JISC Questionnaire

Q11	**Why are you leaving the Trust or your current role? *Respondents are able to tick more than 1 option**	
	Salary	
	Difficult relationships with work colleagues	
	Difficult relationships with manager/supervisor	
	Did not receive adequate training to do my job	
	No sufficient development or progression opportunities	
	Role did not make use of my knowledge, skills and abilities	
	Did not have enough resources to do my role and not making an impact	
	Poor staffing levels	
	Wanted better parking options	
	Not enough flexible working options	
	Poor work / life balance	
	Bullying and Harassment issues	
	Found a job to progress	
	Re-locating	
	other	
Q12	**Can you tell us up to 3 things you really enjoyed about working within this team/organisation?**	
Q13	**Can you tell us up to 3 things we could do better as a team/organisation?**	
Q14	**Is there anything we could do to persuade you to stay?**	

REPORT TO TRUST BOARD – September 2020

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

This report describes the business conducted at the People and Organisational Development Committee on 25 August 2020 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Risk Register	The Datix system has not been funded under intolerable risks and the proposed upgrade solution may not be fit for purpose. Risk around experience and engagement. The new wording has been interpreted in different ways by members and whilst it captures how staff may be impacted by events internal and external to the organisation should read in a consistent way	The system being inefficient and unsupported in the future is of concern as it is a key application for reviewing incidents and risks Should the staff experience and engagement risks be separated?	Features on the Risk Register. Continuing to build a robust solution/option. Will consider the cost as part of the next financial year's budget process People and OD Team to revisit in advance of the next People and OD Delivery Group on the 8th September for group approval.	
Freedom to Speak Up Quarterly Review	Annual Report received. Lower number of concerns noted. The organisation now has 7 Freedom to Speak Up Guardians including medics and a BAME representative. More interventions with Leadership and OD such as	EDI data on those who raise issues is missing and not recorded. Reports should classify protected characteristics.	Benchmarked our Freedom to Speak Up incidents against the Staff Survey questions relating to Speaking Up. We are on a par with National Comparators.	Guardians will begin to capture the data

	coaching and upskilling on how to raise issues has been successful this year. Poor behaviours remain the key feature of reports.	How do we know if all staff issues are captured if colleagues don't go to the Freedom to Speak Up Guardians How fast are matters resolved for staff? Speed of Freedom to Speak Up processes are captured 20% of colleagues suggest they are bullied (staff survey results) is this the case?	There are other routes to raise issues such as HR, 2020 Hub, Trade Unions and open door culture. Timelines for resolution can be provided in future reports. The data is a percentage of staff who completed the survey (c800 people reported bullying). Discussed triangulation of various sources of data which do not indicate there isn't a systemic issue – such as improved retention data, and employee relations cases however the Widening participation review will be able to give a view of these experiences for BAME staff who report higher levels of bullying. The staff survey does not define bullying and leaves this open to personal perception and definition. Understanding how colleagues define this will form part of the deep dive.	
Board	Changes to principle risks			

Assurance Framework	including closures and merging some were agreed. The ratings across the Strategic objectives were agreed			
COVID Report	Report provided reflections of lessons learned for the People and OD team, Health and safety department, Legal services, Trust secretary and charity. The results of 2 Health and Wellbeing Surveys were outlined and an update provided on COVID Secure which was signed off by the Health and Safety committee on 7th August 2020.	Decompression sessions have been reactive to demand. How are we managing areas which might need the service but are not coming forward for it? Does the Trust have sufficient psychological resources to help staff Where does the Trust keep reflections on COVID? Are union concerns on our entrances and maintaining covid secure status being managed?	Capacity is limiting availability beyond areas raising concern but with a new psychology link worker starting in October we enable more proactive work. The new Psychological link worker is part time and contracted for 6 months. Further sources of funding would need to be sought to extend this. The strategy team have reported upon the silver linings and each division is running its own lessons learnt programme of events GMS, IPC and Health and safety teams will continue to ensure our COVID secure status is maintained and volunteers may assist with the public at entrances to mask and sanitise hands	Execs to reconsider the funding envelope if other sources of funding for psychological welfare services such as the NHS Charities Together money is not forthcoming.
Performance Dashboard	Good progress with vacancy levels, turnover and stability and a much improved position with	What plans are in place for Medicine to improve their understanding of their	Improved establishment control processes have given the resourcing team new data	Divisional analysis and exception reporting on performance is on the

	data indicating we are meeting the targets set in the People and OD strategy. Areas of concern remain medicine and their vacancies /turnover	vacancy position.	which Divisions need to review and consider. Meetings have been set to hold Divisions to account and triangulate information such as reported Vacancies vs use of budget for roles Reconfiguration of our services has added a layer of complexity.	work plan and will come to the next committee.
ICS Update	Recruitment and Retention Sub-group has closed and will become a Task and Finish Group with a focus on joining up international recruitment across the system and a BAME/Disabled recruitment 'event' Leadership group has refreshed its offer with virtual learning events Health and Wellbeing groups are working in partnership ahead of the NHS Charities Together phase 3 bidding process. Education Learning Development have focused on how to use Health Education England, CPD Money for registrants.			

	People and OD Directors and their deputies now meet fortnightly and are reviewing the ICS People groups to ensure alignment with the new working groups which will start when the Regional People Board commences in September			
Sustainable Workforce Review	Progress was provided against the People and OD strategy. Most actions were RAG rated Green across year 1 and 2. No concerns were noted in terms of delivering the plans. Using HEE CPD funds and reporting to HEE on allocation will be time consuming (£912k) Trainee Nursing Associates remain on track despite partners not progressing with the offer. Incentives are now available to offer degree nurse apprenticeships to help to offset the cost of supernumerary placements. The Trust is considering if this offer can be supported			People and OD Committee to be provided an overview of allocation of funds and trajectory to spend.
Staff Survey / Equality, Diversity and Inclusion Plan	Combined action plan to prevent duplication of effort was accepted by the committee.	Many actions are open ended. Could some be given due dates so the Trust can measure success.	The actions are linked to the success criteria and measures agreed and signed off in the People and OD	

	Benchmarked data against similar organisations with similar census demographic information was provided for the first time and highlighted areas of good performance and those to improve. The action plan focuses on: Reducing Bullying and Harassment Removing the inequalities relating to discipline cases Improving recruitment processes Driving our EDI plan as ratified by the Board in July 2020	The committee asked why there was a lack of ethnicity data (people not declaring personal data.)	Strategy which link to the Staff Survey and EDI metrics. Theses links will be made more explicit.	A plan had been in place to request staff update their personal characteristic data on ESR but was paused due to COVID. This will recommence this year.
WDES / WRES	The Trends in the latest WRES and WDES data were provided. Some indicators have improved and other remain stable. It remains that disabled staff followed by BAME staff have the worse reported employment experiences New WRES data will be provided to the organisation who will partner the Trust with its widening participation review	The committee expressed concern that disabled staff reported more frequent experiences of harassment/bullying and abuse.	This is an area for improvement and actions have been recorded in the EDI/staff survey action plan.	

Board note/matter for escalation

None

Balvinder Kaur Heran, Chair of People and OD Committee, 2 September 2020

TRUST BOARD – SEPTEMBER 2020
Microsoft Teams at 12:30

Report Title
Safeguarding – Annual Report
Sponsor and Author(s)
Author: Jeanette Welsh, Lead for Safeguarding Adults Sara Motion, Named Doctor Safeguarding Children Sponsor: Carole Webster, Deputy Chief Nurse
Executive Summary
Purpose To assure the Board of safeguarding governance, monitoring and responses in place. Key issues to note Workplans for 2019/20 were achieved. Notably: - Safeguarding Hub has been established and Think Family approach - Safeguarding risk assessments are now available for completion at all points of entry, albeit EPR for inpatient adult areas and paper documents in all other areas. The change to EPR has not yet occurred in Children's Services. - Training programmes at all levels for both adults and children have been revised and improved performance is starting to filter through as a result. COVID halted face-to-face training, but sessions have been revised to enable delivery over Microsoft Teams. Lower of training compliance appear in training reports due to the changeover in training provision. - The HIDVA contract has been reviewed and commissioners have agreed to fund ongoing - A thematic review of injuries in non-mobile infants has been completed - Associate Named Nurse for Safeguarding Children appointed - GHFT and multi-agency partners launched 3 initiatives to safeguard children in response to recommendations from Children's Safeguarding Practice Reviews - Launch of the ICON project for parents of new babies Risks and issues of note are: • Children presenting with self-harm and mental health issues experience delay in accessing the care needed. Whilst staff are paediatric trained, they do not have higher level mental health training, leaving both children and staff exposed to several risks. • Lack of EPR in Children's Services means information is not accessible when needed for clinical assessment and treatment plans • Skilled, consistent levels of administrative support are required in all aspects of safeguarding work and currently insufficient • There is a gap in service provision to patients with complex and multiple conditions as they transition from Paediatrics to Adult Services, which is the root cause of many poor patient experiences, complaints and expression of safeguarding concerns. • There is a gap in care facility provision for alcohol-dependent people who do not wish to stop drinking but have developed care and support needs chronologically early. Detail in section 14 of report.

Safeguarding workloads have been broadly stable, with the exception of Domestic Abuse, which has seen month on month increases, except latterly during the strictest pandemic restrictions. This affects all areas of the Trust, but is most often detected by the Emergency Departments and maternity staff.

During the year there have been several Serious Case Reviews (from 2020 onwards will be known as Children's Safeguarding Practice Reviews), Domestic Homicide Reviews and Serious Adult Reviews with recommendations for all partners coming out of each review. GHFT is obliged to deliver on these recommendations, all of which entail quality improvements to our services. Most notably during 2019/20 a large project to revise our letters to GPs after outpatient appointments has delivered distinct improvements, without clinicians having to remember to do something different for a patient who was not brought to their appointment. This is a Trustwide improvement which applies to all patients of all ages.

Safeguarding Children have been, and are, focusing strongly on developing staff practice and processes to assess vulnerability and risk at the earliest time in child's life, using the evidenced based messages of the ACE's programme, with a continuing focus on the increased risks for the very young/ non-mobile infants. Evidence clearly shows that this is the time in a child's life where intervention can maximise their chances of a childhood free of abuse and neglect.

LeDeR reviews have consistently raised 4 concerns about care at GHFT – these are:

1. Dysphagia management
2. Use of the Hospital Passport (to be known in future as the Health Passport)
3. Communication with non-verbal patients
4. Listening to the experience and concerns of family and paid carers

All of these are being taken forward as workstreams by the Learning Disability Steering Group.

The Emergency Departments are now using a tailored mental health triage tool for all those identified as having mental health needs and the Mental Health Liaison Team are making follow-up calls to all patients who do not wait to be seen in the Emergency Departments, where mental health or alcohol-dependency have been identified. These two improvements have considerably reduced the risks related to these patient groups waiting for extended periods for mental health assessment.

Frequent Attender management has been taken into the Safeguarding workplan so that it is tracked, monitored and reviewed, rather than being *ad hoc.* GHFT will be participating in a regional High Impact Users project and this has enabled additional consultant and safeguarding time to be given to patients who have complex needs and require summarised background knowledge and a consistent approach to management. This approach has already demonstrably worked with patients who have primarily mental health or alcohol-dependence concerns and this project offers the opportunity to extend this improvement to physical health complexities.

QDG has already received reports about Mental Capacity Act assessment. This is fundamental to the introduction of Liberty Protection Safeguards (LPS) as a result of the Mental Capacity (Amendment) Act being passed in 2019. Had COVID-19 not struck then the implementation date for LPS would have been 1st October 2020. Legislation has not yet been passed to move that date back, but assurances have been received that this will be done, albeit that Parliament is due to rise soon for summer recess.

An increase in the number of allegations made against our staff in the early months of 2020 has prompted a review and revision of the process managers are to follow when investigating such allegations. This work is being led by the Operational Director of People and Organisational Development.

Conclusions

At the end of 2019/20 Safeguarding is better able to assure the Board that concerns have been identified, raised to the correct specialities and authorities and responded to in a manner that takes account of the wishes of the patient concerned. That work and recommendations coming out of the many formal case reviews during the year dictates the work required in the forthcoming year.

Implications and Future Action Required

Review recommendations across age groups require that we:

1. Risk assess all patients more robustly on presentation to our services
2. Prioritise the work of safeguarding children in the EPR roll-out to ensure staff are both alerted to risks and can read and share information effectively
3. Demonstrate more professional curiosity about patient histories and answers to questions and are not afraid to compassionately challenge stories that are inconsistent with our observations and examination, with particular emphasis on meeting the needs of children who present in crisis with self-harm and other mental health disorders
4. Demonstrate that mental capacity assessment has been factored into our patient management decisions
5. Demonstrate that we have actively asked patients what their preferred outcomes are for both care and treatment and safeguarding interventions
6. Signpost patients with evidence of alcohol intoxication or alcohol dependence to alcohol services
7. Work towards incorporating the Pathfinder Toolkit into our services to enhance the response to domestic abuse
8. Monitor numbers of head injuries and long bone fractures in pre-mobile infants
9. Address concerns raised about the quality of our care by LeDeR reviews
10. Pursue a county care facility for alcohol-dependent men using a whole system approach

To achieve this staffing levels within the Safeguarding Team will need to be optimised to enable effective service delivery, development and training delivery (i.e. named nurse, named midwife, additional hours domestic abuse and adults with care and support needs and appropriate levels of administrative support). This requirement is being mapped.

Recommendations

That all review recommendations are implemented as quality improvements to GHFT services

Impact Upon Strategic Objectives

All recommendations will improve the quality of the service we offer, aiming to make these outstanding.

Impact Upon Corporate Risks

C3104 – Domestic abuse workload has increased 23% and resource is not matched to workload, resulting in considerable delays contributing information to multi-agency meetings

C2786 – the Mental Capacity (Amendment) Act 2019 will come into force at some point in 2021 (yet to be advised) and we do not have the infrastructure in place to manage our responsibilities as a Responsible Authority for Liberty Protection Safeguards (LPS). We will not be able to send applications for LPS outside the Trust, we will be responsible for all assessments and authorisations and reporting each of these to CQC.

C2738 – poor documentation of Mental Capacity, where clinicians have reason to question it, undermines our ability to make clinical decisions with and for patients and their representatives and our ability to comply with the Mental Capacity (Amendment) Act of 2019

C1373NSafe (adults), C1374NSafechildren and C2430SafeYoungPeople (16 and 17 year olds) – we consistently miss opportunities to safeguard our patients of all ages from abuse and

neglect. This could be mitigated by consistent use of safeguarding risk assessment screening in EPR and on paper documents. Further mitigation could be achieved if risk assessments for children were on EPR, particularly for 16 and 17 year olds on adults wards.
C1850NSafe – providing care outside of licence because of an increasing number of 12 – 18 year olds presenting with self-harming behaviour and having extended stays on Children's Ward
WC2763Obs/Paed – risks to child wellbeing created by delays in communicating with community child services caused by referrals all being on paper records with manual systems to transfer referral to e-mails.

Regulatory and/or Legal Implications

Mental Capacity (Amendment) Act 2019 comes into force on 1st October 2020, introducing Liberty Protections Safeguards and applies to everyone aged 16 years or above. DHSC have indicated that they will be introducing legislation to put this date back, but that has not yet happened and there is no indication yet of the likely revised implementation date.

Equality & Patient Impact

Abuse and neglect are traumatising for the individual who experiences them, regardless of any characteristic of that individual. Secondary healthcare has unique opportunities to detect and respond to such abuse and neglect to minimise the time and intensity of the trauma.

Resource Implications

Finance	X	Information Management & Technology	X
Human Resources	X	Buildings	

Action/Decision Required

For Decision		For Assurance	X	For Approval	X	For Information	X

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

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

Outcome of discussion when presented to previous Committees/TLT

RECOMMENDED FOR BOARD APPROVAL

Annual Safeguarding Report Year to 31st March 2020

Prepared by: Jeanette Welsh – Lead for Safeguarding Adults
Dr.Sara Motion – Named Doctor, Safeguarding Children

Table of Contents

1.Introduction and executive summary 3

2. Governance and Accountability arrangements 4

3. Trust Safeguarding Children Activity Report 7

4. Trust Safeguarding Adult Activity Report 9

5. Domestic Abuse Activity Report 11

6. Mental Capacity Act 11

7. Deprivation of Liberty Safeguards (DoLS) Activity Report 12

8. Liberty Protection Safeguards 13

9. Learning disabilities 14

10. Mental health and safeguarding 14

11. Crime pathway 16

12. PREVENT 16

13. Safeguarding Training 16

14. Risks and issues 17

15. Safeguarding Children Priority Objectives 2020/21 18

16. Safeguarding Adults Priority Objectives 2020/21 19

17. Recommendations...20

Appendix A - WORK PLAN – CHILDREN'S SAFEGUARDING OPERATIONAL GROUP 2019/20................22

Appendix B – Safeguarding Children Dashboard 2019/20 27

Appendix C – Domestic Abuse workload 2019 29

Appendix D – Safeguarding Concerns reported to Safeguarding Adults Team 2019/20......................30

Appendix E – Deprivation of Liberty Safeguards (DoLS) activity 2019/20 31

Appendix F – External safeguarding allegations against GHFT 2019/20 31

1.Introduction and executive summary

This report is made to the Trust Quality and Performance Committee for assurance that the Trustwide arrangements in place to meet our regulatory responsibilities are operating effectively. An update is provided on activity, performance and monitoring of the five safeguarding pathways:

- Safeguarding Children
- Adults with Care and Support Needs
- Victims of Domestic Abuse and their children
- Criminal exploitation in its many forms
- PREVENT.

Gloucestershire Hospitals NHS Foundation Trust (GHFT) is a busy multi-specialty NHS Trust, with ante-and perinatal staff supporting 6,400 births (approximately 1% of the UK total) in the year under report; 153,932 Emergency Department attendances (of which 32,385 were CYP unscheduled attendances across the Emergency Departments and paediatric acute services); 153,458 scheduled outpatient attendances and 143,494 inpatient admissions (emergency and elective).

The Children Act (1989) lays out our responsibilities related to children at risk of harm through abuse or neglect (section 47). Safeguarding Children requires all Trust staff to consider child welfare at every contact. 15% of children and young people (CYP) in Gloucestershire have significant levels of additional social need or disability and 1.5% CYP are Children in Care or on Child Protection plans. The safeguarding children workload demands high quality Trust processes and clinical practice.

The Care Act 2014 (section 42) governs safeguarding activity and applies to an adult aged 18 or over who:

- has care and /or support needs (whether or not the local authority is meeting those needs) and;
- is experiencing or at risk of abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from the risk of , or the experience of abuse or neglect.

This includes people with capacity who self-neglect. This requires that every contact with adult patients must consider safeguarding.

The domestic abuse pathway incorporates safeguarding of young people, aged 16 to 18 years of age. This is coordinated under the Multi Agency Risk Assessment and Conference (MARAC) Information Sharing agreement.

A progress report is provided on the application within practice of the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) and Mental Health Act detentions. Liberty Protection Safeguards legislation (LPS) was scheduled to replace DoLS legislation on 1st October 2020, but indications from the Department of Health and Social Security during the COVID-19 pandemic are that this has been delayed.

A report is included laying out the performance, activities and issues around caring for those with Learning Disabilities within the Trust.

This report summarises activity and progress over the last year and will share information on future developments required.

The emphasis this year has been to change our safeguarding focus from one individual to the whole household and to that end have brought together all the Safeguarding specialists with an adult focus in the Safeguarding Hub, all working closely with Safeguarding children specialists, so that we consistently Think Family.

2. Governance and Accountability arrangements

The Director of Quality and Chief Nurse is the Executive Board member accountable for safeguarding. The Director of Operational Nursing and Deputy Chief Nurse has delegated authority and chairs the Safeguarding Strategic Group supported by the delegated Non-Executive Director.

The Trust Safeguarding Adults and Children Operational Groups meet bi-monthly alternating with the Safeguarding Strategic Group. Additionally senior Safeguarding specialists attend and contribute to the Countywide Strategic Health Safeguarding Groups, which bring together the named professionals from all the County Health Trusts, Commissioning Team and General practice.

The Trust Named Nurse (NN) and Named Doctor (ND) for Children's Safeguarding facilitate the annual program via the Trust Safeguarding Operational and Strategic Group. Practice development and supervision for the NN and ND takes place with the CCG Designated Nurse and Designated Doctor, both roles are signed up to their regional and national strategic networks.

A Lead for Safeguarding Adults was appointed and started work in July 2019 and an Associate Named Nurse for Safeguarding Children was appointed in 2020. We have also appointed part-time additions to both the adult and children teams to strengthen our responses with homeless patients and with children. For most of the year the HIDVAS (Hospital-based Independent Domestic Violence Advocates) have worked on-site in the Safeguarding Hub, interrupted only by COVID-19. This has facilitated increased cross-workstream collaboration enabling the most appropriate specialist to lead on the less clearly defined cases.

The Operational Director of People and Organisational Development is the Senior Manager Responsible for staff allegations and liaises with the Local Authority Designated Officer if concerns are raised about Trust staff working with adults.

National Governance requirement, Section 11 Audit

The Gloucester Safeguarding Children Executive (GSCE) Audit of GHFT performance going forwards from 2020 will be requested as below, with reporting broken down into 4 domains :-

- Leadership and accountability
- Safe recruitment, Induction, Training and Development
- Safeguarding Policies and procedures
- Listening to Children and Young People

A framework to report on these areas will need to be developed for GHFT and will be included in future annual reports.

Role and Responsibility of the Gloucestershire Safeguarding Adults Board (GSAB)

The main function of the local Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the section 42 criteria of the Care Act 2014.

GSAB publish an annual report on their activity and performance. The Gloucestershire Safeguarding Unit currently have c.6000 contacts per year of which c.1000 result in an investigation and only a small proportion of these are found to meet the threshold for section 42. As a result GSAB have been able to prioritise working on harder to manage high risk individuals who are either very complex and/or in the 18 – 25 year age range who are transitioning from Safeguarding Children legislation.

2.1 Safeguarding Adults Governance

The Safeguarding Adults Operational Group has met bi-monthly alternating with Safeguarding Strategic Committee. Focus has been on all elements of Safeguarding and vulnerabilities groups reporting into this group to ensure that divisions have visibility of concerns arising and work undertaken.

2.2 Monitoring arrangements – Safeguarding Adults

Keeping accurate records has been a priority in each safeguarding workstream and we have moved all our recording systems to secure on-line platforms

a) Safeguarding Adult at Risk concerns
These relate to concerns of possible abuse or neglect or self-neglect where the harm is considered to be by another and not linked to Trust care experience. These are scrutinised by Adult Social Care (Appendix D)

b) Safeguarding Adult Allegations
These relate to GHNHSFT care experience raised under safeguarding pathway to Gloucestershire Safeguarding Adult Unit and reported within Datix. Trust Safeguarding Adult Allegation reporting to CQC is via Datix. (Appendix F)

c) Deprivation of Liberty Safeguards (DoLS) considerations
DoLS applications made by Trust clinical teams, daily monitoring of practice, tracking, and outcome reporting. DoLS outcome notification forms are completed and submitted to CQC for every DoLS application made. (Appendix E)

d) Domestic abuse referrals
Risk levels re-assessed and additional background work done prior to onward referral (Appendix C)

e) Information sharing requests
These are received from MARAC for high risk domestic abuse referrals by agencies other than GHFT (Appendix C)

f) Safeguarding Log
GHFT secure repository of high risk safeguarding information not generated by health and therefore not able to be included in patients' health records, but vital knowledge prior to clinical assessment.

g) Homeless patients
Tracking activity and outcomes of homeless patients raised to Specialist nurse for Homeless patients

h) Frequent attenders
Local monitoring standard of patients who are coming to our Emergency Departments 9 times or more in a 3 month period and their allocated lead professional. There is a comprehensive system of management plan for these patients, which is also available for complex patients who require consistency of approach.

2.3 CQC 'must do' actions

At their last inspection, whilst rating GHFT 'good' overall, the CQC had 3 concerns related to safeguarding:

a) Mental Capacity Act
The concern was specifically related to the Surgical Division (Regulation 11, Need for Consent) – please see section (5) below for detail on performance and work undertaken to address CQC concerns.

b) Deprivation of Liberty Safeguards

The concern was specifically related to the Surgical Division (Regulation 13, Safeguarding service users from abuse and improper treatment) – please see section (5) below for detail on performance and work undertaken to address CQC concerns.

c) Managing patients living with mental health needs (Regulation 13, Safeguarding service users from abuse and improper treatment) – please see section 10 below for detail on work undertaken to address CQC concerns.

2.4 Role and Responsibility of the Gloucestershire Safeguarding Children Executive (GSCE)

Working Together 2018 represented a significant milestone in the development of collective arrangements to safeguard children and young people in Gloucestershire. It places a 'shared and equal duty' on NHS Gloucestershire Clinical Commissioning Group (and its provider Trusts), Gloucestershire Constabulary and Gloucestershire County Council (i.e. Health, Police and Local authority). Previously, the local authority was the sole accountable body for local arrangements. The various operational & strategic groups of the new GSCE (Gloucestershire Children's Safeguarding Executive) partnership Board were fully implemented in July 2019, and include representation from GHFT's Children's Operational & Strategic Teams.

2.5 Monitoring arrangements – Safeguarding Children

a) Supervision of safeguarding work
Supervision increases levels of effective practice and managerial oversight and offers staff some emotional support with this emotive area of work in addition to supporting learning from reflective practice. This is now routinely embedded in the Women and Children Division and Emergency Departments, with nursing supervision further improved by the safeguarding nurse specialists supporting a number of clinical areas. Staff are supported, and increasingly confident with, the use of escalation procedures.

b) Staff Development
Learning for Trust staff is lifted from the analysis of Datix and incident reviews, from regional and national learning, from complaints and serious case reviews (SCR's), practice audits and when indicated, from child deaths. These different activities feed in to the work of the Safeguarding Children's Operational Group.

c) Audits/Quality Improvement focus from the last 12 months
- Midwife led pathways for increased identification and support of infant welfare risks.
- Communication pathway from Unscheduled Care to the Public Health Nurse Team
- Practice in early recognition of concerns and completion of the 'risk screening' questions in unscheduled care areas (ED and paediatric clinical areas)
- Thematic analyses of systems and care from 3 IMR's (3 children) and the infant thematic review of significant infant injuries.
- Learning and development messages lifted from Datix and complaints

d) Training and staff development

Level 1 completion rates have stayed above 90%
Level 2 completion rates average 84% over 12 months
Level 3 completion rates average 69% over 12 months

The Training needs matrix review had commenced just prior to the Covid era, and is due to be completed over the next year , with a need to improve both the Level 2 and Level 3 children's safeguarding Training attainment across GHFT .

e) Serious Case Review (SCR) investigations

Under new arrangements going forward these will in future be referred to as Child Safeguarding Practice Reviews (CSPR). Rapid reviews now take place prior to a decision going to the national team with respect to commissioning the CSPR. 3 new SCR's were commissioned in this last year requiring GHFT IMRs and including one infant death. There are service developments to be operationalized.

3. Trust Safeguarding Children Activity Report

3.1 Actions completed from the work plan (Appendix A) of 2018/19

- The safeguarding children's dashboard (Appendix B) has been further developed to progress work to enable management oversight, analysis of trends and begin to develop KPI's.
- Development of Quality and Performance metrics for monthly reporting to Board
- Review of operational safeguarding leadership, with planned development, including recruitment to an Associate Named Nurse for Safeguarding Children WTE role and a dedicated Named Midwife role (0.4 WTE), in accordance with 2019 Intercollegiate recommendations.
- Completed thematic analysis on the non-mobile infants experiencing serious non-accidental injury and illness over 12 months of attendances to GHFT.
- Development of Trust policy to support safeguarding the Pre Mobile Infant
- Completion and launch of 3 key multiagency Policies (pre-birth Protocol; Revised County 'Levels of Intervention' Guidance and the protocol for the Discharge of infants & children into Care). These policies improve the safety and wellbeing of infants from the earliest point in their health lives, and were developments triggered by Gloucestershire Serious Case Reviews (SCR's).
- Progression of Trust service development in response to research outcomes on ACE experiences in childhood and their impact on adult physical and mental health and the impact of these on parenting, with QI maternity project and Grand Round presentation.
- Focussed work on the pathways of care for CYP with self-harm, overdose and mental health conditions. This is complex operational and strategic work, with GHFT working together with the multiagency children's partnership.
- Completion of 2 separate SCR's and contribution to 4 further SCR's, with corresponding GHFT Internal Management Reviews (IMRs) and staff involved attending the inter-agency analysis and learning events.
- Further 'Roll out' of staff practice development in relation to the two statutory National pathways of Risk management (pathways with defined legal thresholds) – the national CP-IS system and FGM–IS.
- Review of the Safeguarding Children training programme, alongside revised 2019 intercollegiate guidance, with planned redesign of the Level 3 Training programme.
- Commencement of the work highlighted by SCR's to provide stronger pathways of assessment for children at section 47 Threshold, with GHFT's Commissioning and multiagency partners
- Commencement of work on building better internal electronic safeguarding systems to ensure that relevant information is available to frontline clinical and administrative staff and that key clinical and welfare information can be shared with external partners and agencies.
- Further contribution from the GHFT named professionals to the GSCB (now GSCE) improvement plan.

3.2 Additional activity from Clinical Areas

Emergency Departments

- There were increased numbers of CYP assessed in Unscheduled Care with an attendance signalling a level of welfare concern. Targeted communication using a checklist of welfare concerns (the Public Health Nurse liaison form) were sent on 2,677 attendances (2,166 in 2018/19)
- There were increased Unscheduled care adolescent attendances with self-harm (407 in CYP < 16 years, compared to 367 in 2018/19)

- Increased numbers of children or unborns were affected by parent/carer attendances relating to domestic abuse (85 referrals to social care for CYP when the parent is the victim of abuse, compared to 80 in 2018/19)
- Progression of work to ensure improved practice relating to identification of and response to safeguarding risks. Silver QI project with focus on nursing and clinical staff completing the required Safeguarding 'risk assessment' triage process. Baseline median completion was 38%, and since project was launched, recent completion rates were > 90%. This was an area targeted for improvement in many of the recent 7 SCR's.
- Royal College Emergency Medicine (RCEM) national audit identified 2 areas for improvement in GHFT children's safeguarding practice – firstly for CYP who leave ED before being assessed and secondly in relation to the need to complete psychosocial assessments in adolescents. Both areas now have action and improvement plans.
- Work in relation to the impact on CYP relating to the Domestic abuse between their parents/carers. GHFT shares information on affected CYP with social care referrals and with staff involvement in multiagency risk assessment. This has required allocation of increased resource to this area of work, which is often very time consuming.
- Increased safeguarding related training at staff induction

Maternity

- Increased numbers of women were identified with perinatal mental health issues requiring early help and support (1,295 concerns/6,400 births)
- There has been much work in relation to the earlier recognition of factors that cause infant adversity and harm; this work progressing from several recent Gloucestershire SCR's and with the advocacy of the National Better Births programme.
- Important multiagency practice guidelines have been launched, with dominant focus on the GHFT health assessment and care and the work between health and early help partnerships.
  These include – The Unborn Baby/Pre-birth Protocol; Hospital discharge of infant and child into Care; Healthy me, baby and beyond; Launch of the ICON initiative (a national program for all professionals to share with parents the risks of shaking/rough handling of infants)
- The midwifery led Silver QI project developed a pilot pathway to implement the introduction of the ACE (Adverse Childhood Experience) enquiry in to maternity services, together with strategies and information sharing to deliver more effective 'early help' actions for the most vulnerable pregnancies. The aim being to identify risk and build resilience to promote positive parenting, breaking the cycle of adversity
- Operational training and development of the FGM–IS alert tool has been rolled out in GHFT clinical practice and records, to ensure that all female infants who are at risk of FGM have an alert on their Summary Care Record.

Neonatal/Special Care (NNU) Infants

- The number of children discharged from NNU directly in to Care has increased year on year in last 2 years, 12 infants in 2019 and 14 in the last year. This requires considerable additional staff time, preparing and submitting reports, attending multiagency meetings and preparing the carers to leave with new-born infants
- Going forwards, it is agreed that a relevant indicator of safeguarding workload, is the number of 'cot days' spent in NNU by infants who are on CP plans, this is the first year this data has been collected.

Paediatric Department

- Targeted work on the safeguarding 'risk assessment decision support tool' for Triage of unscheduled attendances, with monthly audits as recommended in several local SCR's. Over a 3 month period, clinician completion rates increased from 32 to 84%.
- Thematic review of the epidemiology and assessments for non-mobile infants presenting with serious non accidental injuries to GHFT over a 12 month period. This led to the co-production of a new Gloucestershire joint agency protocol for the referral and assessment of injuries in non-mobile infants.

- 9 infants under 6 months were confirmed with serious infant and non-accidental injuries, with one death related to the safeguarding of infant and maternal welfare issues.
- Development of a joint working document on operating procedure between MASH (Multi-Agency Safeguarding Hub) and GHFT child protection clinical team
- Development of a policy and discharge checklist for the discharge of infants and CYP in to Care for the first time
- Revision of the policy for situations where Child 'Does Not Attend' a scheduled appointment (DNA, which may mean 'was not brought'), to ensure that CYP safeguarding/welfare is considered on each occasion. It is recognised nationally and in recent Gloucestershire SCR's, that CYP who DNA may be experiencing child neglect.
- GHFT paediatric team have highlighted the need for a County Multiagency pathway for children who may have experienced sexual harm. This is a development need identified in several local SCR's; with a current shortfall in local resource for this area of child protection assessment. GHFT has this item on the Trust Risk Register and is working with the CCG commissioning team on a multiagency project plan.
- GHFT paediatric staff support the needs and welfare of CYP with more complex additional needs and disabilities. Statutory reports (620 reports in 2019) are completed by the paediatric team for each CYP who requires a specialised plan (The Education, Health and Care Plan - EHC plan) outlining the higher level of support in education needed for their Disability or other additional needs. GHFT staff have highlighted to childrens and local authority commissioning teams that there are increasing numbers of CYP for whom their low attainment and Social and Emotional needs link back to ACE events in their lives. These factors are similar for CYP who present with self-harm, or are Children in Care and are linked to poor health, life and educational outcomes in adult life.
- There were increased numbers of infants and children discharged into care for the first time, following an episode of clinical care in GHFT.

COVID Contingency planning

- NHSE gave early advice at the onset of service redeployment in March 2020, that safeguarding related work was a priority clinical activity to continue as 'business as usual'.
- A contingency plan was written for GHFT, with clinical areas outlining how assessment and care to include safeguarding is delivered in COVID times.

4. Trust Safeguarding Adult Activity Report

The Safeguarding Adults Team activities include:

- Safeguarding casework
- Safeguarding Adult Reviews (when convened)
- Domestic Homicide Review (when convened)
- Monitoring and logging of all Deprivation of Liberty Safeguards (DoLS) and informing CQC of the outcomes
- Monitoring and logging of all information requests for multi-agency meetings
- Assessing all domestic abuse referrals prior to escalating to MARAC

Activity is presented in Appendices C, D, E and F.

4.1 Activity completed against workplan 2019/20

- The Safeguarding Adult Hub has been formed, drawing together staff working in divisions and HIDVAs
- The HIDVA contract was renewed in March 2020 and will now continue as an established ongoing commissioned function.

- Metrics across Safeguarding Adults and Children have been reviewed and developed and are now regularly reported to the Trust Board, but there is more detailed work still to be done as the first metrics did not illustrate workload or provide sufficient assurance.

- Alcohol-induced problems across age-range have been mapped, but there is considerably more work to be done on this. It is already clear, however, that there is a need for a care facility in Gloucestershire which can care for alcohol-dependent people who have cognitive and/or physical impairments. Preliminary discussions with commissioners have begun to establish the feasibility of such a facility.

- Safeguarding have worked alongside EPR/Trakcare projects to ensure safeguarding risk assessments have been included in the nursing admission documents, but there is more work to be done as the project develops to ensure consistency across points of entry

- Work has been done to scope Liberty Protection Safeguards (in place of DoLS) from October 2020, but this has been limited firstly by the continued lack of Code of Practice an Regulations from the Department of Health and Social Care and secondly by the COVID pandemic, which has delayed national implementation of the Mental Capacity (Amendment) Act 2019.

- Adult Safeguarding training has been redesigned to comply with Intercollegiate guidelines, but is being further developed to work on virtual platforms in COVID/post-COVID times.

4.2 The Care Act (2014) requires that it is preferable that the individual at risk/suffering harm is able and facilitated to express their preferred outcome i.e. that professionals 'Make Safeguarding Personal'. This can be very challenging for healthcare professionals who want to see that the person comes to no harm and find it difficult to step back to a place of reduced, but not 'no risk'.

4.3 In response to a recommendation from a Serious Adult Review (SAR) all letters to GPs following an outpatient appointment have been changed. These highlight that where the appointment was not attended, it may be that the patient was not brought, rather than them deciding of their own volition not to attend. A new letter format has been agreed drawing the attention of the GP to the possibility that non-attendance of an appointment might constitute a safeguarding concern. These letters are sent for all appointments not attended, whether by adults or children.

4.4 Training of Safeguarding Ambassadors began towards the end of 2019, with the intention that each clinical area would have a member of staff with a higher level of training to be a resource for staff raising awareness, providing additional team training and to cascade and champion best practice in relation to Safeguarding, MCA, DoLS and the Mental Health Act. Progress in rolling this out to all areas was slowed by the arrival of the COVID-19 pandemic and therefore is an ongoing action for 2020/21

4.5 Safeguarding allegations are reported within Datix either as an incident or as a Complaint and investigated by the assigned senior Datix/Complaint lead for that clinical area. Safeguarding allegations may be reported to Gloucestershire Safeguarding Adult Unit (GSAU) by an external source however may not relate to safeguarding pathway. These are also reported within Datix for investigation and learning and are still required to have the outcomes reported to GSAU by the Safeguarding Adults Team.

No safeguarding adult at risk staff allegation has been substantiated as abuse under safeguarding pathway during 2019/2020.

4.6 Whilst there have been small numbers of allegations against GHFT staff during 2019/2020, it has become clear that the Allegations Management protocol needs review and additional guidance, as 2 malicious allegations against our staff have been received. This work stream is being coordinated by the Operational Director of People and Organisational Development.

5. Domestic Abuse Activity Report

5.1 Activity is presented in Appendix C

5.2 There has been a year on year increase in workload since we commenced this work in 2009, we expect this to continue - possibly rapidly following roll-out of our Safeguarding Education Program in the coming months and years as more staff become aware of Risk and Response strategies.

5.3 Loss of staffing resource earlier in the year saw response times for Information-sharing requests from MARAC (Multi-Agency Referral and Assessment Conference) and adding Safeguarding Alerts to our systems increase dramatically while we focused resource on early referral to help and support victims and their families who had disclosed abuse while using our services. At the lowest point our information sharing performance was 4% against a target of 3 days. This is articulated as a corporate risk on the Risk Register.

5.4 As all agencies in the county were also finding themselves slipping behind target we were able to negotiate a reduction in the timeline of information shared, from 5 years to 6 months. The county Domestic Abuse and Sexual Violence (DASV) coordinator will be reviewing the effects of this at the June 2020 MARAC Steering Group meeting.

5.5 3 year reviews of Safeguarding Alerts on Trakcare and Safeguarding Log systems have not been possible due to workloads and current lack of resource. This means adult victims of domestic abuse, and their children, may be asked about domestic abuse after the situation we were aware of has been resolved. Whilst this may annoy some patients it will not cause them harm.

5.6 Domestic Abuse was included in Adult Safeguarding Training for all Trust staff at the end of 2019, this was intended to be a rolling programme but has currently had to be suspended due to COVID-19 activity and we expect this to continue at an appropriate point. Domestic Abuse workload is expected to rise as more GHFT staff are educated to recognise and respond to disclosure of domestic abuse. Delivery of this training will require additional resource, as current resource is fully utilised managing referrals and information sharing. This is articulated in the corporate risk on the Risk Register related to domestic abuse.

5.7 Additional resource was provided to the Safeguarding Adults Team at the end of 2019/20 and this has already made a significant impact on target times. To maintain current resource, sustain our achieved performance, commitments to Trust Safeguarding Training needs, facilitate timely alert reviews and the increasing future workloads; an increase in resource will be needed.

6. Mental Capacity Act

6.1 The improvement plan in response to the CQC report 'Must Do' action to ensure best practice application of the Mental Capacity Act includes:

a) The Trust MCA policy was fully reviewed to ensure clarity of practical application.

b) There are systems in place to identify patients with known cognitive impairment on admission. This has been strengthened over the past year by inclusion of trigger questions in nursing admission documents on Sunrise, the newly established electronic patient record (EPR). The alert symbol on ward whiteboards continues to be a purple butterfly.

c) MCA audits have been completed monthly with and for each division. All divisions have completed their own analysis of mental capacity practice and training and developed action plans to address the identified deficits.

d) MCA training was added into all levels of face-to-face Safeguarding training to widen the number of staff being trained to consider a patient's ability to make decisions. Focused refresher sessions have also been provided on wards upon request and the e-learning package remains in place.

e) Learning Disability staff are now line managed by the Lead for Safeguarding Adults and attend the Safeguarding Adults Operational Group. The Mental Health Liaison Team have moved into larger office accommodation which enables full age-range working. Already strong links between learning disabilities, mental health liaison and safeguarding teams have been further strengthened over the past year.

6.2 DoLS in current practice and Liberty Protection Safeguards (LPS), in due course are entirely dependent on the application of the MCA within practice. Improvements in DoLS practice are wholly co-dependent upon improvements within MCA practice.

6.3 Our Trust is a core partner of Gloucestershire's Multi agency Mental Capacity Act Governance Group (MCAGG). This group reports to Gloucestershire Health and Wellbeing Board and to GSAB. During 2020 each MCAGG partner organisation was tasked with to auditing, monitoring and reporting on the application of the MCA within practice within their organisation, to establish how well MCA is applied.

This has been completed through joint audit visits with a member of the Trust Safeguarding Adults Team and the chair of the MCAGG in a programme of unannounced, monthly joint clinical visits to wards, both at Cheltenham General Hospital and Gloucestershire Royal Hospital. During the joint clinical visits, conversations are held with the care team and the care record is reviewed. 30 patients care records are audited during each visit and the results reported to Trust MCA Delivery Group and to the County wide MCAGG.

7. Deprivation of Liberty Safeguards (DoLS) Activity Report

7.1 Trust wide DoLS activity for April 2019 to end March 2020 is shown in Appendix E.

7.2 In addition to phone access or team email access to the Trust MCA and DoLS Team, face to face ward team contacts and clinical visits are part of the working role.Face to face support has received positive feedback from clinical teams and numerically has a positive impact on DoLS practice as it promotes real time actions, increases DoLS applications and provides visable, accessable DoLS guidance and leadership.

7.3 Real time DoLS applications, by the care team, where the needs of the adult in-patient meet the Acid Test for DoLS is championed by the MCA and DoLS Advisory Sister, the Learning Disability Liaison Nurse Team and Mental Health Liaison Nurse Team during clinical visits.

7.4 Trustwide DoLS scoping suggests that on a typical day, across all Trust adult in-patient settings that there are potentially a minimum of 100 patients who require a DoLS application; this is a conservative estimate of need. The DoLS application is made by the Registered Nurse caring for the patient at that time. This has a clinical and workload impact for the Nursing Team on a daily and shift by shift basis.

7.5 DoLS applications are increasingly being made by care teams where identified restrictions are in place, however not all applications are being made where the needs of the patient meet the pure definition of the 'Acid Test' for DoLS, but there is evidence of some improvement.

7.6 Team resources allocated to DoLS are currently 1 x WTE Band 7 working Trustwide across the Safeguarding Adult at Risk, MCA and DoLS pathways and 1 x WTE Band 3 administration and clerical post.

7.7 The majority of DoLS applications submitted by GHFT are not assessed by the Local Authority DoLS Team. This is due to the numbers of Country wide DoLS application received by Gloucestershire County Council DoLS Team. This is also the trend where a patient is from out of county and where the application is required to be submitted to that county's DoLS team. This is a national trend.

7.8 There have been only 6 DoLS authorisations during 2019/2020. Where there is an objection or risk factors are identified the need for urgent DoLS Best Interests Assessment (BIA) is escalated to the relevant external DoLS Team so that assessment can be prioritised by that team.

7.9 The update and review of Trust DoLS Policy, in light of the improvements to the DoLS application pathway was approved by Safeguarding governance groups in May and June 2020 and is now with Trust Policy Approval Group.

7.10 Gloucestershire County Council DoLS Team have now implemented within our Trust, the pilot testing of an e-DoLS application link. Feedback has been given by the MCA and DoLS Advisory Sister to Gloucestershire County Council DoLS Team as refinements have been required to be made and to request extension of the time allowed for completion of the applications' as for a ward nurse there may be elements of interruption, and the form cannot be saved and then re-loaded. The has been extended to 15 minutes however it is considered that this requires to be further extended, particularly as there is no ability to save and restart the application. Re-entering lost data is not best use of a front line Registered Nurse's time.

8. Liberty Protection Safeguards

8.1 The Mental Capacity (Amendment) Act 2019 which was due to come into force in law on the 1st October 2020, with the new Trustwide arrangements to assess, authorise and administer LPS required to be implemented by our Trust on this date. We have been advised by the regional Safeguarding lead that this has been delayed, due to the COVID pandemic. At time of writing, no formal notice has been received from government that the commencement date has been re-set, albeit that Parliament is due to shortly rise for the summer recess.

8.2 Within our Trust, our adult in-patients, whose needs are currently eligible under DoLS will still be eligible under LPS, as the 'Acid Test' for DoLS is not changed. In addition, for the majority of LPS applications, these will be made where patient needs are in response to an urgent and immediate situation as opposed to previously planned arrangements anticipated to take place as part of a planned, future admission.

Unlike DoLS which only applies to adults aged 18 years and above, LPS will also apply to those aged 16 and above and may therefore affect paediatric as well as adult areas of the Trust.

8.3 LPS will significantly change the requirements relating to those who will have legal responsibility for undertaking and managing the new assessment and authorisation process. Under LPS all these processes will become the legal responsibility of GHFT, not the local authority, if the person aged 16 years or above lacks capacity for their care and treatment and for that to be undertaken in our accommodation.

8.4 The LPS Code of Practice and Regulations have still not been published by the Department of Health and Social Care (DHSC). At the point of the pandemic starting information was that these would be available in June 2020. Advice since indicates

publication dates have slipped.

8.5 A OneGloucestershire approach is being taken to LPS in the county as GHFT, Gloucestershire Health and Care (GHC) and Gloucestershire County Council (GCC) will all have Responsible Authority (RA) status and will need to coordinate processes. GHC and GCC have appointed project managers, but without the Code of Practice no progress can be made. GHFT are aware that a project manager will be needed and have requested that a programme manager be appointed at ICS level to coordinate organisation level projects. All organisations will be accountable to the Gloucestershire Mental Capacity Act Governance Group (MCAGG).

9. Learning disabilities

9.1 Learning disabilities patients make up a proportion of patient attendances at GHFT, in common with every other group of people and we are proud of our Learning Disabilities Liaison Team (LDLT), who the CQC rated as providing an outstanding service at our last inspection.

9.2 The Learning Disability Liaison Team are now managed by the Lead for Safeguarding Adults. One of the Liaison Team will be retiring at the end of June 2020 and the post will be advertised nationally.

9.3 An improvement plan for Learning Disabilities is in progress responding to gaps identified by the Learning Disability Audit. Pivotal to all improvements is achieving additional alerts on Trakcare to enable GHFT to identify patients with autism, neurodisabilities and ADHD. These have been requested, but have not yet been authorised. Once these alerts are in place it will be possible to improve data on numbers of patients with various types of learning disabilities, which will increase our ability to respond positively to the national Learning Disability Audit.

9.4 The GHFT Lead for Safeguarding Adults is now sitting on the county LeDeR quality assurance panel and has been able to obtain all the recommendations for GHFT coming out of LeDeR reviews. These have been themed into 4 areas for improvement and each of these areas has a plan to achieve the required level of improvement. Those four areas are:

- Dysphagia management
- Use of the Hospital Passport (hence forward to be known as the Health Passport)
- Listening to relatives and carers
- Communication with non-verbal patients

9.5 The Learning Disability Steering Group has not met since 2019 and restoring this group to shape and monitor the Learning Disability Improvement Plan is a priority for 2020/2021.

9.6 The work of the Learning Disability Liaison Team has been reported into the Safeguarding Adults governance processes.

10. Mental health and safeguarding

10.1 The last CQC report included a ‘Must Do’ to assure them that if staff use restraint on patients this is in line with current national guidance and good practice and that staff are educated and supported to manage patients living with mental health needs safely. Progress on this plan during 2019/20 was:

a) The Trust restraint policy was ratified in November 2019 and an Enhanced Care improvement programme put in place, including metrics for violence and aggression. During the last year data indicates that the number of violence and aggression calls is showing a decreasing trend, with occasional spikes. It is not clear exactly why these occur, although anecdotally it would appear that some patients have two or three calls before the nature of the problem is recognised and adequately addressed.

This has reduced the need for enhanced care,'specialling', by RMNs and reduced patients' levels of agitation. Across the 9 pilot wards for Enhanced Care there has been an overall 25% reduction in agency spend, tapering to nil by the end of the year. The roll-out of Enhanced Care is now in progress to all other wards.

b) The Trust Emergency Sedation Policy has been revised.

c) The Sectioned Patient Policy was ratified in November 2019. Mental health Awareness week was used to highlight this policy and several sessions were run, targeting senior staff meetings and all clinical areas. Site management all had 1:1 training with the MHLT manager to ensure they were confident using MHA documentation. A sharepoint site has been set up for all Mental Health Act paperwork, which has resolved previous difficulties about finding the forms required.

d) Focused refresher training has been provided for staff on request from clinical areas and for matrons and site managers. The mental health liaison lead nurse is working with the GHFT safeguarding senior staff to develop a mental health training strategy completing the Vulnerabilities Framework including multi-modal delivery.

e) A Quality Improvement project within the Emergency Departments has embedded the Australasian Triage Model for patients presenting with mental health needs, which is resulting in more timely referrals to the mental health liaison team. There has been a 65% improvement in triage category allocation – commensurate with mental health need.

f) A business case has been submitted to GCCG in support of a dedicated Mental Health Emergency Department Triage model to enable co-streaming and reduce waiting times, 4 hour breaches and leaving before being seen. Data indicates that there will be limited value in this being a 24 hour service, but there will need to be some trial before deciding optimum hours of availability.

g) Patients attending with mental health / alcohol needs who do not wait (DNW) to be seen are now being identified to the Mental Health Liaison Team and a telephone call back system is in place. Further work on the timely identification of these people is required.

h) Partnership working with Mental Health Liaison Team continues to increase and a dedicated mental health intranet page is being established. MHLT have moved into purpose-designed office space and MHLT lead nurse is working closely with Safeguarding Adults Team to cross-check patients of concern.

i) The Enhanced Care strategy and implementation plan has been completed across the identified pilot wards and has shown significant cost avoidance against the previous year's agency spend.

10.2 The Gloucestershire High Intensity Network project has now reported on the first 12 months of activity. The project results have been significantly positive for all partner agencies (and, more importantly, patients) and a business case is being prepared for submission to GCCG.

10.3 The MHLT includes a Frequent Attender Manager for mental health presentations who has worked collaboratively with the GHFT Lead for Safeguarding Adults to exceed the Mental Health CQuIN targets. Frequent attenders with mental health problems are now quickly identified and managed and consequently the most frequent Emergency Department attenders are rarely people with a primary mental health need.

10.4 In a new appointment funded by the CCG, the MHLT now includes a Frequent Attender Manager for patients with primary alcohol problems. Whilst existing systems have

been able to quickly populate a large workload, it is too early to measure the impact of this post.

11. Crime pathway

11.1 Whilst Human Trafficking and Modern Day Slavery remain a very low number of overall safeguarding adult concerns received, there has been a small increase in the last year of staff questioning whether this might be an issue for patients. It is usually suspected either at point of admission or during discharge planning, but there have also been a small number of queries raised in outpatient settings. Awareness is covered in safeguarding training, but it does take staff a while to start to suspect this. As with all safeguarding, until staff learn to suspect such things are happening they struggle to believe it is possible. Generally doctors and midwives tend to pick up on these issues, perhaps because they spend longer taking patient histories.

12. PREVENT

12.1 PREVENT is a community safeguarding programme aimed at safeguarding people and communities from the threat of terrorism. It is 1 of the 4 elements of CONTEST, the Government's counter-terrorism strategy. PREVENT aims to stop people becoming terrorists or supporting terrorism.

12.2 PREVENT forms part of Safeguarding Adult at Risk Pathway in the event that an adult with care and support needs, under the Care Act (2014) is suspected of, or detected to have been recruited into risk activities linked to PREVENT or marginalised.

12.3 The South-West and Gloucestershire as a county continue to be considered to be low risk for PREVENT. Gloucestershire's PREVENT Partnership Board is attended by our Trust Lead, the Associate Director of Education and Development.

12.4 Training related to PREVENT has been included in all face-to-face Safeguarding Adults training, as the Training Needs Analyses are complementary.

13. Safeguarding Training

13.1 Intercollegiate compliant training was piloted and then implemented at all levels at the beginning of 2020, but had to be suspended due to the COVID-19 pandemic. Feedback from participants up to that point was very positive.

13.2 Training compliance levels are not possible to report because of suspension of training reports, but Level 1 and Level 2 e-learning packages were made available again during the pandemic, so it will be possible to report this retrospectively.

13.3 There is no Level 3 Safeguarding Adults e-learning, so all registered clinical staff that require Level 3 training have been allocated the Level 2 e-learning package until alternatives can be provided.

13.4 Multi-modal training options are being planned for when training is re-commenced to cater for social distancing requirements.

13.5 GHFT have not yet received the evaluation of the safeguarding simulation training project run by 2getherNHSFT and in the meantime this training is no longer available.

14. Risks and issues

14.1 Child and Adolescent Mental Health and Self Harm attendances

Current capacity issues in specialist CAMHS provision leads to CYP with defined significant mental health needs, but without specific acute medical needs, being admitted for social, emotional and mental health reasons to an acute ward area and then not accessing CAMHS therapeutic interventions at their times of significant need. Work with commissioners is ongoing. This situation continues to place pressure on clinical staff and the ward environment. This item is on the Risk register.

The more acute short term attendances for self-harm /overdose /intoxication, have increased further this year (see dashboard Appendix B) , although the admission rate for CYP <18 with this category of need has slightly decreased, reflecting positively on the work of the Mental Health Liaison Team all age service, which has seen some improvement with access to more timely assessment for CYP.

14.2 IT/EPR related issues and child safeguarding

Successful children's safeguarding depends on staff recognising the signs of concern and communicating these effectively to co-professionals. This requires staff to have immediate access to the key information that highlights to the clinician the known risks in the infant or child's life. This information is not currently readily available to frontline clinicians. Improved IT support and data delivery are urgently needed for this work to increase levels of safe and effective practice and care for CYP.

Areas of development needed with the clinical care record have been highlighted and a work plan commenced with the Trust IM&T team. This work has progressed slowly, due to current priority setting within the roll out of the EPR and the TrakCare recovery programme. The following areas continue to be on the Womens and Childrens Risk register:

There are a number of key documents that need to be both available to front-line clinical staff and embedded in auditable electronic pathways. A high volume of need is evidenced by the number of forms manually scanned and sent by email to the public health nurse team when the child's Trust attendance highlighted a welfare risk (2,888 forms sent from ED, from a total of 29,800 0 - 18yr ED attendances in 2018/19). Other examples include the need for known family welfare information to be present and readily accessible in the infant EPR and for the child's legal status information to be readily accessible at the point of care.

Electronic communication between GHFT and partner IT systems e.g. Liquid Logic (Local Authority) and the Health IT system of GHC (SystemOne) is needed to complete effective clinical care work within GHFT. The interface between these important systems for Trust staff is not established, other than by limited email exchange. Development in this area would make an immediate difference for GHFT practice for Children in Care, a national priority group.

Data should be, but is currently not, collected on staff compliance with reports and attendance at children's legally relevant planning meetings (Strategy meetings and child protection conferences). Staff share that the time needed to deliver the professional input to keep children safe has increased over the last few years and that the Trust is not capturing this activity. This work increases emotional and physical stress on staff and can impact on the detail and quality of care across the system. Evidencing this is important. The Trust needs accurate data on the numbers and quality of staff professional reports submitted and on the time taken by staff attending legally defined planning meetings. This data is needed to begin to give assurance that Trust that its staff are contributing relevant information for decisions and the planning needed for CYP, examples being the need for quality input at Section 47 threshold, and for children on the Child in Care pathway.

14.3 Administrative support for safeguarding children

Trust work to safeguard children has been impacted by difficulties with continuity and consistency of administrative support. The administrative work has tight timescales and requires accuracy and a level of skill. There has been restructuring of the Trust safeguarding hub for adults, but further administrative review of the needs for CYP is needed going forwards.

14.4 Risks identified related to Adults

Within the Trust the missed opportunities to safeguarding adults at risk are reducing, but nevertheless one error can have significant consequences. The additional Trust Safeguarding resources and the Safeguarding Hub model have further mitigated this risk. Safeguarding Ambassadors have the opportunity to positively impact prevention of missed opportunities.

GHFT care teams do not have access to information regarding safeguarding concerns which have been raised to Adult Social Care Team prior to presentation or admission.

The implementation of the Liberty Protection Safeguards (LPS) will have significant implications for our Trust as a whole and for care teams. A new model will be required to be scoped and implemented, when we receive the Code of Practice and Regulations from government (no date yet advised). All aspects of LPS pathway will be the responsibility of our Trust and under Trust management; this will have a significant financial implication as our Trust will be both the managing body and the supervisory body for this new pathway. Our Trust will also be responsible for any legal challenges or objections and for the administration of all aspects of this pathway.

There is a gap in service provision to patients with complex and multiple conditions as they transition from Paediatrics to Adult Services, which is the root cause of many poor patient experiences, complaints and expression of safeguarding concerns. This could be mitigated by having a dedicated consultant physician commissioned to be named consultant for such complex patients from transition onwards.

15. Safeguarding Children Priority Objectives 2020/21

15.1 Prioritise the resolution of IT/EPR /Communication issues as described on the risk Register, to assist staff in delivery of safer and better quality of care and support for CYP. Assure the GHFT safeguarding team that the Sunrise EPR programme has this as a priority area of work, with a clear action plan for the next 12 months

15.2 Staff development - Recruitment to the Trust Named Nurse and Named Midwife roles; Review of the administrative team and roles; Review job descriptions and recruit to the safeguarding nurse specialist roles.

15.3 Embed a revised Operational Structure to ensure staff practice, development and Training can be assured in line with the Section 11 Audit standards.

15.4 Training - Further develop the Level 3 training materials and programme

15.5 Training – Review and revise the Level 2 training materials

15.6 Review and revise the Trust Safeguarding children Policies

15.7 Continue to develop the multiagency assessment and care pathways for CYP experiencing physical and sexual harm, with Commissioning and external partners

15.8 Continue to support work with commissioners on pathways of care for CYP who present to GHFT with self-harm, overdoses and mental health conditions

15.9 For Gloucestershire Serious Case Reviews – develop an action plan to ensure that learning is shared within the GHFT Training programme.

15.10 Review and further develop the safeguarding children information available for staff on the Trust Intranet

15.11 Review and revise the Dashboard with focus on developing data that can be captured from the EPR.

15.12 Strengthen existing Trust operational and strategic safeguarding governance structures

16. Safeguarding Adults Priority Objectives 2020/21

16.1 Seeking the voice of the patient in their safeguarding case, so that we make safeguarding actions personal to individual patients and their families. This is also essential in improving compliance with the Mental Capacity Act (2005).

16.2 Work with divisions to support training and auditing of Mental Capacity Act assessment practice.

16.3 Promote both professional curiosity and compassionate persistence through consistent and timely safeguarding risk assessments at all points of entry, followed by specific risk assessments as then required and actions initiated promptly as a result of these risk assessments. This will be monitored by NAAS2.

16.4 Promotion amongst inpatient staff of the value of re-visiting and reading Emergency Department and Ambulance service documentation. A significant amount of information in support of a safeguarding concern is evident within both records and is frequently overlooked by inpatient staff.

16.5 Promotion of completion of safeguarding and social assessments on EPR during nursing admissions to enable early conversations with Adult Social Care ahead of discharge where a safeguarding concern has been identified. This is particularly important where the adult is admitted on a Friday after 5pm and discharge is being explored for that same weekend. This is an area where missed opportunities are apparent.

16.6 Ensure that a Safeguarding Adult at Risk concern referral is made where a patient presents having self-harmed within any care setting, including GHFT in compliance with

16.7 Strengthen and promote the role of Safeguarding Ambassadors as a within-team resource to staff.

16.8 Promote recognition of excellent safeguarding practice by all staff, awarding 'Safeguarding Star of the month' when a ward, department or individual's recognition or response to safeguarding concerns has been outstanding.

16.9 Review the Safeguarding Adults policy.

16.10 Review and clarify the staff Allegations Management protocol and guidance.

16.11 Work alongside ICS partners to develop our systems for Liberty Protection Safeguards, once the Code of Practice and Regulations have been published.

17. Recommendations

This is a system with a high volume of activity, with evidence of increases in levels of need and complexity from the antenatal pathways through to old age. The infrastructure to deliver safe, compassionate and outstanding care needs to be a Trust priority for safeguarding work, alongside core clinical care.

The Quality and Performance Committee is asked to

17.1 Acknowledge the scope and detail of the work completed in the last year, being aware of the risks and challenges identified.

17.2 Endorse the priorities, which will form the basis of detailed work plans for the coming year.

Appendices

A. Childrens annual work plan
B. Safeguarding Childrens Dashboard
C. Domestic Abuse referral and information sharing activity 2019/20
D. Safeguarding Adults concerns raised 2019/20
E. Deprivation of Liberty Safeguards activity 2019/20
F. Safeguarding allegations against GHFT staff 2019/20

Abbreviations

ACE's - Adverse Childhood Experiences
CCG - Gloucestershire Commissioning Group
CIC - Child in Care
CP plan - Child Protection Plan
CP-IS - Child Protection Information system
CYP - Child and /or young person (includes infants)
FGM-IS - Female Genital Mutilation Information service
GHC - Gloucestershire Health and Care Trust
GSCE - Gloucestershire Safeguarding Children Executive
ND - Named Doctor
NN - Named Nurse
SCR -Serious Case Review

Presenting Director: **Carole Webster**
Trust Deputy Chief Nurse and Trust Safeguarding Lead

Date **July 2020**

Appendix A - WORK PLAN – CHILDREN'S SAFEGUARDING OPERATIONAL GROUP 2019/20

Working Group Action Plan updated 6 April 2020

Aim / Objective	Action Plan	Responsible Lead	Progress Update	Status (inc. completion date)
To progress work in relation to information sharing & the electronic patient record and the IT related objectives for safeguarding children, from pregnancy booking, until the young person has 18th birthday To facilitate transition of information from the antenatal pathway, into the infant's clinical record, such that clinical staff are aware of previously identified risks within families. This work is in the operational work stream on communication / information sharing / IT	Safeguarding Operation Group IT and Communication work stream To review the format of information shared at infant's / child's discharge. Discharge communication in other areas of the country has an information field for safeguarding / welfare information. This work is within the Operational communication / IT / EPR related work stream.	Named Nurse/Named Vivien Mortimore (with Thelma Turner)	Further meeting VM/TT/SM Jan 2020 See TT overview report feb'20 With sunrise EPR roll-out it needs to be understood if key legal safeguarding documents could be held on EPR	
To provide strategic oversight and agreements on data to be prioritised to indicate effective work of GHT staff in relation to safeguarding children	GHT Safeguarding Strategy Group to agree an initial group of safeguarding quality and performance metrics, together with the wider group of objective indicators (on the dashboard)	Named nurse/Named Doctor	4 Metrics agreed (Sept 2019) , with data to be collected for first time in Nov 2019 , highlighted on dashboard in yellow	Complete 12/11/2019
To ensure an improved managerial oversight and understanding of both the safeguarding children total workload, and effectiveness of safeguarding clinical practice.	The Safeguarding Paediatric dashboard, developed 18 months ago, will be reviewed, revised and updated in 2019	Operational Group Safeguarding dashboard work stream, Sara	Dashboard revision completed 12/11/2019, with review and agreement by	

		Motion	Strategy group	
Aim / Objective	**Action Plan**	**Responsible Lead**	**Progress Update**	**Status (inc. completion date)**
A review of operational safeguarding leadership, and further development. Including a review of the administrative support needed for effective delivery of children's safeguarding practice.	Trust to appoint Named Nurse for Children's Safeguarding as a full time position. In addition, dedicated sessional time to be agreed for a Named Midwife, and guidance for role of Named Doctor to be reviewed	Exec leads – S Hams, Carole Webster	Named Nurse job description to be finalised and advertised in Nov2019. Interview held in Dec'19/Jan'20 with no appointee. CW/VM will support SG nurse specialist (CF) to build some experience in Named roles. Review of A&C support, and total work force is still on work plan	
To review the Safeguarding Children training programme, utilising the 2019 intercollegiate guidance	For the review of training programme and content, and delivery methods .	Training work stream Operational Group, Jeanette Welsh	Needs full Training needs analysis , to include a map of all sessions delivered by Trust , and staff mapped to do so. March '20 - progress with this phase has been impacted by Covid and high demand on training Dept for other training for acute staff.	

To complete the analysis and learning from the ongoing 7 serious case reviews, currently in process, with development of related staff training and practice . Ensure local and multiagency recommendations and associated actions from completed SCRs are completed	This work to be coordinated by a Serious Case Review operational work stream	Named Nurse Operational Group work stream	First Coordination meeting held on 20/12/2019, then staff capacity has paused this work stream. April '20 –Action from operation group to draw together master table with all service and training needs .	
To undertake a thematic analysis on the non-mobile infants experiencing serious non-accidental injury and illness	Thematic review to be coordinated, and learning built in to trust Training programmes and shared with partner agencies .	Named Doctor with Governance lead	First meeting with Amy Shepherd held 13/11/19 , scope and detail agreed. Jan'20 Thematic review written up (SM) & shared with GHT Strategic group and GSCE with suggested action plan to be delivered operationally,	
Completion and embedding of GHT pathways of care, for children in care CIC and FGM		Named Nurse , named Doctor, named Midwife	14/11/19 CP-IS embedded, staff should complete the relevant notifications for CIC attending unscheduled work areas . Further work to do with IT for CIC 'registration' on system. On IT / Comms work plan – for TT/VM/SM	

To progress Trust developments in relation to ACE experiences in childhood and their impact on adult physical and mental health	QI maternity pilot on ACEs	Vivien Mortimore / Michelle Richardson / Sally Unwin	QI presentation delivered Dec 2019	
To improve the safety and wellbeing of infants from the earliest point in their health lives with a multi-agency unborn baby protocol	Safeguarding Specialist Midwives co-working with the wider group of Children's Agencies to finalise, publish and utilise this protocol	Vivien Mortimore / Sue Maxwell	Multiagency Unborn baby protocol launched by GSCE November 2019	

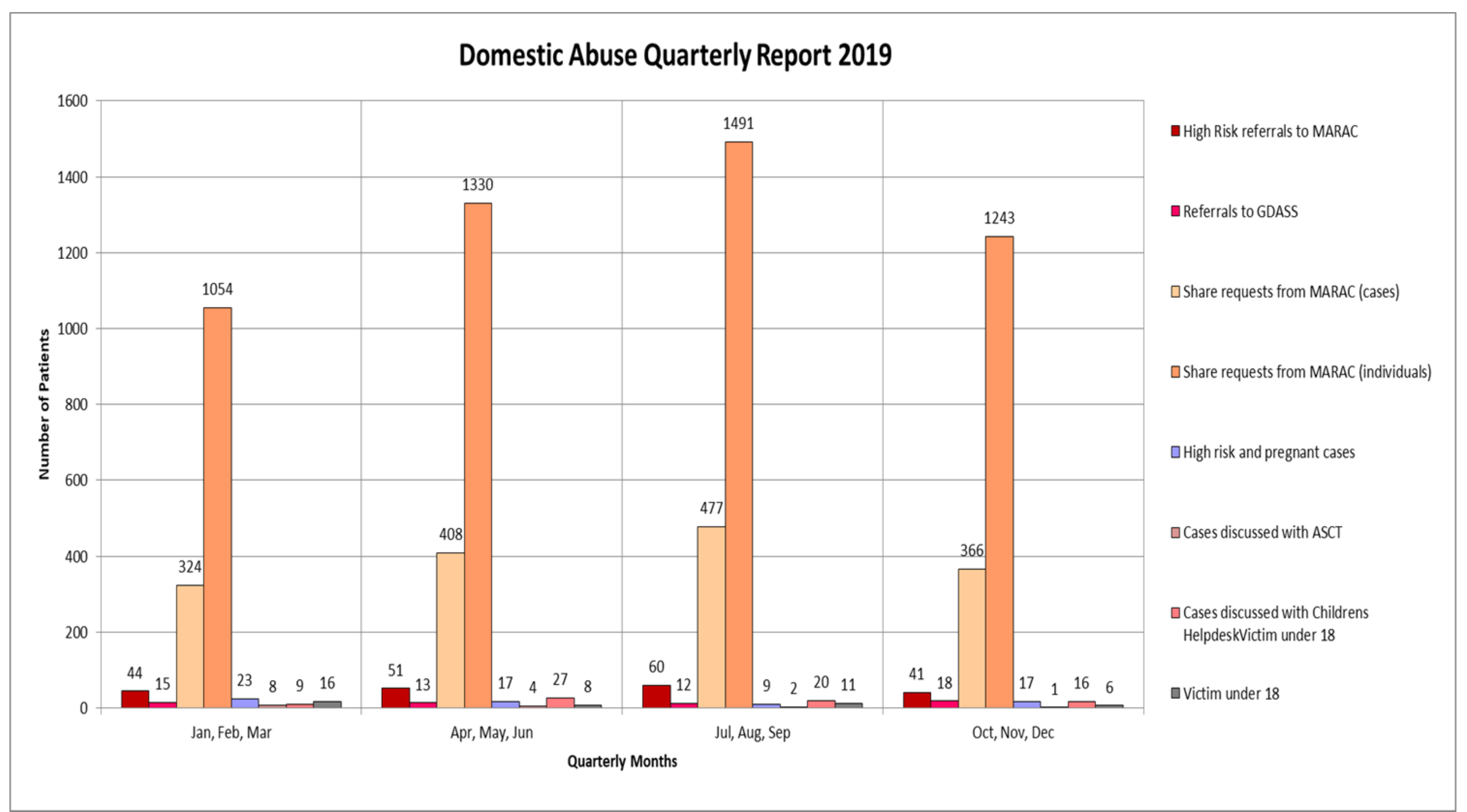
Aim / Objective	Action Plan	Responsible Lead	Progress Update	Status (inc. completion date)
To progress work with the GSCE partnership on pathways of assessment and care for infants and children at and above the Section 47 threshold Contribute to further development of Multiagency pathways of care for suspected CSA medicals	Joint working at the County Health Strategic level to deliver an integrated care pathway, clearly understood by multi-agency partners of GHT	Named doctor, W&C manager Peter Wathen, Designated Doctor CCG	Meeting Dec 2019 , minutes and project plan to follow Mar'20 MASH guidance for work at sec 47 published , full sec47 pathway needs meetings organised by Designated Dr/nurse	
To improve the pathways of care for CYP with self-harm, overdose and mental health conditions	An extensive piece of work across all health Trusts , and CCG commissioning ; on work programme of CPG	Paediatric matron; specialty director and manager W&C	Jan'20 on risk Register scored at 12. April '20 further concerns may arise due to CAHMS altered service arrangements due to COVID	

Appendix B – Safeguarding Children Dashboard 2019/20

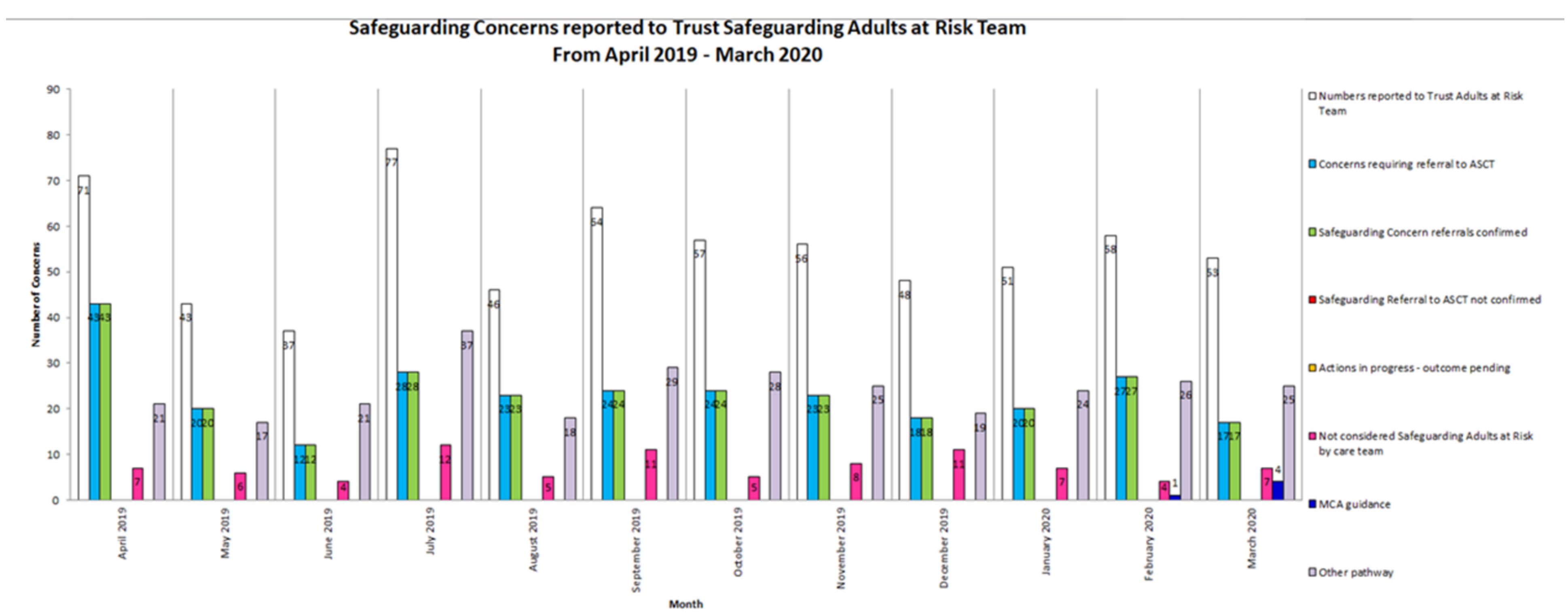
Paediatric Safeguarding Dashboard 0-18 years Description	Data Owner	Green Flag	Red Flag	2018/2019 Actual	2019/20 Total To Date	Q1	Q2	Q3	Q4	Commentary
Emergency Department										
Total ED attendances aged 0-18yrs				29800	27606	7183	7046	7536	5841	**NB Figures adjusted April 2019 from age 0 - end of 17th year (previously included 18th year). There are in addition 4779 CYP who are referred directly to the Paediatric Dept by GP and external referrers, or are the open access patients, ie Total unscheduled CYP 32,385**
ED attendances aged <1yr	HJR			2,714	2826	637	700	894	595	
ED attendances aged 1-16yrs	HJR			23,072	22902	6046	5877	6130	4849	
ED attendances aged 17yrs	HJR			1834	1878	500	469	512	397	
Total ED attendances for infants aged <1yr, all head injuries / long bone fractures	HJR			275	171	61	76	23	11	Coding characteristics were narrowed down for this year , and going forwards
Total ED attendances for infants aged 0-6m, all head injuries / long bone fractures	HJR			89	71	19	30	17	5	Coding characteristics were narrowed down for this year , and going forwards
Admitted (0-6 months)				40	59	22	15	17	5	
of above, aged 7-12mths	HJR			186	100	42	46	6	6	
Admitted	HJR			21	32	9	11	6	6	
% ED attendances for infants aged <1yr, all head injuries / long bone fractures as % of total aged < 1 yr	HJR			10.10%	0	9.6%	10.9%	2.2%	1.80%	Average is 6%
TOTAL ED attendances aged 0-18yrs where deliberate self harm (DSH)	HJR			701	557	161	109	152	135	**NB** Figures adjusted April 2019 from age 0 - end of 17th year (previously included 18th year)
DSH attendances aged 0-16yrs	HJR			367	407	105	79	113	110	
DSH attendances aged 17yrs	HJR			160	150	56	30	39	25	
Admitted - DSH attendances resulting in admission				291	264	65	55	79	65	
TOTAL ED attendances aged 0-18yrs where the DSH includes an overdose OD (this is a proportion of all the DSH)	HJR			454	289	82	50	78	79	NB Figures adjusted April 2019 from age 0 - end of 17th year (previously included 18th year)
OD attendances aged 0-16yrs	HJR			245	210	48	37	61	64	
OD attendances aged 17yrs	HJR			98	79	34	13	17	15	
Admitted - OD attendances resulting in admission				242	181	46	34	58	43	
Total number of ED referrals to PLHV	CS			2166 (Q2+)	2677	737	717	675	548	
Paediatrics										
Attendance and transfer or admission of infant <6ms with a serious injury (judged non-accidental)	HJR			9	9	2	4	1	2	
Patient's discharged with a specific maltreatment diagnosis *	HJR			138	139	42	36	24	37	
Patient's discharged with a diagnosis of Intentional self-harm (X60 - X84)	HJR			226	222	68	55	48	51	
Patient's discharged with a diagnosed History of self-harm (Z915)	HJR			62	141	39	43	23	36	
Paediatric Child Protection telephone consultation (CP ROTA)	CS			223	212	43	42	45	82	
Child Protection (s47) medical completed as unscheduled care outpatient	CS			99	87	17	15	21	34	
Maternity	**Data Owner**									
Total number of maternity social concerns forms completed	SU/WT			1,202	590	159	117	146	168	
Total number of perinatal mental health forms completed.	PMHT			778 (May 2019+)	1295	320	307	346	322	
Total number of pregnant teenagers <16yrs	VP			3 ?	7				7	
Infants placed in care following birth/or at time of discharge	SU/WT			5	10	4	4	2		
Neonates										
Infant with safeguarding needs (green form)	MR			92	62	15	18	11	18	
BED DAYS FOR BABIES ON CP PlanS ON NNU	MR			N/A	336	42	71	140	83	
Infants discharged to foster care	MR			12	14	4	4	2	4	
MARF forms submitted from SCBU/NNU				3	3	0	2	0	1	

Domestic Abuse at (Section 47 threshold)										
ED domestic abuse referrals to CSC (actively referred to CSC no consent to share - have concerns but not due to high risk)	JW/GR			80	85	27	20	29	9	***referrals to CSC as result of GHT staff completing a DASH (adults attendance impacts on childs in adutls care)***
For new MARACS, number of CYP <18yrs (flagged to SG log)	GR				43	8	11	8	16	
DA High risk Victims know to be pregnant attending ED (new notifications)	GR			67 (2018)	73	17	9	24	23	
Child Protection Conference work										
CPP Notifications needing ALERT on Trak (TOTAL)	CS			3,243	1,674	626	251	561	236	
Number of children where information requested from GHT for initial CP conference	CS			N/A	1,069	470	428	29	142	
Children open to GHT or seen in last 6 months at time of initial CP conference for whom reports were requested from staff	CS			N/A	189			94	95	
Total number of child with CP conference invitations received (I + R)	CS			N/A	4,011	1,122	977	863	1049	
Total number of Reviews CPP inviations reveived (TOTAL)	CS				3,022	652	549	1236	585	
Review invitaions subtype - emotional	CS				1,123	383	258	196	286	
Review invitation subtype - neglect	CS				1,222	463	277	239	243	
Review inviations subtype - physical	CS				400	271	55	39	35	
Review invitaions subtype - sexual	CS				353	254	53	17	29	
Review invitations subtype - multiple	CS				67		58	8	1	
Children in Care										
Notifications of child placed in care, added to EPR				Not recorded - awaiting admin support						
Safeguarding Training Compliance				Standard required		Compliance	Compliance	Compliance	Compliance	
Level 1	SM/Training						95%			
Level 1 (W &C)	SM/Training			>90%			96%			
Level 2	SM/Training						82%			
Level 2 (W&C)	SM/Training			>90%			83%			
Level 3	SM/Training						72%			
Level 3 (W&C)	SM/Training			>90%			78%			
Governance										
Total number of datix incidents relating to safeguarding CYP <18yrs (W&C division)	AS			20	19	3	2	10	4	
Total number of datix incidents relating to safeguarding CYP <18yrs (ED/medical division)	?									
Total number of complaints related to safeguarding (Patient/parent and staff escalation of concerns because process not followed)	AS			3	5	2	0	0	3	
Staff allegations management				4	0					
Adverse clinical incidents (ACIs) relating to safeguarding	AS			2	0					
Child deaths (TOTAL) + subdivided:-	ST/CDOP			20	0					
Expected deaths	ST			13	0					
Unexpected	ST			7	0					
Death triggering a SCR or Child protection investigations	ST									

Appendix C – Domestic Abuse workload 2019



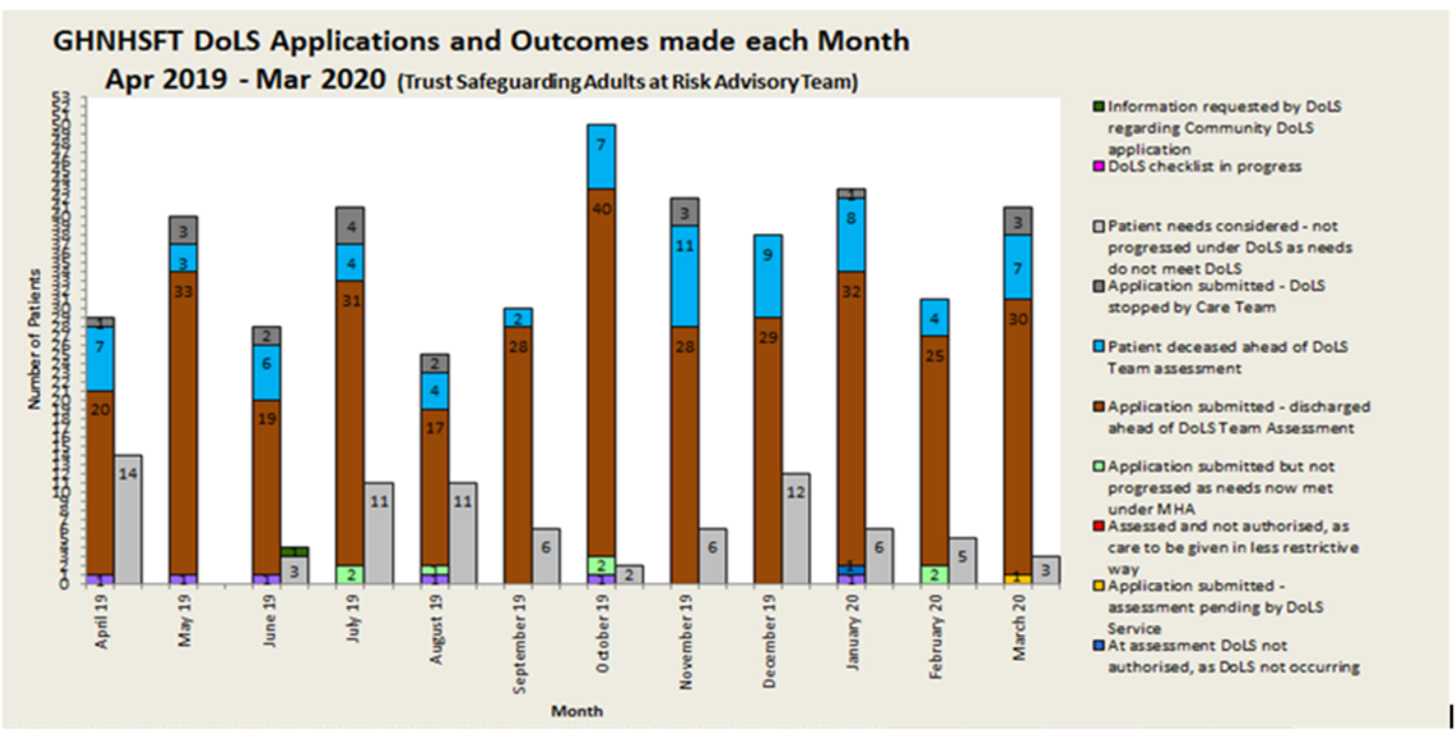
Appendix D – Safeguarding Concerns reported to Safeguarding Adults Team 2019/20



Total contacts = 661
Total concerns reported under Safeguarding Adults at Risk Pathway = 279
Total where concern required to be reported under Safeguarding Adults at Risk pathway and was not confirmed as reported = 0
Total where concern does not meet Safeguarding Adults at Risk threshold and other pathway applied = 87
Total where contacts made not linked to Safeguarding Adult at Risk pathway = 290
Logging of contacts made in support of specialist MCA guidance was commenced in February 2020 = 5

Appendix E – Deprivation of Liberty Safeguards (DoLS) activity 2019/20

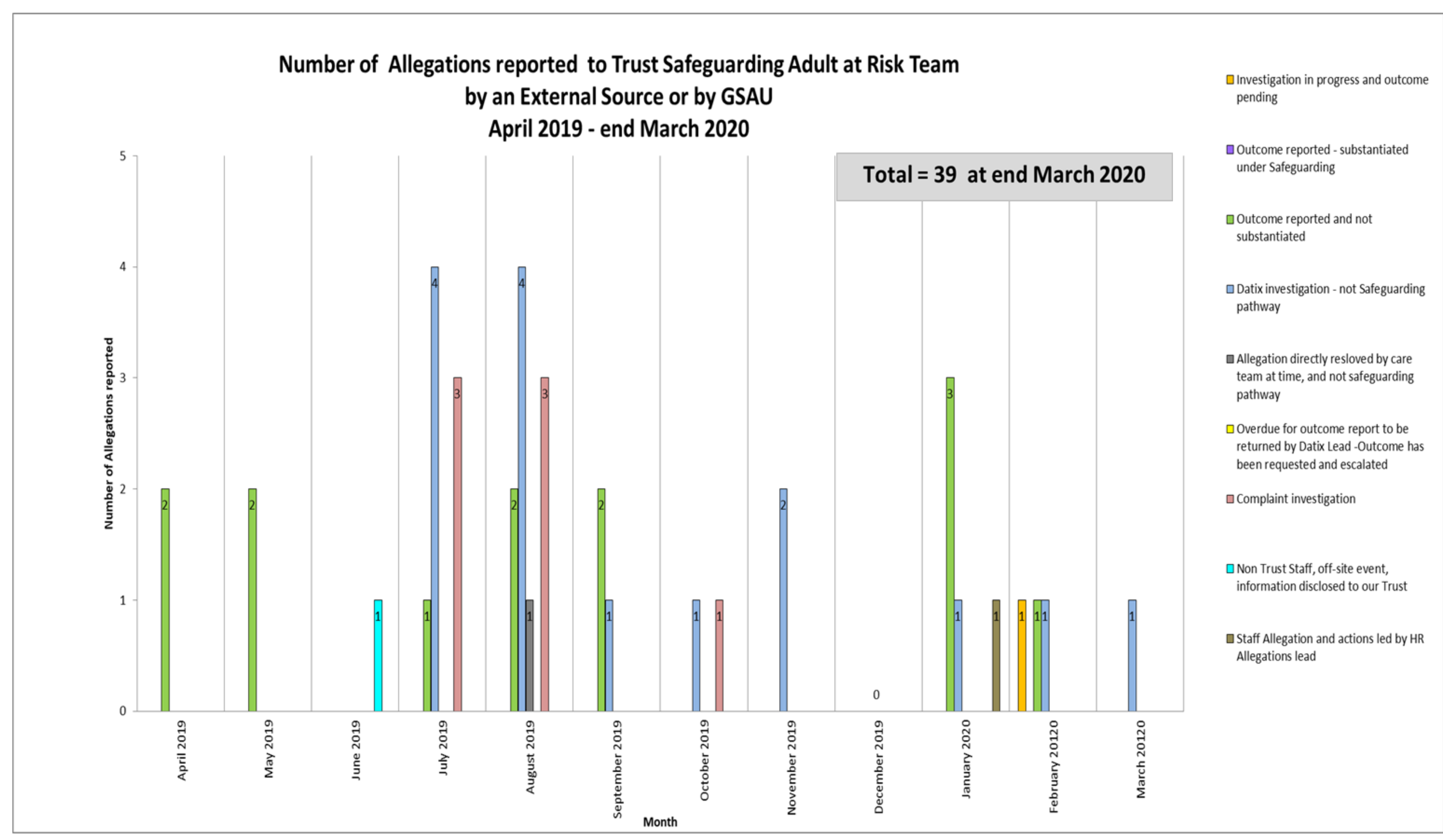
Trust wide DoLS activity for April 2019 to end March 2020

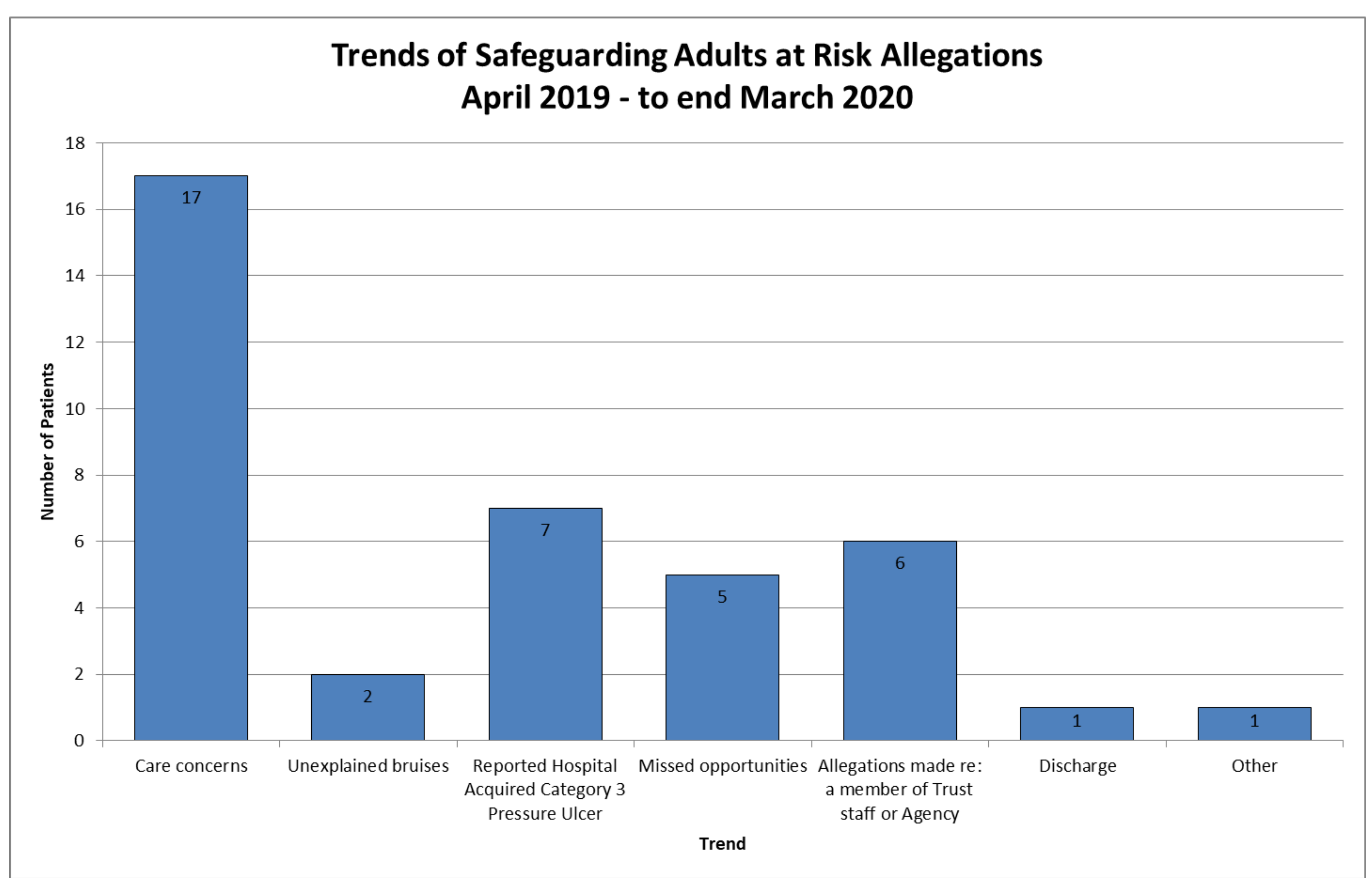


Total DoLS considerations	520
Total DoLS applications	440
Total CQC DoLS outcome notifications completed by Trust Safeguarding Adult at Risk, MCA and DoLS Team	424
Total CQC DoLS notifications to be completed	16

Total Assessed and Authorised by Gloucestershire Countywide DoLS team (external to our Trust) April, May, June, August and January	5
Total Assessed and Authorised by Bath Countywide DoLS team	1
Total inpatients with DoLS authorised	6
At end march 2020 - 1 current in-patient with DoLS assessment pending by Gloucestershire Countywide DoLS team (external to our Trust)	1

Appendix F – External safeguarding allegations against GHFT 2019/20




Trends of Safeguarding Adults at Risk Allegations
April 2019 - to end March 2020
Number of Patients
18
16
14
12
10
8
6
4
2
0
17
2
7
5
6
1
1
Care concerns
Unexplained bruises
Reported Hospital Acquired Category 3 Pressure Ulcer
Missed opportunities
Allegations made re: a member of Trust staff or Agency
Discharge
Other
Trend

TRUST BOARD – SEPTMBER 2020
MICROSOFT TEAMS – Commencing at 12:30

Report Title

QUALITY AND PERFORMANCE REPORT

Sponsor and Author(s)

Author: Felicity Taylor-Drewe, Director Planned Care / Deputy COO
Sponsor: Rachael De Caux, Chief Operating Officer

Executive Summary

Purpose
This report summarises the key highlights and exceptions in Trust performance for the June 2020 reporting period.

The Quality and Performance (Q&P) committee receives the Quality Performance Report (QPR) on a monthly basis. The supporting exception reports from Quality; Emergency Care; Cancer and Planned Care Delivery Groups support the areas of performance concerns.

We continue to report a number of nationally suspended indicators within this report with the QPR and QPR SPC, when national reporting regimes recommence we will include this within the respective indicators narrative. Any data that was un-validated at the time of the last report will be updated within this months. Un-validated data, broadly due to timing of reporting is identified within the QPR.

Quality Delivery Group QPR

The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics.
The Quality and Performance Committee receive the data before the QDG.

Safe
Never Event Thematic Analysis
There were 2 new never events reported in June and these are currently being investigated. There is a contributing factor review for the wrong site surgery never events and this report will be received by QDG in September 2020.

VTE risk assessment
This indicator has been amber for a number of consecutive months and this will be reviewed by QDG in August to check the controls and actions we have put in place improve performance.

Caring
Friends and Family Test and Real-time Surveys
Our FFT scores are now reported by Division at QDG and we are mapping each specialty to enable staff to have visibility of their data. Once each specialty can see their data the expectation will be that they use their insight to design their improvement programmes and involve their teams on improving their scores. Each service can carry out local surveys to do more in depth work and the Patient Experience Faculty of the GSQIA will be there to support with the data collection and reporting. Real-time surveys remain paused until volunteers return to site and this is anticipated in September 2020.

Falls Metrics and Improvement Plan progress

The Preventing Falls Improvement Programme Director and Lead presented their work to QDG and the report will be reviewed by Q&P for assurance.
QDG had agreed that the EPR usage metric for Falls Assessment should be added to the QPR and this will be included as part of the review of the QPR metric review.

Pressure Ulcers Metrics and Improvement Plan
Pressure ulcer prevention strategies are now going to be driven by the risk assessment on EPR. The plan is for this metric to be added to the QPR. The preventing pressure ulcers annual report will presented at August's QDG to check the right actions are being taken and that we have controls in place for our risks.

Maternity - % of women booked by 12 weeks
An analysis of why we are not able to book women by 12 weeks has been undertaken with issues identified such as delayed transfer of booking details by the GP and also data quality issues. The Maternity Team hope that improvements to the system will see an increase in the percentage.

Dementia
This indicator has been paused by NHSI and the improvement group is reviewing the collection of different metrics. QDG received a scoping document for the newly revised improvement plan. The metrics for dementia will be reviewed as part of this programme as the nationally reported metric is under review as well.

Performance

During June the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard, 52 week waits and the 62 day cancer standard. The Trust performance (type 1) for the 4 hour standard in April was 86.4%. The Trust did not meet the diagnostics standard for June at 29.54%, this is as yet un-validated performance at the time of the report. . We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review.

The Trust did meet the standard for 2 week wait cancer at 98.00% in June, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance 58% in June, un-validated at the time of the report, Our focus is to ensure that patients are risk stratified and we can step up to fully utilise our clinics and theatres during the next period.

Key issues to note

The key areas of focus remain the assurance of patient care and safety during this time. Teams across the hospital continue to supported each other to offer the best care for all our patients. We are also planning further communication to patients to support attendance face to face when identified.

A review and recovery plan is being formulated with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

Recommendations

The Trust Board is requested to receive the Report as assurance that the Executive team and Divisions fully understand the current levels of non-delivery against performance standards and have action plans to improve this position, alongside the plans to clinically prioritise those patients that need treatment planned or un-planned during the pandemic.

Impact Upon Strategic Objectives

Current performance jeopardises delivery of the Trust's strategic objective to improve the

quality of care for our patients.
Impact Upon Corporate Risks
Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators, subject to C-19.
Regulatory and/or Legal Implications
No fining regime determined for 2020 within C-19 at this time.
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People & OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
✓						
Outcome of discussion when presented to previous Committees						

Quality and Performance Report

Reporting Period July 2020

Presented at August 2020 Q&P and September 2020 Trust Board

Contents

Contents	2
Executive Summary	3
Performance Against STP Trajectories	4
Summary Scorecard	5
Demand and Activity	6
Trust Scorecard – Safe	7
Trust Scorecard – Effective	10
Trust Scorecard – Caring	12
Trust Scorecard – Responsive	13
Trust Scorecard – Well Led	16
Exception Reports - Safe	17
Exception Reports – Effective	18
Exception Reports – Caring	20
Exception Reports – Responsive	21
Benchmarking	26

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Executive Summary

The key areas of focus remain the assurance of patient care and safety during this time. Key reductions in non-urgent elective care took place in March to support organisational response to Covid-19 and continued into July. This has led to a number of changes and opportunities to deliver patient care in an enhanced way. The Trust through support of IM&T colleagues has embraced remote working with our patients & with Primary Care. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. During this time we also enacted a CAS to support primary care and remain open for referrals requiring a secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients.

A review and recovery plan is being formulated with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety.

During July the Trust did meet the national standards for 62 day cancer standard but did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in July was 84.46%, against the STP trajectory of 85.90%. The system did meet the delivery of 90% for the system in July, at 90.05%. Note that the July performance targets / trajectories have not been formally agreed as the Operating Plan process was paused due to C-19, we have therefore taken the appropriate performance target from the national or previous local target where applicable.

The Trust did not meet the diagnostics standard for July at 26.07%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests.

The Trust met the standard for 2 week wait cancer at 96.50% in July, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 55.36% in July, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, of which there were 1,033 in July. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

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Performance Against STP Trajectories

The following table shows the monthly performance of the Trust's STP indicators for 2019/20. RAG Rating: The STP indicators are assessed against the monthly trajectories agreed with NHS Improvement.
Note that data is subject to change.

Indicator		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Count of handover delays 30-60 minutes	Trajectory	52	50	48	46	43	40	40	40	40	40	40	40	40	40	40	40
	Actual	57	53	42	50	77	96	145	159	127	161	105	105	61	57	88	78
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	1	2	3	11	10	5	2	0	0	5	1
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	90.39%	91.70%	91.05%	92.20%	92.01%	89.13%	86.36%	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%	85.32%	85.37%	85.17%	85.90%
	Actual	86.01%	87.99%	86.80%	88.53%	88.16%	84.03%	80.58%	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	78.00%	78.00%	78.00%	78.30%	78.60%	79.00%	79.30%	79.60%	80.00%	80.30%	80.60%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	79.46%	80.63%	81.11%	81.80%	81.41%	81.38%	81.33%	80.29%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.36%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	95	93	90	86	83	80	74	67	60	40	20	0	0	0	0	0
	Actual	93	91	90	78	77	78	62	45	39	28	14	33	156	366	694	1033
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.98%	0.98%	0.99%	0.99%	0.98%	0.99%	0.98%	0.99%	0.98%	0.98%	0.98%	0.98%	0.99%	0.99%	0.99%	0.99%
	Actual	0.54%	0.67%	1.08%	0.76%	0.71%	0.72%	0.54%	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	87.50%	86.70%	89.50%	92.70%	86.00%	96.50%	94.40%	94.60%	96.90%	95.10%	96.10%	95.10%	90.60%	99.10%	98.00%	96.50%
2 week wait breast symptomatic referrals	Trajectory	93.10%	93.20%	93.20%	93.30%	93.30%	93.00%	93.00%	93.10%	93.20%	93.20%	93.20%	93.20%	93.00%	93.00%	93.00%	93.00%
	Actual	96.90%	97.30%	99.00%	96.30%	98.40%	99.30%	98.20%	96.00%	97.40%	96.30%	97.80%	98.40%	87.90%	97.80%	95.70%	96.40%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.10%	96.20%	96.20%	96.20%	96.20%	96.10%	96.10%	96.10%	96.20%	96.20%	96.20%	96.20%	96.00%	96.00%	96.00%	96.00%
	Actual	92.10%	92.00%	93.80%	92.60%	92.30%	91.00%	91.40%	91.40%	93.00%	95.50%	94.30%	95.50%	96.60%	96.00%	95.30%	98.10%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.10%	98.30%	98.20%	98.90%	98.10%	98.00%	99.00%	98.00%	98.90%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	97.50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.00%	97.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.90%	94.40%	94.80%	94.30%	94.00%	95.10%	95.10%	95.10%	95.10%	95.10%	95.10%	95.10%	94.00%	94.00%	94.00%	94.00%
	Actual	96.40%	97.90%	98.80%	100.00%	84.80%	80.80%	99.20%	94.80%	95.60%	96.70%	97.50%	100.00%	98.30%	96.70%	86.50%	83.00%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	95.50%	95.30%	94.80%	94.40%	95.10%	95.50%	95.40%	95.60%	94.80%	94.80%	94.80%	94.00%	94.00%	94.00%	94.00%
	Actual	91.10%	89.10%	96.20%	89.60%	89.80%	97.60%	100.00%	98.00%	90.20%	98.30%	97.40%	94.10%	98.20%	92.60%	81.30%	78.90%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.30%	90.90%	91.70%	90.90%	91.40%	91.70%	91.40%	91.40%	92.30%	90.60%	90.60%	90.60%	90.00%	90.00%	90.00%	90.00%
	Actual	100.00%	96.60%	85.20%	85.20%	100.00%	100.00%	96.40%	95.10%	91.10%	97.80%	96.70%	94.70%	90.90%	54.50%	60.00%	66.70%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	36.40%	44.40%	63.20%	91.70%	75.00%	66.70%	61.50%	83.30%	87.50%	69.20%	63.60%	76.50%	100.00%	88.90%	73.70%	91.70%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	81.80%	82.30%	82.40%	82.60%	84.30%	85.00%	85.20%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	80.10%	71.80%	68.20%	72.70%	75.40%	71.00%	76.70%	71.40%	74.20%	68.00%	76.50%	78.20%	78.00%	69.00%	78.00%	85.60%

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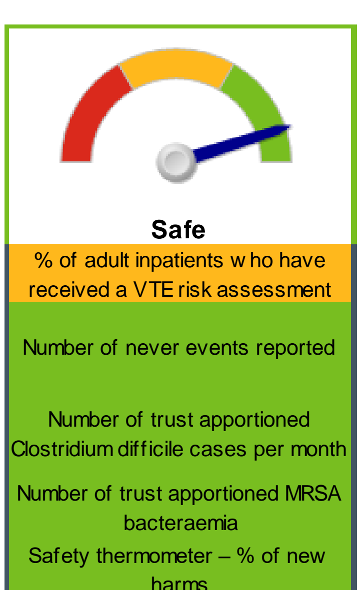
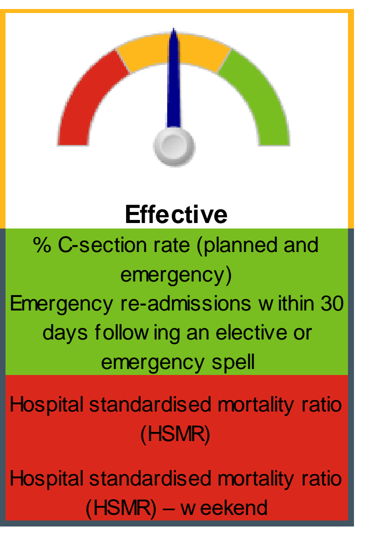
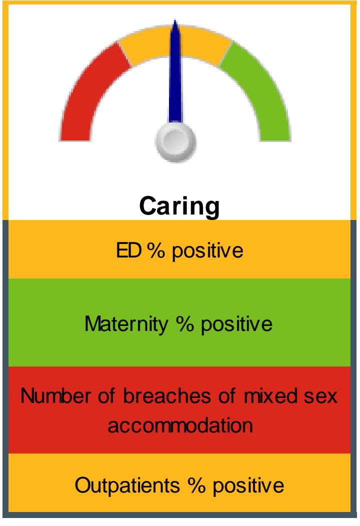
Summary Scorecard

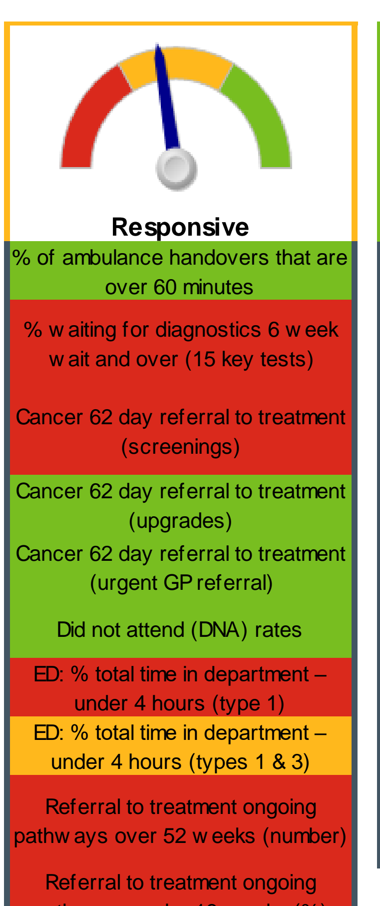
The following table shows the Trust's current monthly performance against the chosen lead indicators within the Trust Scorecard.

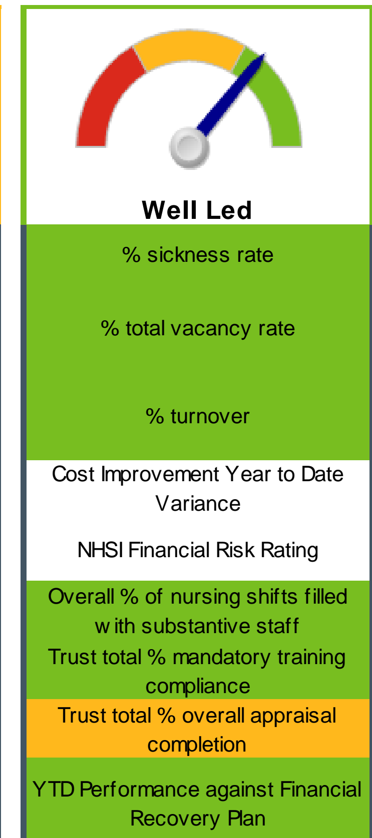
RAG Rating: Overall RAG rating for a domain is an average performance of lead indicators against national standards. Where data is not available the lead indicator is treated as red.











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Demand and Activity

The table below shows monthly activity for key areas. The columns to the right show the percentage change in activity from:

1) The same month in the previous year
2) The same year to date (YTD) period in the previous year

Measure	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Monthly (July)	YTD
GP Referrals	12,061	10,302	10,429	11,836	13,356	11,169	10,191	9,595	7,888	3,076	3,946	3,185	8,119	-32.68%	-64.26%
OP Attendances	13,856	11,850	13,534	14,545	13,661	10,823	13,634	12,167	10,637	5,241	6,332	31,029	32,690	135.93%	43.12%
New OP Attendances												8,773	9,911		
FUP OP Attendances												17,060	22,779		
Day cases	6,955	6,348	6,276	7,142	6,578	6,228	7,067	5,304	4,216	1,473	1,786	2,721	3,467	-50.15%	-62.94%
All electives	8,096	7,378	7,238	8,275	7,690	7,155	8,039	6,294	4,966	1,780	2,183	3,252	4,242	-47.6%	-61.96%
ED Attendances	14,066	13,267	13,240	13,329	13,066	13,287	12,624	11,695	9,721	7,128	8,913	10,350	11,533	-18.01%	-29.38%
Non Electives	4,802	4,698	4,833	5,083	4,837	5,052	4,664	4,353	3,874	3,110	3,728	4,205	4,421	-7.93%	-18.37%

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Trust Scorecard – Safe (1)

Note that data in the Trust Scorecard section is subject to change.

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission											250	64	9	5	318	323	TBC	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission											68	7	1	1	76	77	TBC	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission											38	1	2	1	41	42	TBC	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission											33	4	1	1	38	39	TBC	
Number of trust apportioned MRSA bacteraemia	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days	.6			3.6													Zero	
Number of trust apportioned Clostridium difficile cases per month	97	10	9	9	11	12	7	8	6	5	4	7	2	7	13	20	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	5	7	6	1	10	3	5	4	6	2	1	4	1	2	6	8	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	45	3	4	8	1	9	2	4	0	3	3	3	1	5	7	12	<=5	
Clostridium difficile – infection rate per 100,000 bed days	28.8	35.7	32.5	32.8	37.9	42.4	24.4	29.7	21.5	17.6	25.6	38.6	9.9	30.3	24.1	25.9	<30.2	
Number of MSSA bacteraemia cases	18	4	1	2	2	1	2	1	1	2	1	0	3	1	4	4	<=8	
MSSA – infection rate per 100,000 bed days	5.3	14.3	3.6	7.3	6.9	3.5	7	3.3	3.6	7	6.4		14.9	4.3	7.4	6.5	<=12.7	
Number of ecoli cases	46	1	4	3	2	5	9	3	3	2	1	3	2	4	6	10	No target	
Number of pseudomona cases	9	2	1	0	1	0	0	3	0	1	0	2	0	0	2	2	No target	
Number of klebsiella cases	18	1	3	4	1	1	1	1	2	1	1	2	0	1	3	4	No target	
Number of bed days lost due to infection control outbreaks	1,264	70	136	0	0	240	276	100	13	0		0	0	4		4	<10	>30

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Trust Scorecard – Safe (2)

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Zero	
Number of falls per 1,000 bed days	6.4	6.6	5.5	6.2	6.6	6.4	6.7	7.1	7	6.4	6	7.9	7.2	7	7	7	<=6	
Number of falls resulting in harm (moderate/severe)	4	7	1	5	7	1	4	5	5	0	2	4	4	3	10	13	<=3	
Number of patient safety incidents – severe harm (major/death)	6	4	12	4	7	3	3	6	5	2	4	1	5	2	10	12	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	2	3	1	2	1	1	5	2	1	2	3	2	6	7	13	No target	
Medication error resulting in low harm	12	11	11	10	21	23	7	10	8	11	9	15	7	8	31	39	No target	
Number of category 2 pressure ulcers acquired as in-patient	30	38	36	30	24	31	29	27	12	23	13	15	16	9	44	53	<=30	
Number of category 3 pressure ulcers acquired as in-patient	5	6	6	4	4	4	2	2	3	1	0	1	0	1	1	2	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient	6	14	12	5	6	5	2	4	6	3	3	4	7	4	14	18	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	6	8	7	2	3	8	3	5	3	4	4	6	1	2	11	13	<=5	
RIDDOR																		
Number of RIDDOR	35	3	2	1	2	1	2	4	2	2	2	1	5	3	11		SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package			93.00%	93.00%	94.00%	95.00%											TBC	
Number of DoLs applied for					45	36	50			33			41	59			TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures											1			18			TBC	
Total attendances for infants aged < 6 months, other serious injury											17			30			TBC	
Total admissions aged 0-18 with DSH											6			31			TBC	
Total ED attendances aged 0-18 with DSH											26			55			TBC	
Total number of maternity social concerns forms completed					55	44	53			31			48				TBC	

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Trust Scorecard – Safe (3)

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Safety Thermometer																		
Safety thermometer – % of new harms	97.1%	97.4%	97.9%	96.3%	97.3%	95.8%	97.9%	96.5%	98.1%	97.8%							>96%	<93%
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	67.00%			64.70%			71.00%			68.00%							>=90%	<50%
Serious Incidents																		
Number of never events reported	6	1	0	0	1	0	1	1	1	0	0	0	2	0	2	2	Zero	
Number of serious incidents reported	3	2	1	5	4	3	1	2	3	2	0	0	2	2	2	4	No target	
Serious incidents – 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	93.2%	96.7%	92.9%	91.6%	95.9%	91.8%	92.6%	90.1%	94.2%	92.7%		90.1%	94.0%	93.8%	92.3%	92.9%	>95%	

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Trust Scorecard – Effective (1)

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	0.8%	66.0%	85.0%	63.0%	62.0%	50.0%	37.0%	37.0%	86.0%	74.0%	67.0%	63.0%	68.0%				>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	29.4%	0.0%		50.0%	0.0%	0.0%	18.0%	0.0%	10.0%	0.0%							>=90%	<70%
% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were then referred for further diagnostic advice/FU (within 72 hours)	0.0%			50.0%			0.0%										>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway								4.30%	5.00%	4.40%	4.70%	3.00%	0.80%	0.00%	3.00%	2.00%	No target	
% C-section rate (planned and emergency)	28.39%	32.49%	25.61%	27.99%	25.97%	26.57%	31.30%	28.66%	30.23%	28.90%	27.73%	28.82%	25.94%	26.51%	27.43%	26.98%	<=27%	>=30%
% emergency C-section rate	15.74%	17.42%	14.02%	16.04%	13.70%	15.77%	13.48%	13.60%	16.36%	14.48%	12.73%	15.27%	12.08%	12.73%	13.32%	13.17%	No target	
% of women booked by 12 weeks gestation	88.9%	89.0%	85.3%	89.6%	91.8%	92.2%	91.9%	90.3%	89.5%	89.7%	89.6%	93.1%	93.3%	93.0%	92.1%	92.3%	>90%	
% of women that have an induced labour	28.65%	28.38%	26.83%	29.66%	29.04%	29.59%	30.00%	27.20%	28.42%	27.98%	27.50%	28.60%	29.70%	35.49%	28.63%	29.84%	<=30%	>33%
% of women smoking at delivery	10.95%	9.78%	10.16%	9.14%	10.22%	13.63%	11.52%	13.18%	8.64%	12.39%	9.55%	10.97%	11.29%	9.39%	10.63%	10.31%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.22%	0.38%	0.20%	0.19%	0.20%	0.43%	0.43%	0.21%	0.00%	0.23%	1.14%	0.00%	0.20%	0.42%	0.42%	0.42%	<0.52%	
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.1	1.1	1.1	1.1	1.1	1	1.1	1.1	1.1	1.1							NHS Digital	
Hospital standardised mortality ratio (HSMR)	108	98.6	98	97.6	99.7	99.8	103.9	99.9	107.2	108							Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	112.7	97.9	100.5	101.6	102.7	102.1	110.3	104.3	110.9	112.7							Dr Foster	
Number of inpatient deaths	1,964	125	124	143	144	152	212	215	167	192	249	126	112	120	487	607	No target	
Number of deaths of patients with a learning disability	15	2	2	0	0	0	1	4	0	0	4	2	0	1	6	7	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	6.5%	7.5%	7.2%	6.7%	7.1%	6.4%	6.6%	6.7%	8.4%	10.2%	8.8%	7.1%		8.5%	8.5%	<8.25%	>8.75%
Research																		
Research accruals		123	103	76	121	101	73	110	98								No target	

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Trust Scorecard – Effective (2)

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	49.5%	53.5%	50.6%	48.6%	52.5%	39.4%	48.7%	45.2%	56.4%	46.2%	37.0%	53.0%	45.0%	63.5%	45.0%	49.5%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.7%	80.9%	98.8%	87.9%	84.5%	81.1%	87.3%	88.5%	87.7%	90.4%	88.5%	78.0%	84.0%		83.5%	83.5%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours	54.80%	67.90%	68.40%	62.00%	64.90%	41.40%	40.00%	38.40%	30.80%	49.30%	49.00%	21.00%	65.00%	74.50%	45.00%	45.00%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival	70.70%	73.10%	67.60%	71.40%	77.80%	71.20%	71.70%	69.20%	71.00%	65.20%	68.00%	76.00%	65.00%	78.60%	69.70%	71.90%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.7%	67.1%	46.6%	66.7%	39.6%	56.1%	58.3%	73.1%	58.6%	48.6%	75.0%	62.4%	72.7%	56.7%	68.9%	67.6%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.90%	65.70%	45.21%	66.70%	37.90%	56.06%	58.30%	73.10%	55.20%	48.60%	53.10%	60.60%	70.91%	56.70%	67.00%	60.80%	>=65%	<55%

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Trust Scorecard – Caring (1)

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	90.7%	90.7%	91.1%	91.5%	90.6%	91.8%	90.2%	90.2%	90.5%	91.1%	90.0%	90.2%	91.9%	87.0%	90.9%	90.0%	>=96%	<93%
ED % positive	82.1%	79.8%	83.3%	82.3%	82.9%	87.9%	78.9%	79.9%	79.2%	79.6%	90.2%	85.8%	86.8%	81.8%	87.5%	85.9%	>=84%	<81%
Maternity % positive	97.4%	96.2%	100.0%	96.9%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	97.2%	100.0%	90.2%	100.0%	94.4%	95.5%	>=97%	<94%
Outpatients % positive	93.0%	92.8%	93.2%	92.7%	92.8%	93.8%	93.2%	93.1%	93.0%	94.3%	94.0%	93.6%	93.9%	93.7%	93.9%	93.8%	>=94%	<91%
Total % positive	91.2%	90.7%	91.3%	91.0%	91.1%	92.8%	91.3%	91.4%	91.1%	92.2%	92.9%	91.8%	92.4%	91.3%	92.3%	92.0%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?	79.00%	79.67%	83.69%	77.40%	83.00%	83.00%	74.00%	81.00%	84.00%	78.00%							>=90%	
Are you involved as much as you want to be in decisions about your care and treatment?	92.00%	90.61%	95.03%	89.66%	93.00%	91.00%	88.00%	93.00%	95.00%	92.00%							>=90%	
Do you feel that you are treated with respect and dignity?	98.00%	96.09%	98.58%	99.32%	98.00%	100.00%	97.00%	99.00%	99.00%	100.00%							>=90%	
Do you feel well looked after by staff treating or caring for you?	99.00%	98.33%	97.16%	99.31%	99.00%	98.00%	98.00%	100.00%	100.00%	99.00%							>=90%	
Do you get enough help from staff to eat your meals?	89.00%	97.20%	97.17%	100.00%	100.00%	90.00%	63.00%	80.00%	96.00%	67.00%							>=90%	
In your opinion, how clean is your room or the area that you receive treatment in?	99.00%	96.45%	96.40%	90.97%	100.00%	98.00%	99.00%	98.00%	98.00%	100.00%							>=90%	
Do you get enough help from staff to wash or keep yourself clean?	96.00%	98.87%	97.86%	99.32%	100.00%	85.00%	96.00%	97.00%	93.00%	86.00%							>=90%	
MSA																		
Number of breaches of mixed sex accommodation	82	16	11	9	0	0	2	2	1	8	6	13	21	23	40	63	<=10	>=20

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Trust Scorecard – Responsive (1)

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait											53.9%	79.6%	77.9%	79.9%	71.4%	73.8%	TBC	
Cancer – 28 day FDS breast symptom two week wait											91.4%	95.7%	98.6%	99.1%	100.0%	97.5%	TBC	
Cancer – 28 day FDS screening referral											76.0%	50.0%	76.9%	100.0%	72.7%	79.7%	TBC	
Cancer – urgent referrals seen in under 2 weeks from GP	92.5%	92.7%	86.0%	96.5%	94.4%	94.6%	96.9%	95.1%	96.1%	95.1%	90.6%	99.1%	98.0%	96.5%	96.7%	95.0%	>=93%	<90%
2 week wait breast symptomatic referrals	97.5%	96.3%	98.4%	99.3%	98.2%	96.0%	97.4%	96.3%	97.8%	98.4%	87.9%	97.8%	95.7%	96.4%	94.6%	92.6%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	93.4%	92.6%	92.3%	91.0%	91.4%	91.4%	93.0%	95.5%	94.3%	95.5%	96.6%	96.0%	95.3%	98.1%	96.2%	97.2%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.0%	97.0%	98.3%	99.3%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	93.6%	89.6%	89.8%	97.6%	100.0%	98.0%	90.2%	98.3%	97.4%	94.1%	98.2%	92.6%	81.3%	78.9%	89.8%	88.4%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	94.9%	100.0%	84.8%	80.8%	99.2%	94.8%	95.6%	96.7%	97.5%	100.0%	98.3%	96.7%	86.5%	83.0%	93.4%	89.5%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	73.1%	72.7%	75.4%	71.0%	76.7%	71.4%	74.2%	68.0%	76.5%	78.2%	78.0%	69.0%	78.0%	85.6%	76.4%	79.7%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	95.4%	85.2%	100.0%	100.0%	96.4%	95.1%	91.1%	97.8%	96.7%	94.7%	90.9%	54.5%	60.0%	66.7%	82.1%	79.1%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	72.2%	91.7%	75.0%	66.7%	61.5%	83.3%	87.5%	69.2%	63.6%	76.5%	100.0%	88.9%	73.7%	91.7%	85.4%	88.1%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	170	18	13	9	15	12	6	5	4	3	4	8	8	21		4	Zero	
Number of patients waiting over 104 days without a TCI date	407	37	32	28	36	22	25	19	14	20	33	79	66			33	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	3.16%	0.76%	0.71%	0.72%	0.54%	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	29.54%	26.07%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	825	770	714	756	756	763	835	853	803	825	1,035	1,230	1,367	1,465	3,632	3,632	<=600	
Discharge																		
Number of patients delayed at the end of each month	15	43	41	35	44	32	22	55	54	15	4	3	7	11	14	25	<=38	
Patient discharge summaries sent to GP within 24 hours	56.5%	57.4%	55.1%	56.5%	58.0%	56.4%	56.3%	58.9%	59.4%	57.7%	55.5%	57.8%	60.2%		58.1%	58.1%	>=88%	<75%

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Trust Scorecard – Responsive (2)

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	81.58%	88.53%	88.16%	84.03%	80.58%	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	86.16%	85.55%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	87.40%	92.20%	92.01%	89.13%	86.36%	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	89.68%	89.79%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	93.70%	95.44%	96.20%	92.68%	95.54%	90.92%	88.74%	91.50%	93.02%	94.10%	95.42%	96.43%	98.93%	99.85%	96.91%	97.57%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	81.59%	85.09%	84.25%	79.90%	73.72%	69.25%	65.20%	63.30%	64.91%	71.69%	84.28%	80.59%	84.01%	84.46%	83.37%	83.56%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	Zero	
ED: % of time to initial assessment – under 15 minutes	71.2%	71.3%	75.7%	71.4%	68.4%	66.5%	64.3%	68.0%	65.8%	70.1%	80.4%	77.0%	72.7%	72.5%	76.3%	75.1%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	31.3%	30.3%	31.2%	29.9%	28.3%	26.6%	26.0%	31.9%	29.0%	40.9%	68.0%	57.5%	52.0%	44.5%	58.2%	54.1%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	2.40%	1.25%	1.93%	2.48%	3.48%	3.71%	2.81%	3.76%	2.76%	2.87%	2.09%	1.74%	2.57%	2.04%	2.14%	2.11%	<=2.96%	
% of ambulance handovers that are over 60 minutes	0.07%	0.00%	0.00%	0.02%	0.07%	0.07%	0.24%	0.23%	0.13%	0.05%	0.00%	0.00%	0.15%	0.03%	0.05%	0.04%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.03%	96.30%	90.48%	95.12%	91.18%	64.71%	80.00%	88.89%	74.07%	74.03%	-120.00%	100.00%	100.00%	94.00%	21.00%	47.00%	>=95%	
Urgent cancelled operations	8	0	0	2	3	0	1	1	1	0	0	0	0	11	0	11	No target	
Number of patients stable for discharge	86	79	88	88	90	87	81	112	101	70	14	33	45	66	31	97	<=70	
% of bed days lost due to delays	3.10%	3.47%	4.32%	4.58%	3.67%	3.19%	2.70%	4.69%	4.54%	3.10%	0.56%	0.58%	0.93%	2.00%	0.70%	1.02%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	423	371	360	371	380	406	403	431	427	358	204	213	248	288	222	238	<=380	
Average length of stay (spell)	5.14	4.87	4.78	4.88	4.84	4.95	5.25	5.68	5.36	6.16	5.22	4.49	4.54	4.7	4.72	4.71	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	5.45	5.25	5.38	5.35	5.56	5.77	6.43	6.07	6.91	5.37	4.75	4.81	5.15	4.96	5.01	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.66	2.64	2.76	2.61	2.83	2.65	2.87	2.42	2.62	2.65	3.73	2.17	2.63	2.47	2.75	2.64	<=3.4	>4.5
% day cases of all electives	85.59%	85.91%	86.04%	86.71%	86.31%	85.54%	87.04%	87.91%	84.27%	84.90%	82.75%	81.81%	83.67%	81.73%	82.88%	82.46%	>80%	<70%
Intra-session theatre utilisation rate	87.20%	87.40%	87.60%	87.70%	88.20%	88.00%	87.40%	86.40%	87.50%	85.60%	91.80%	87.60%	84.05%	87.30%	85.20%	87.20%	>85%	<70%

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Trust Scorecard – Responsive (3)

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.88	1.88	1.92	1.8	1.75	1.81	1.89	1.86	1.93	2.03	2.56	2.33	2.29	2.03	2.37	2.26	<=1.9	
Did not attend (DNA) rates	6.90%	7.00%	6.90%	7.20%	6.70%	6.80%	6.90%	6.90%	6.50%	7.80%	4.20%	4.30%	4.70%	5.50%	4.40%	4.80%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	81.01%	81.80%	81.41%	81.38%	81.33%	80.29%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.36%	66.40%	63.50%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	1,833	1,772	1,703	1,699	1,650	1,792	1,790	1,658	1,653	1,833	2,719	3,794	4,967	6,250	3,827	3,827	No target	
Referral to treatment ongoing pathways 40+ Weeks (number)	912	1,437	1,378	1,390	1,312	824	1,263	1,298	1,203	912	1,615	2,522	3,312	4,463	2,483	2,483	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	33	78	77	78	62	45	39	28	14	33	156	366	694	1,033	405	405	Zero	
SUS																		
Percentage of records submitted nationally with valid GP code	99.7%	100.0%	100.0%	99.8%	99.8%	99.8%	99.9%	99.9%	99.9%	99.9%	100.0%	100.0%					>=99%	
Percentage of records submitted nationally with valid NHS number	99.7%	99.8%	99.8%	99.8%	99.8%	99.9%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%					>=99%	

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Trust Scorecard – Well Led (1)

	19/20	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	20/21 Q1	20/21	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	85.0%	83.0%	81.0%	79.0%	80.0%	82.0%	82.0%	83.0%	85.0%	85.0%	85.0%	85.0%	78.0%	80.0%	76.0%		>=90%	<70%
Trust total % mandatory training compliance	92%	92%	92%	91%	91%	92%	92%	90%	90%	90%	90%	90%	90%	91%	90%		>=90%	<70%
Finance																		
Total PayBill Spend		30.7	31.7	30.9	31.5	31.3	31.4	30.1	31.6	30.2	32.5	33.8	34.3	33.2				
YTD Performance against Financial Recovery Plan		.5	.5	.6	.7	.6	.4	.3	.1	1.5	0	-.1	0	0				
Cost Improvement Year to Date Variance		2	2	2	1	1	-2	-2	-4	-8	0	0	0	N/A				
NHSI Financial Risk Rating		3	3	3	3	3	3	3	3	3	3	3	3	N/A				
Capital service		4	4	4	4	4	4	4	4	3	3	3	3	N/A				
Liquidity		4	4	4	4	4	4	4	4	4	4	4	4	N/A				
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3	3	3	3	3	3	3	N/A				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	97.40%	97.40%	95.40%	96.40%	98.40%	99.40%	98.30%	99.30%	98.30%				90.52%	100.77%	90.52%	95.60%	>=75%	<70%
% registered nurse day	98.20%	98.70%	96.50%	97.40%	99.40%	100.70%	98.70%	98.50%	98.10%				89.23%	100.82%	89.23%	94.90%	>=90%	<80%
% unregistered care staff day	100.20%	101.00%	99.40%	98.60%	101.40%	104.20%	98.60%	102.10%	100.20%				110.83%	120.86%	110.83%	115.80%	>=90%	<80%
% registered nurse night	95.70%	94.80%	93.30%	94.50%	96.40%	97.10%	97.50%	100.80%	98.60%				92.99%	100.69%	92.99%	96.90%	>=90%	<80%
% unregistered care staff night	106.20%	105.70%	105.30%	106.70%	108.60%	115.50%	105.40%	107.80%	109.70%				112.80%	131.01%	112.80%	121.70%	>=90%	<80%
Care hours per patient day RN	4.7	4.8	4.7	4.7	4.7	4.8	4.9	4.6	4.7				6.2	5.8	2.1	6	>=5	
Care hours per patient day HCA	3	3	3	2.9	3	3	3	2.9	3				4.5	4.2	1.5	4.4	>=3	
Care hours per patient day total	7.7	7.8	7.6	7.6	7.7	7.8	7.9	7.6	7.7				10.8	10.1	3.6	10.4	>=8	
Vacancy and WTE																		
% total vacancy rate		8.65%	8.60%	7.20%	7.00%	6.95%	7.00%	6.70%	6.15%	6.15%			5.97%	5.14%			<=11.5%	>13%
% vacancy rate for doctors		8.20%	0.53%	2.70%	2.25%	2.80%	2.80%	3.62%	1.24%				4.90%	2.70%			<=5%	>5.5%
% vacancy rate for registered nurses		8.65%	8.65%	8.07%	8.22%	8.30%	8.30%	9.92%	10.26%	10.26%			8.12%	8.44%			<=5%	>5.5%
Staff in post FTE		6171.97	6226.64	6350.1	6358.09	6354.32	6355	6351.41	6387.05	6422.86	6421.87	6549.97	6573.86	6493.56			No target	
Vacancy FTE		652.42	500	492.55	478.95	474.24	475	457.45	418.47	418.47			416.06	358			No target	
Starters FTE		66.66	60.55	147.7	72.72	51.61	69.42	55.75	63.74	44.17	32.81	30.05	57.65	49.45			No target	
Leavers FTE		44.69	46.75	84.63	40.81	47.02	49.37	52.49	36.99	58.37	43.37	46.93	38.57	86.03			No target	
Workforce Expenditure and Efficiency																		
% turnover		11.8%	11.1%	11.9%	11.6%	11.7%	11.5%	11.5%	11.3%	11.1%	10.8%	10.9%	10.4%	10.2%			<=12.6%	>15%
% turnover rate for nursing		10.99%	10.77%	11.40%	11.09%	10.75%	10.93%	11.12%	10.92%	10.73%	10.59%	10.72%	10.14%	9.93%			<=12.6%	>15%
% sickness rate		3.8%	3.9%	3.9%	3.9%	3.9%	4.0%	3.9%	3.9%	3.5%	3.8%	3.8%	3.8%	3.7%			<=4.05%	>4.5%

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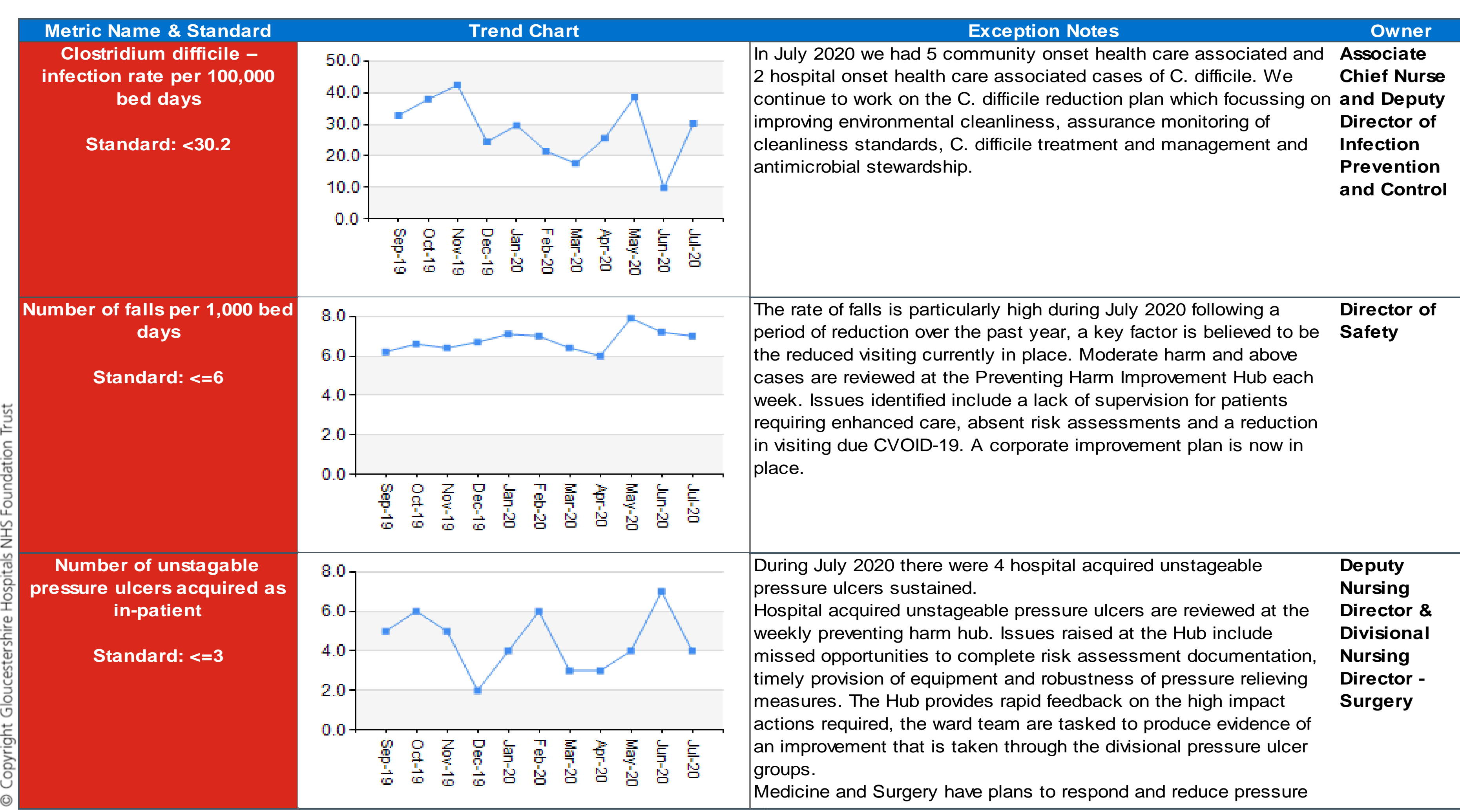
Exception Reports – Safe (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Clostridium difficile – infection rate per 100,000 bed days **Standard: <30.2**		In July 2020 we had 5 community onset health care associated and 2 hospital onset health care associated cases of C. difficile. We continue to work on the C. difficile reduction plan which focussing on improving environmental cleanliness, assurance monitoring of cleanliness standards, C. difficile treatment and management and antimicrobial stewardship.	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of falls per 1,000 bed days **Standard: <=6**		The rate of falls is particularly high during July 2020 following a period of reduction over the past year, a key factor is believed to be the reduced visiting currently in place. Moderate harm and above cases are reviewed at the Preventing Harm Improvement Hub each week. Issues identified include a lack of supervision for patients requiring enhanced care, absent risk assessments and a reduction in visiting due CVOID-19. A corporate improvement plan is now in place.	**Director of Safety**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		During July 2020 there were 4 hospital acquired unstageable pressure ulcers sustained. Hospital acquired unstageable pressure ulcers are reviewed at the weekly preventing harm hub. Issues raised at the Hub include missed opportunities to complete risk assessment documentation, timely provision of equipment and robustness of pressure relieving measures. The Hub provides rapid feedback on the high impact actions required, the ward team are tasked to produce evidence of an improvement that is taken through the divisional pressure ulcer groups. Medicine and Surgery have plans to respond and reduce pressure	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

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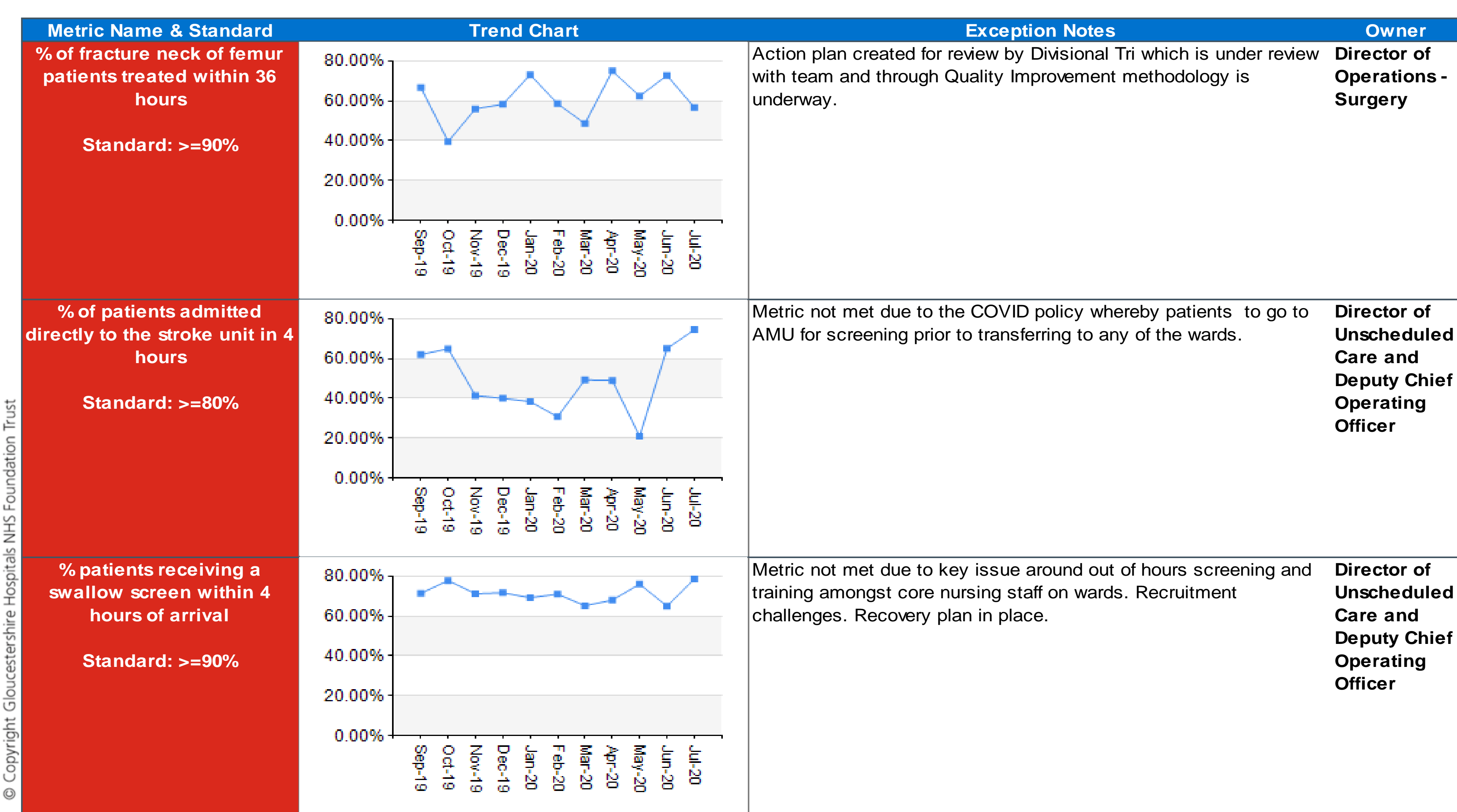
Exception Reports – Effective (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours Standard: >=90%		Action plan created for review by Divisional Tri which is under review with team and through Quality Improvement methodology is underway.	Director of Operations - Surgery
% of patients admitted directly to the stroke unit in 4 hours Standard: >=80%		Metric not met due to the COVID policy whereby patients to go to AMU for screening prior to transferring to any of the wards.	Director of Unscheduled Care and Deputy Chief Operating Officer
% patients receiving a swallow screen within 4 hours of arrival Standard: >=90%		Metric not met due to key issue around out of hours screening and training amongst core nursing staff on wards. Recruitment challenges. Recovery plan in place.	Director of Unscheduled Care and Deputy Chief Operating Officer

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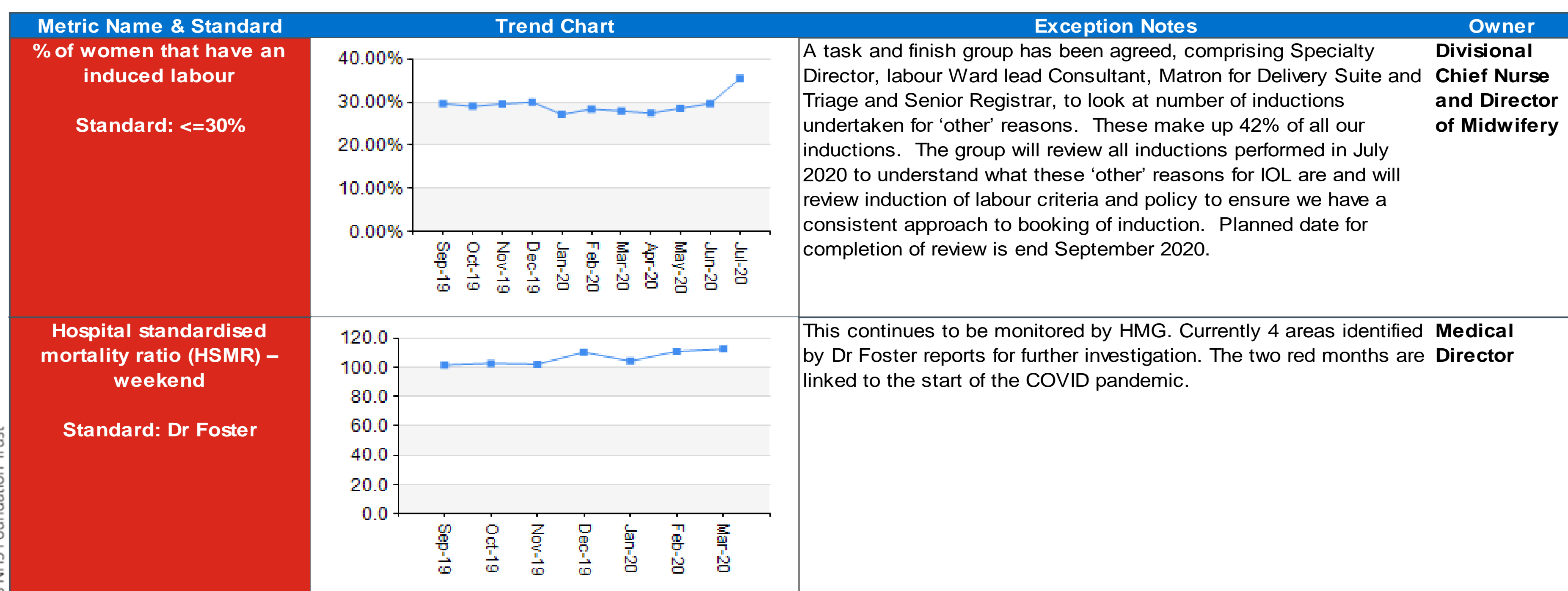
Exception Reports – Effective (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of women that have an induced labour Standard: <=30%		A task and finish group has been agreed, comprising Specialty Director, labour Ward lead Consultant, Matron for Delivery Suite and Triage and Senior Registrar, to look at number of inductions undertaken for 'other' reasons. These make up 42% of all our inductions. The group will review all inductions performed in July 2020 to understand what these 'other' reasons for IOL are and will review induction of labour criteria and policy to ensure we have a consistent approach to booking of induction. Planned date for completion of review is end September 2020.	**Divisional Chief Nurse and Director of Midwifery**
Hospital standardised mortality ratio (HSMR) – weekend Standard: Dr Foster		This continues to be monitored by HMG. Currently 4 areas identified by Dr Foster reports for further investigation. The two red months are linked to the start of the COVID pandemic.	**Medical Director**

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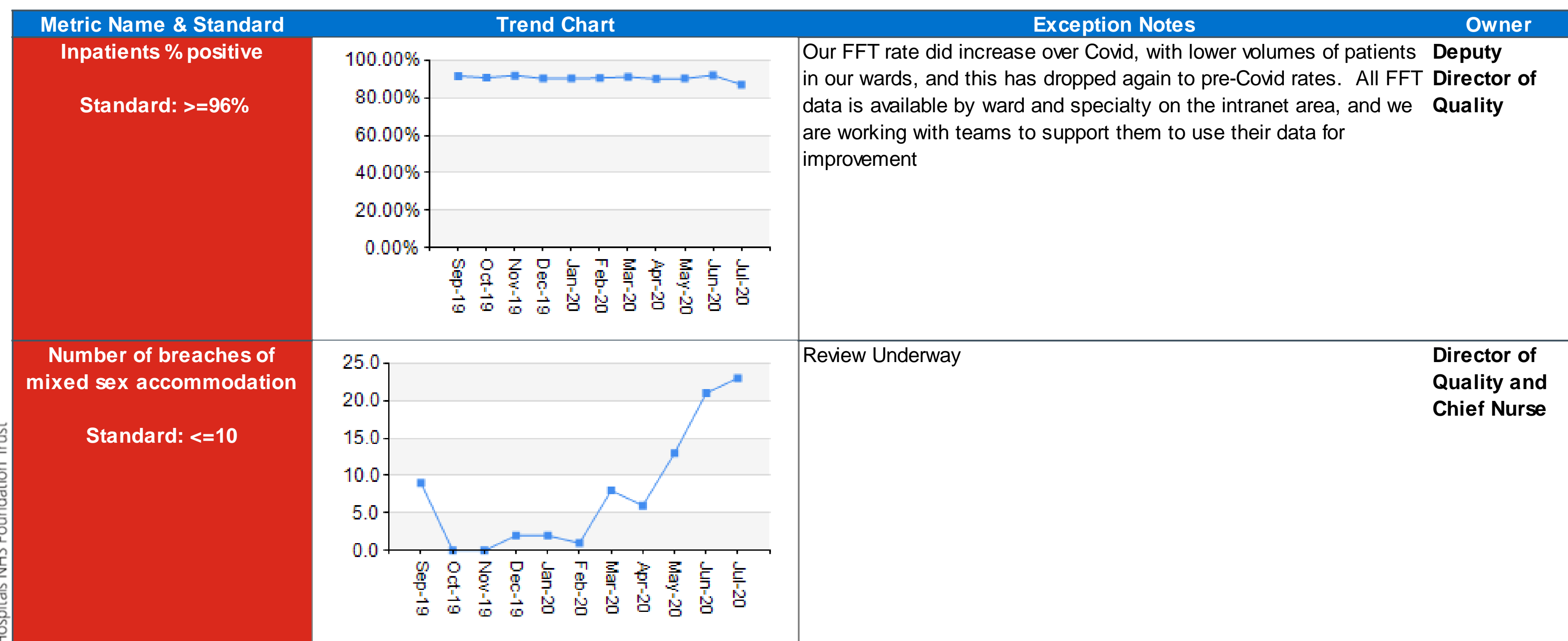
Exception Reports – Caring (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Inpatients % positive Standard: >=96%		Our FFT rate did increase over Covid, with lower volumes of patients in our wards, and this has dropped again to pre-Covid rates. All FFT data is available by ward and specialty on the intranet area, and we are working with teams to support them to use their data for improvement	**Deputy Director of Quality**
Number of breaches of mixed sex accommodation Standard: <=10		Review Underway	**Director of Quality and Chief Nurse**

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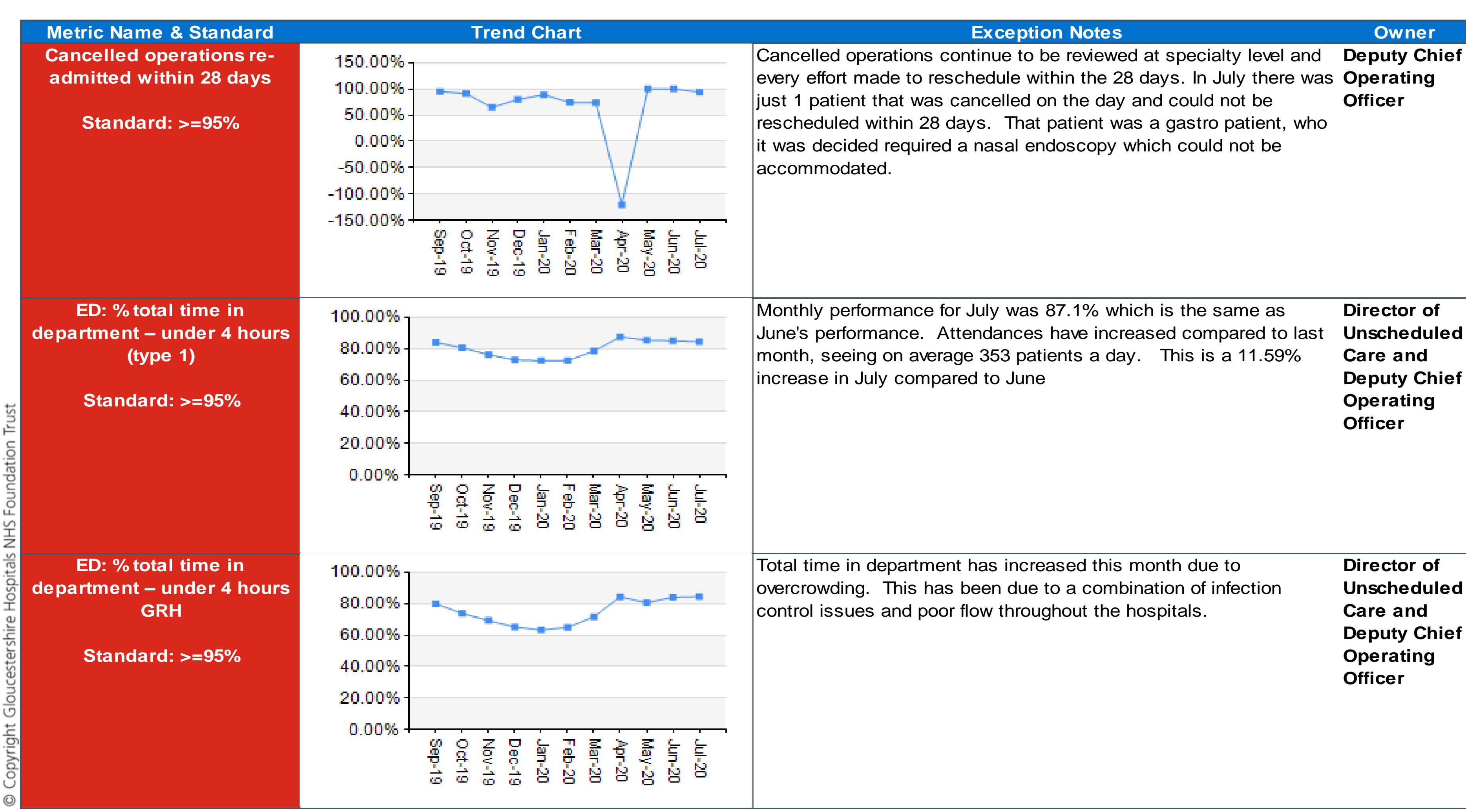
Exception Reports – Responsive (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancelled operations re-admitted within 28 days Standard: >=95%		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In July there was just 1 patient that was cancelled on the day and could not be rescheduled within 28 days. That patient was a gastro patient, who it was decided required a nasal endoscopy which could not be accommodated.	Deputy Chief Operating Officer
ED: % total time in department – under 4 hours (type 1) Standard: >=95%		Monthly performance for July was 87.1% which is the same as June's performance. Attendances have increased compared to last month, seeing on average 353 patients a day. This is a 11.59% increase in July compared to June	Director of Unscheduled Care and Deputy Chief Operating Officer
ED: % total time in department – under 4 hours GRH Standard: >=95%		Total time in department has increased this month due to overcrowding. This has been due to a combination of infection control issues and poor flow throughout the hospitals.	Director of Unscheduled Care and Deputy Chief Operating Officer

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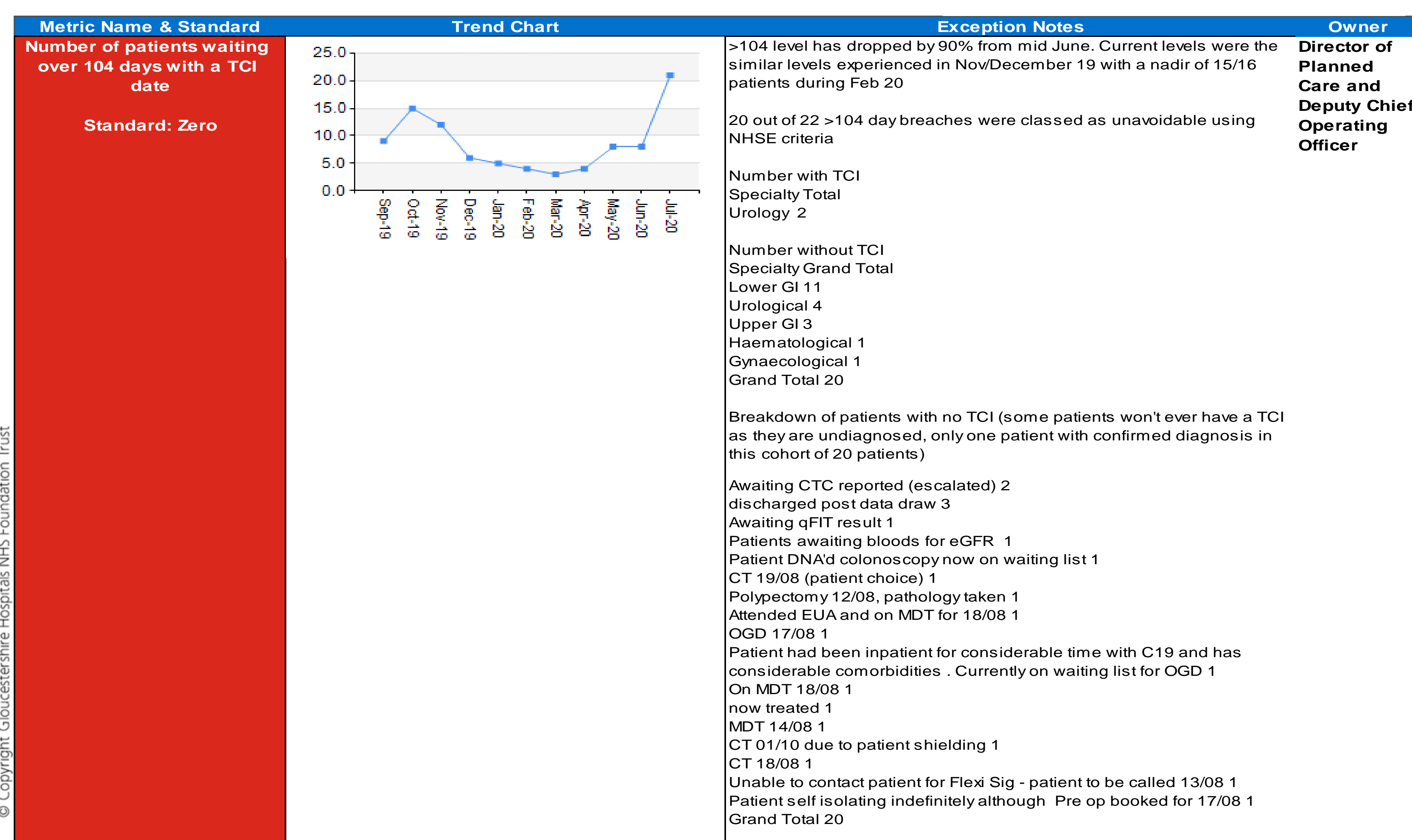
Exception Reports – Responsive (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		>104 level has dropped by 90% from mid June. Current levels were the similar levels experienced in Nov/December 19 with a nadir of 15/16 patients during Feb 20 20 out of 22 >104 day breaches were classed as unavoidable using NHSE criteria Number with TCI Specialty Total Urology 2 Number without TCI Specialty Grand Total Lower GI 11 Urological 4 Upper GI 3 Haematological 1 Gynaecological 1 Grand Total 20 Breakdown of patients with no TCI (some patients won't ever have a TCI as they are undiagnosed, only one patient with confirmed diagnosis in this cohort of 20 patients) Awaiting CTC reported (escalated) 2 discharged post data draw 3 Awaiting qFIT result 1 Patients awaiting bloods for eGFR 1 Patient DNA'd colonoscopy now on waiting list 1 CT 19/08 (patient choice) 1 Polypectomy 12/08, pathology taken 1 Attended EUA and on MDT for 18/08 1 OGD 17/08 1 Patient had been inpatient for considerable time with C19 and has considerable comorbidities . Currently on waiting list for OGD 1 On MDT 18/08 1 now treated 1 MDT 14/08 1 CT 01/10 due to patient shielding 1 CT 18/08 1 Unable to contact patient for Flexi Sig - patient to be called 13/08 1 Patient self isolating indefinitely although Pre op booked for 17/08 1 Grand Total 20	**Director of Planned Care and Deputy Chief Operating Officer**

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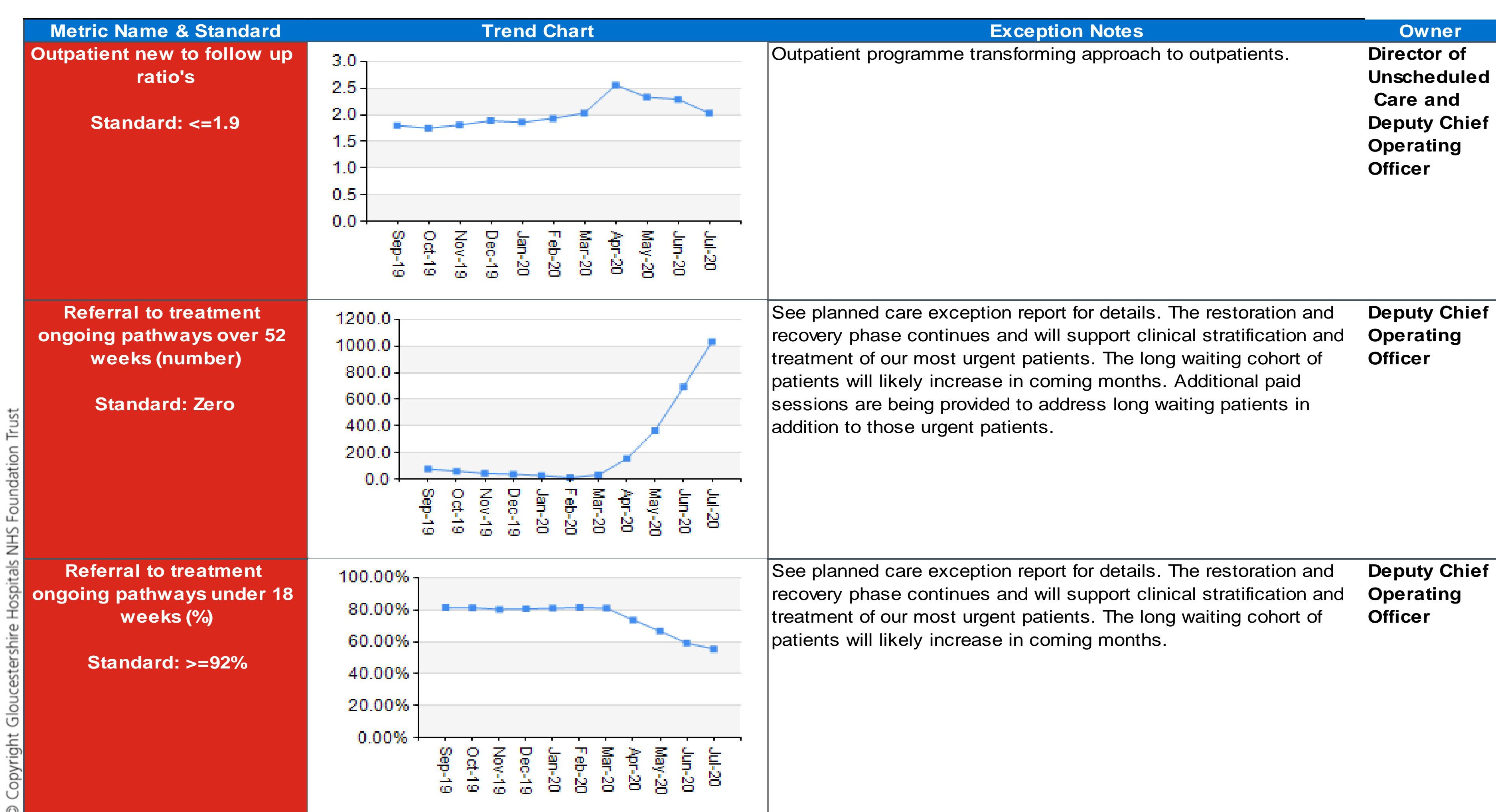
Exception Reports – Responsive (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Outpatient new to follow up ratio's **Standard: <=1.9**		Outpatient programme transforming approach to outpatients.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: Zero**		See planned care exception report for details. The restoration and recovery phase continues and will support clinical stratification and treatment of our most urgent patients. The long waiting cohort of patients will likely increase in coming months. Additional paid sessions are being provided to address long waiting patients in addition to those urgent patients.	**Deputy Chief Operating Officer**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See planned care exception report for details. The restoration and recovery phase continues and will support clinical stratification and treatment of our most urgent patients. The long waiting cohort of patients will likely increase in coming months.	**Deputy Chief Operating Officer**

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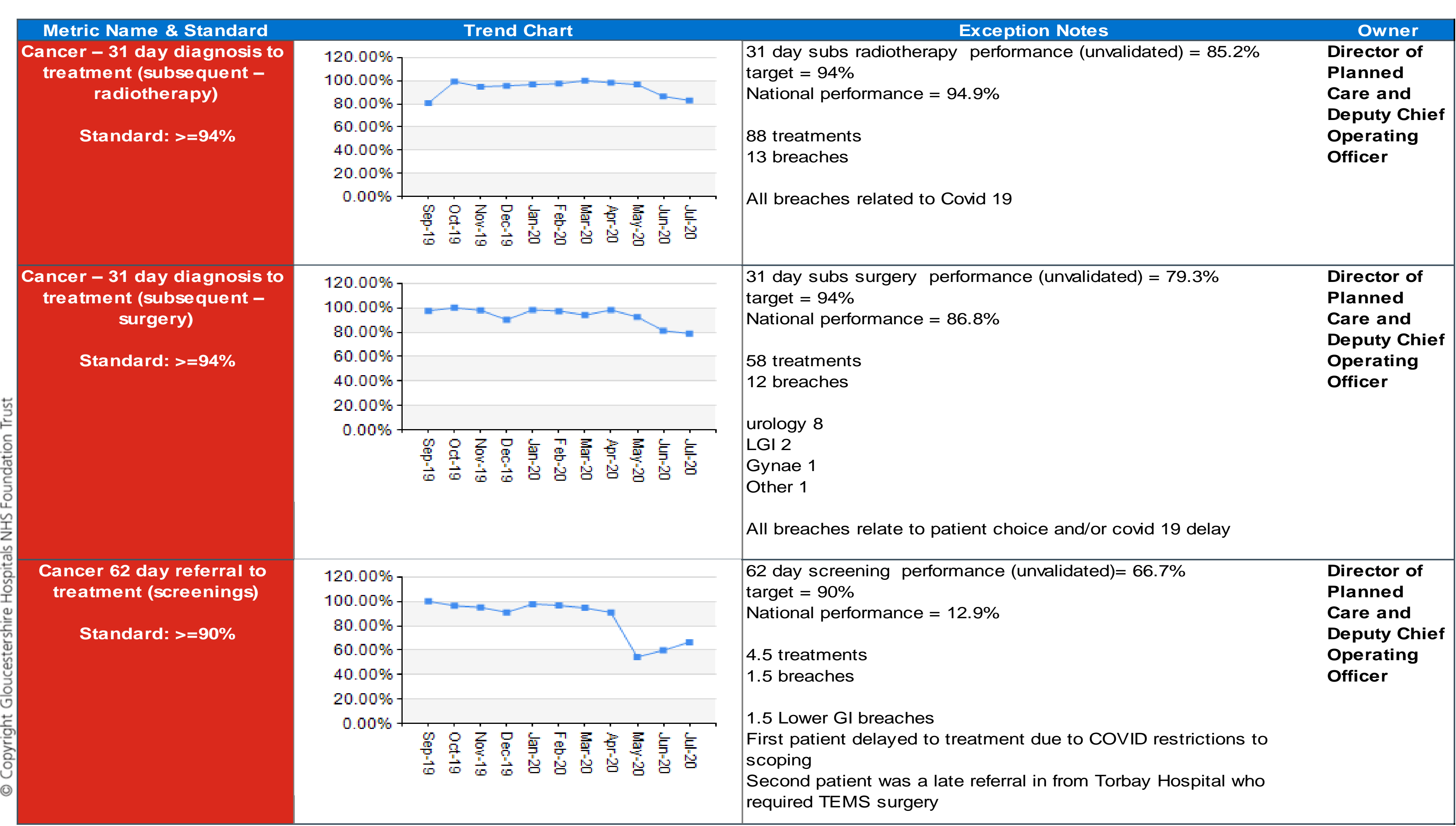
Exception Reports – Responsive (4)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) Standard: >=94%		31 day subs radiotherapy performance (unvalidated) = 85.2% target = 94% National performance = 94.9% 88 treatments 13 breaches All breaches related to Covid 19	Director of Planned Care and Deputy Chief Operating Officer
Cancer – 31 day diagnosis to treatment (subsequent – surgery) Standard: >=94%		31 day subs surgery performance (unvalidated) = 79.3% target = 94% National performance = 86.8% 58 treatments 12 breaches urology 8 LGI 2 Gynae 1 Other 1 All breaches relate to patient choice and/or covid 19 delay	Director of Planned Care and Deputy Chief Operating Officer
Cancer 62 day referral to treatment (screenings) Standard: >=90%		62 day screening performance (unvalidated)= 66.7% target = 90% National performance = 12.9% 4.5 treatments 1.5 breaches 1.5 Lower GI breaches First patient delayed to treatment due to COVID restrictions to scoping Second patient was a late referral in from Torbay Hospital who required TEMS surgery	Director of Planned Care and Deputy Chief Operating Officer

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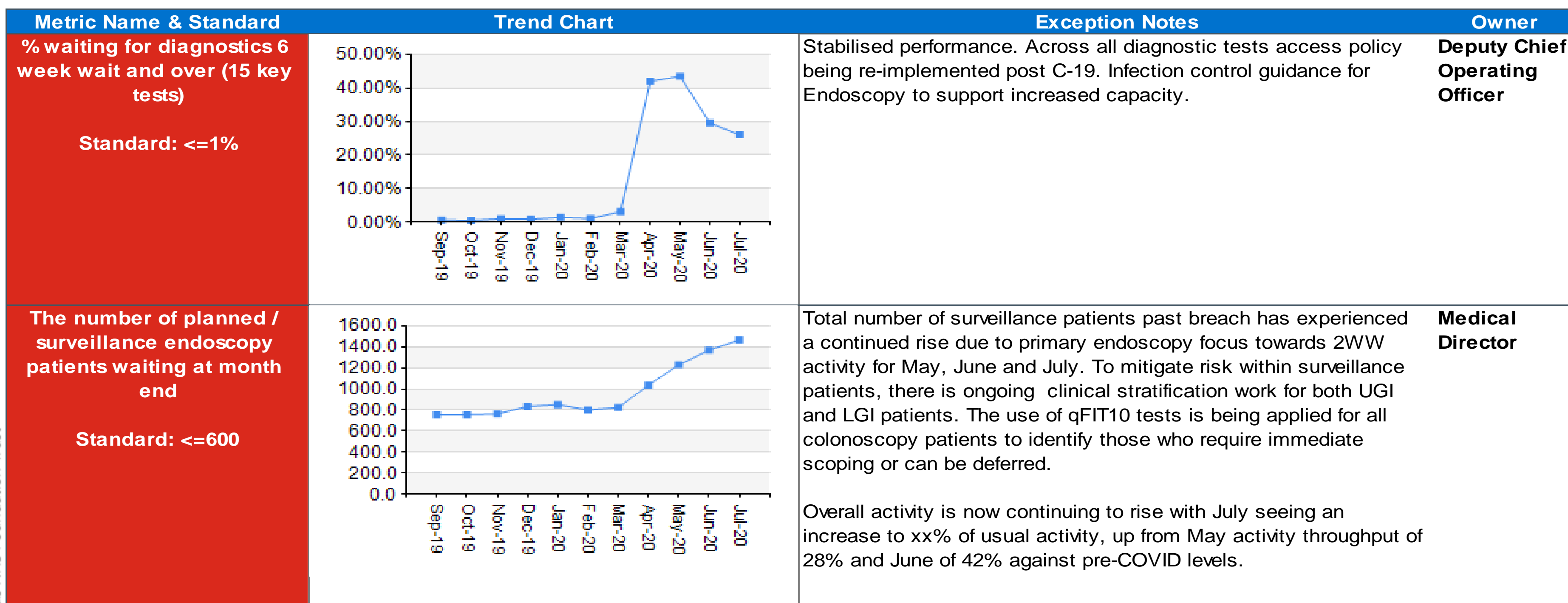
Exception Reports – Responsive (5)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**	50.00% 40.00% 30.00% 20.00% 10.00% 0.00% Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20	Stabilised performance. Across all diagnostic tests access policy being re-implemented post C-19. Infection control guidance for Endoscopy to support increased capacity.	**Deputy Chief Operating Officer**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**	1600.0 1400.0 1200.0 1000.0 800.0 600.0 400.0 200.0 0.0 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20	Total number of surveillance patients past breach has experienced a continued rise due to primary endoscopy focus towards 2WW activity for May, June and July. To mitigate risk within surveillance patients, there is ongoing clinical stratification work for both UGI and LGI patients. The use of qFIT10 tests is being applied for all colonoscopy patients to identify those who require immediate scoping or can be deferred. Overall activity is now continuing to rise with July seeing an increase to xx% of usual activity, up from May activity throughput of 28% and June of 42% against pre-COVID levels.	**Medical Director**

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Benchmarking (1)

Standard (grey dashed line) **England** (dark grey) **Other providers** (blue)
GHT (light blue) **Best in class*** (green)

*Where there is more than one top performing provider, the first in alphabetical order is reported here

Metric	Period	Peer Group	Rank	Quartile
Diagnostics	June-20	15%, 10%, 5%, 0%; Aintree University…, County Durham And…, University Hospitals…, Gloucestershire…, Norfolk And Norwich…, Western Sussex…, Epsom And St Helier…, Oxford University…, South Tees Hospitals…, Worcestershire Acute…, England, Great Western Hospitals…, United Lincolnshire…, Portsmouth Hospitals…, University Hospitals Of…, York Teaching Hospital…	32 / 161	1st
Dementia	February-20	100%, 80%, 60%, 40%, 20%, 0%; Bolton NHS FT, County Durham And…, University Hospitals Of…, South Tees Hospitals…, Great Western Hospitals…, Norfolk And Norwich…, England, Western Sussex…, Oxford University…, York Teaching Hospital…, Gloucestershire…	82 / 82	4th

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Benchmarking (2)

Standard **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	July-20	100%, 95%, 90%, 85%, 80%, 75%, 70%, 65%; Liverpool Women'S…, Gloucestershire…, South Tees Hospitals…, Epsom And St Helier…, Western Sussex…, England, Oxford University…, University Hospitals…, Great Western Hospitals…, University Hospitals Of…, York Teaching Hospital…, County Durham And…, United Lincolnshire…, Norfolk And Norwich…, Worcestershire Acute…	88 / 115	4th
Cancer 62 Days GP Referrals	June-20	100%, 90%, 80%, 70%, 60%; Bridgewater Community…, County Durham And…, Epsom And St Helier…, Great Western Hospitals…, University Hospitals…, South Tees Hospitals…, York Teaching Hospital…, Portsmouth Hospitals…, England, Western Sussex…, Norfolk And Norwich…, United Lincolnshire…, Gloucestershire…, University Hospitals Of…, Oxford University…, Worcestershire Acute…	60 / 139	2nd

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Benchmarking (3)

Standard — **England** — **Other providers**
GHT — **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

Metric	Period	Peer Group	Rank	Quartile
RTT	June-20	100% 90% 80% 70% 60% Berkshire Healthcare... County Durham And... University Hospitals Of... Epsom And St Helier... England South Tees Hospitals... University Hospitals... United Lincolnshire... Western Sussex... Norfolk And Norwich... Portsmouth Hospitals... Great Western Hospitals... Oxford University... Gloucestershire... Worcestershire Acute... York Teaching Hospital...	54 / 158	2nd
VTE (published quarterly)	December-1	100.00% 98.00% 96.00% 94.00% 92.00% 90.00% 88.00% 86.00% Cambridgeshire And... Great Western Hospitals... Norfolk And Norwich... Oxford University... County Durham And... United Lincolnshire... University Hospitals... York Teaching Hospital... Worcestershire Acute... Western Sussex... Gloucestershire... University Hospitals Of... Portsmouth Hospitals... England South Tees Hospitals... Epsom And St Helier...	116 / 149	4th

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Benchmarking (4)

Standard (dashed grey line) **England** (dark grey) **Other providers** (blue)
GHT (light blue) **Best in class*** (green)

*Where there is more than one top performing provider, the first in alphabetical order is reported here

Metric	Period	Peer Group	Rank	Quartile
FFT - ED	February-20	100%, 90%, 80%, 70%, 60% Yeovil District Hospital…, County Durham And…, Western Sussex…, Norfolk And Norwich…, Portsmouth Hospitals…, Oxford University…, University Hospitals Of…, Epsom And St Helier…, Worcestershire Acute…, England, South Tees Hospitals…, United Lincolnshire…, Gloucestershire…, York Teaching Hospital…, University Hospitals…, Great Western Hospitals…	109 / 131	4th
FFT - Inpatient	February-20	100.00%, 90.00%, 80.00%, 70.00%, 60.00% Birmingham Women'S…, County Durham And…, Portsmouth Hospitals…, University Hospitals Of…, Western Sussex…, York Teaching Hospital…, South Tees Hospitals…, England, Norfolk And Norwich…, Oxford University…, Worcestershire Acute…, Epsom And St Helier…, Great Western Hospitals…, United Lincolnshire…, University Hospitals…, Gloucestershire…	135 / 144	4th

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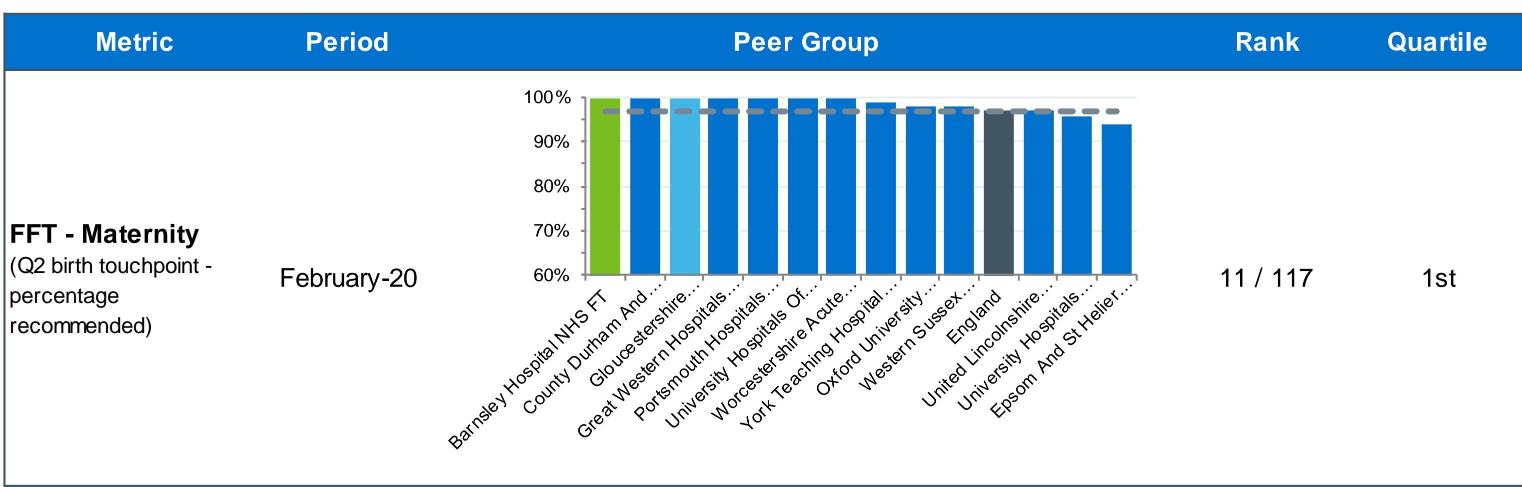
Benchmarking (5)

Standard - - - - **England** **Other providers**
GHT **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

Metric	Period	Peer Group	Rank	Quartile
FFT - Maternity (Q2 birth touchpoint - percentage recommended)	February-20		11 / 117	1st

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Quality and Performance Report Statistical Process Control Reporting

Reporting Period July 2020

Presented at August 2020 Q&P and September 2020 Trust Board

Contents

Contents	2
Guidance	3
Executive Summary	4
Access	5
Quality	27
Financial	41
People & OD Risk Rating	42

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Guidance

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

How to interpret variation results:

- Variation results show the trends in performance over time
- Trends either show **special cause variation** or **common cause variation**
- **Special cause variation: Orange icons** indicate **concerning** special cause variation requiring action
- **Special cause variation: Blue icons** indicate where there appears to be **improvements**
- **Common cause variation: Grey icons** indicate **no significant change**

How to interpret assurance results:

- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey icons** indicate that **sometimes the target will be achieved and sometimes it will be missed**

Source: NHSI Making Data Count

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Executive Summary

The key areas of focus remain the assurance of patient care and safety during this time. Key reductions in non-urgent elective care took place in March to support organisational response to Covid-19 and continued into July. This has led to a number of changes and opportunities to deliver patient care in an enhanced way. The Trust through support of IM&T colleagues has embraced remote working with our patients & with Primary Care. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. During this time we also enacted a CAS to support primary care and remain open for referrals requiring a secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients.

A review and recovery plan is being formulated with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety.

During July the Trust did meet the national standards for 62 day cancer standard but did not meet the national standards for 52 week waits, diagnostics and the 4 hour standard.

The Trust performance (type 1) for the 4 hour standard in July was 84.46%, against the STP trajectory of 85.90%. The system did meet the delivery of 90% for the system in July, at 90.05%. Note that the July performance targets / trajectories have not been formally agreed as the Operating Plan process was paused due to C-19, we have therefore taken the appropriate performance target from the national or previous local target where applicable.

The Trust did not meet the diagnostics standard for July at 26.07%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests.

The Trust met the standard for 2 week wait cancer at 96.50% in July, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 55.36% in July, work continues to ensure that the performance is stabilised. Significant work is underway to reduce our longest waiting patients of over 52 weeks, of which there were 1,033 in July. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.
The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics with the Divisions providing exception reports. The delivery of any action plans to deliver improvement are also reviewed within the meeting. There are improvement plans in place for any indicators that have consistently scored in the “red” target area.

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Access Dashboard

This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer – 28 day FDS two week wait	TBC	Jul-20	79.9%
Cancer	Cancer – 28 day FDS breast symptom two week wait	TBC	Jul-20	99.1%
Cancer	Cancer – 28 day FDS screening referral	TBC	Jul-20	100.0%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Jul-20	96.5%
Cancer	2 week wait breast symptomatic referrals	>=93%	Jul-20	96.4%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Jul-20	98.1%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Jul-20	97.0%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Jul-20	78.9%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Jul-20	83.0%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Jul-20	85.6%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Jul-20	66.7%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Jul-20	91.7%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Jul-20	21
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Jun-20	66
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Jul-20	26.07%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Jul-20	1,465
Discharge	Number of patients delayed at the end of each month	<=38	Jul-20	11
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Jun-20	60.2%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Jul-20	84.46%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Jul-20	90.05%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Jul-20	99.85%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Jul-20	87.10%
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Jul-20	0
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Jul-20	72.5%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Jul-20	44.5%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Jul-20	2.04%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Jul-20	0.03%
Maternity	% of women booked by 12 weeks gestation	>90%	Jul-20	93.0%
Operational Efficiency	Number of patients stable for discharge	<=70	Jul-20	66
Operational Efficiency	% of bed days lost due to delays	<=3.5%	Jul-20	2.00%
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Jul-20	288
Operational Efficiency	Average length of stay (spell)	<=5.06	Jul-20	4.7
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Jul-20	5.15
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Jul-20	2.47
Operational Efficiency	% day cases of all electives	>80%	Jul-20	81.73%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Jul-20	87.3%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Jul-20	94.00%
Operational Efficiency	Urgent cancelled operations	No target	Jul-20	11
Outpatient	Outpatient new to follow up ratio's	<=1.9	Jul-20	2.03
Outpatient	Did not attend (DNA) rates	<=7.6%	Jul-20	5.50%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Jun-20	7.1%
Research	Research accruals	No target	Feb-20	98

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Access Dashboard

This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Jul-20	55.36%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Jul-20	6250	
RTT	Referral to treatment ongoing pathways 40+ Weeks (number)	No target		Jul-20	4463	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Jul-20	1033	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=50%		Jul-20	63.5%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=80%		Jun-20	84.0%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=80%		Jul-20	74.5%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=90%		Jul-20	78.6%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		May-20	100.0%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		May-20	99.8%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Jul-20	56.7%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Jul-20	56.7%	

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Cancer – 31 day diagnosis to treatment (first treatments) - GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

31 day new performance (unvalidated) = 97.8%
target = 96%
National performance = 93.7%

- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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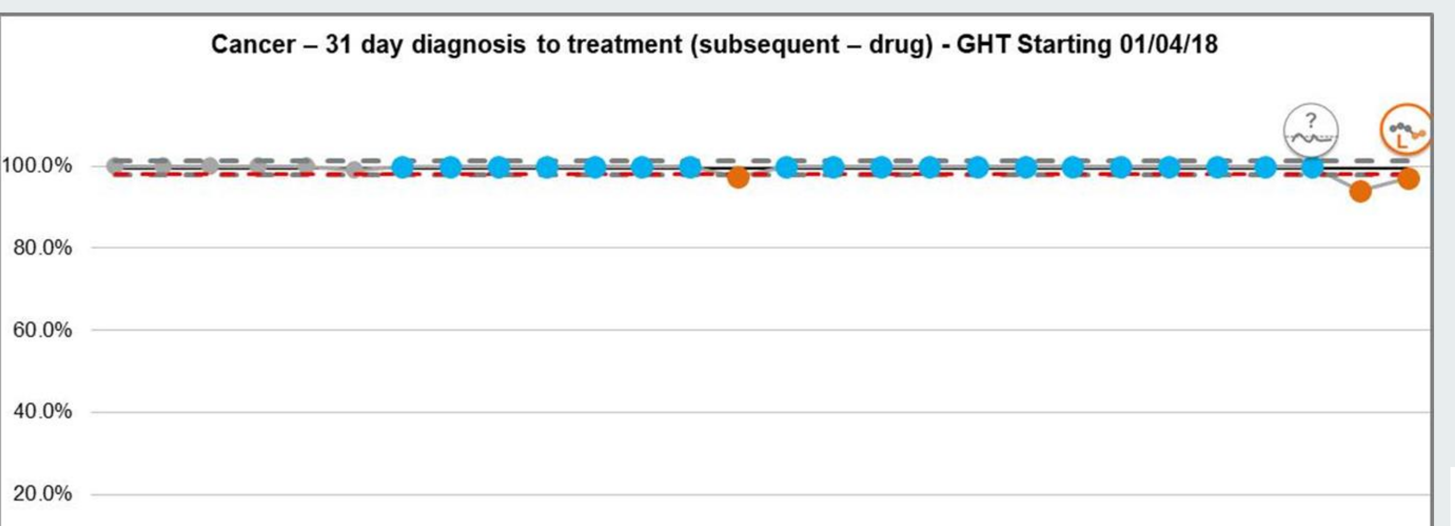

Commentary

31 day subs chemotherapy performance (unvalidated)= 100.0%
target = 98%
National performance = 98.7%

- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

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Cancer – 31 day diagnosis to treatment (subsequent – surgery) - GHT Starting 01/04/18

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Commentary

31 day subs surgery performance (unvalidated) = 79.3%
target = 94%
National performance = 86.8%

58 treatments & 12 breaches
All breaches relate to patient choice and/or covid 19 delay:
Urology 8; LGI 2; Gynae 1; Other 1

- Director of Planned Care and Deputy Chief Operating Officer

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Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Commentary

31 day subs radiotherapy performance (unvalidated) = 85.2%
target = 94%
National performance = 94.9%

88 treatments & 13 breaches

All breaches related to Covid 19

- Director of Planned Care and Deputy Chief Operating Officer

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Cancer 62 day referral to treatment (screenings) - GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

62 day screening performance (unvalidated)= 66.7%
Target = 90%
National performance = 12.9%
4.5 treatments
1.5 breaches
1.5 Lower GI breaches
First patient delayed to treatment due to COVID restrictions to scoping
Second patient was a late referral in from Torbay Hospital who required TEMS surgery
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

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% waiting for diagnostics 6 week wait and over (15 key tests) - GHT Starting 01/04/18

50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Stabilised performance. Across all diagnostic tests access policy being re-implemented post C-19. Infection control guidance for Endoscopy to support increased capacity.

- Director of Planned Care and Deputy Chief Operating Officer

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The number of planned / surveillance endoscopy patients waiting at month end - GHT Starting 01/04/18

1,400
1,200
1,000
800
600
400
200
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Total number of surveillance patients past breach has experienced a continued rise due to primary endoscopy focus towards 2WW activity for May, June and July. To mitigate risk within surveillance patients, there is ongoing clinical stratification work for both UGI and LGI patients. The use of qFIT10 tests is being applied for all colonoscopy patients to identify those who require immediate scoping or can be deferred.

Overall activity is now continuing to rise with July seeing an increase to xx% of usual activity, up from May activity throughput of 28% and June of 42% against pre-COVID levels.
- Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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Number of patients delayed at the end of each month - GHT Starting 01/04/18

60
50
40
30
20
10
0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

OCT are carrying out weekly 21 & 14 day reviews with the divisions. There have been a number of complex discharges involving funding requirements, complex care needs and family dispute. Where appropriate the Choice Policy has been exercised and letter B's issued. Twice weekly meeting s with System partners focus on 'unblocking' specific patients by escalating within the System

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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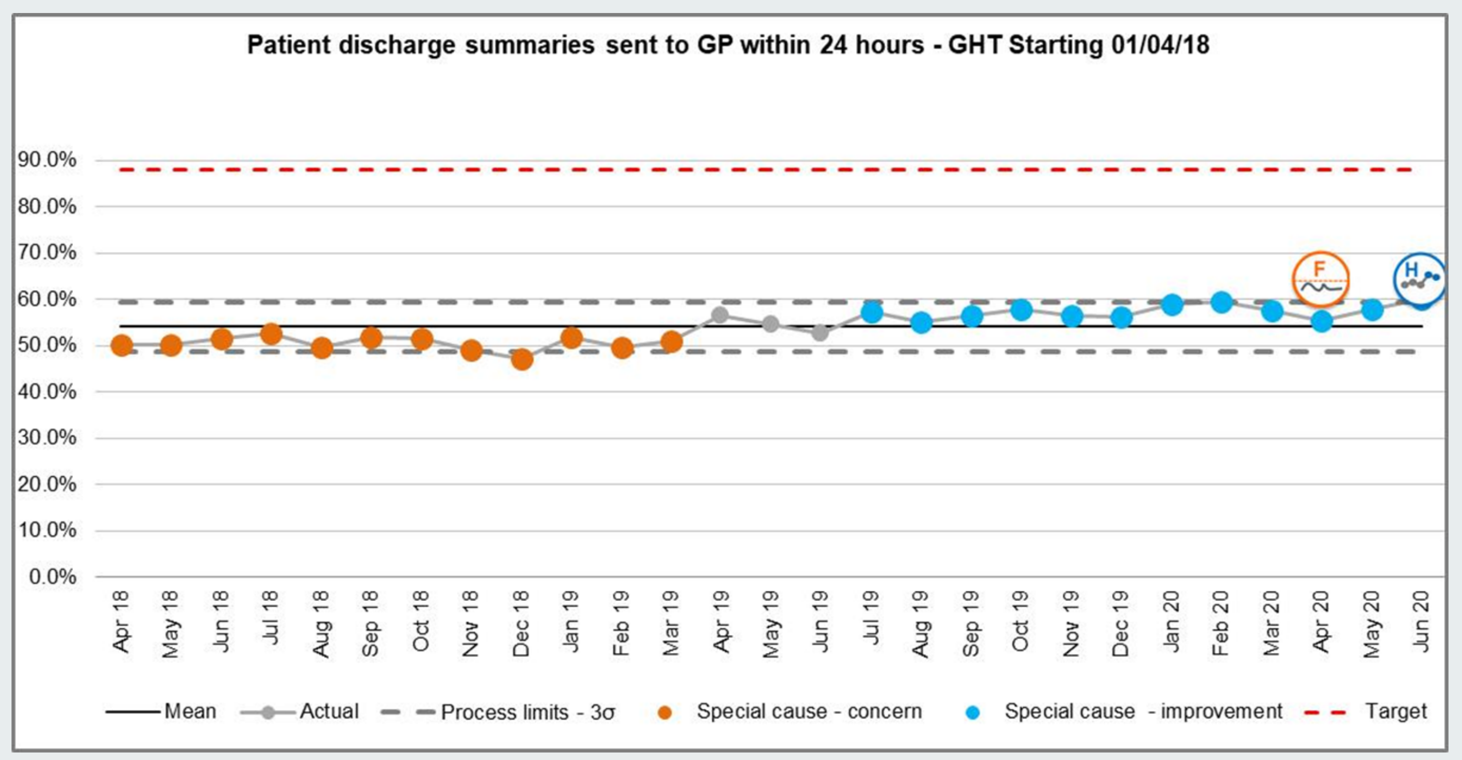

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Results remain disappointing. Currently these are being presented at divisional executive reviews to raise the profile. Reports are being generated for wards and individual patients to improve engagement. Further work in progress to target new junior doctors.

- Medical Director

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ED: % total time in department – under 4 hours CGH - GHT Starting 01/04/18

Commentary

Review Underway

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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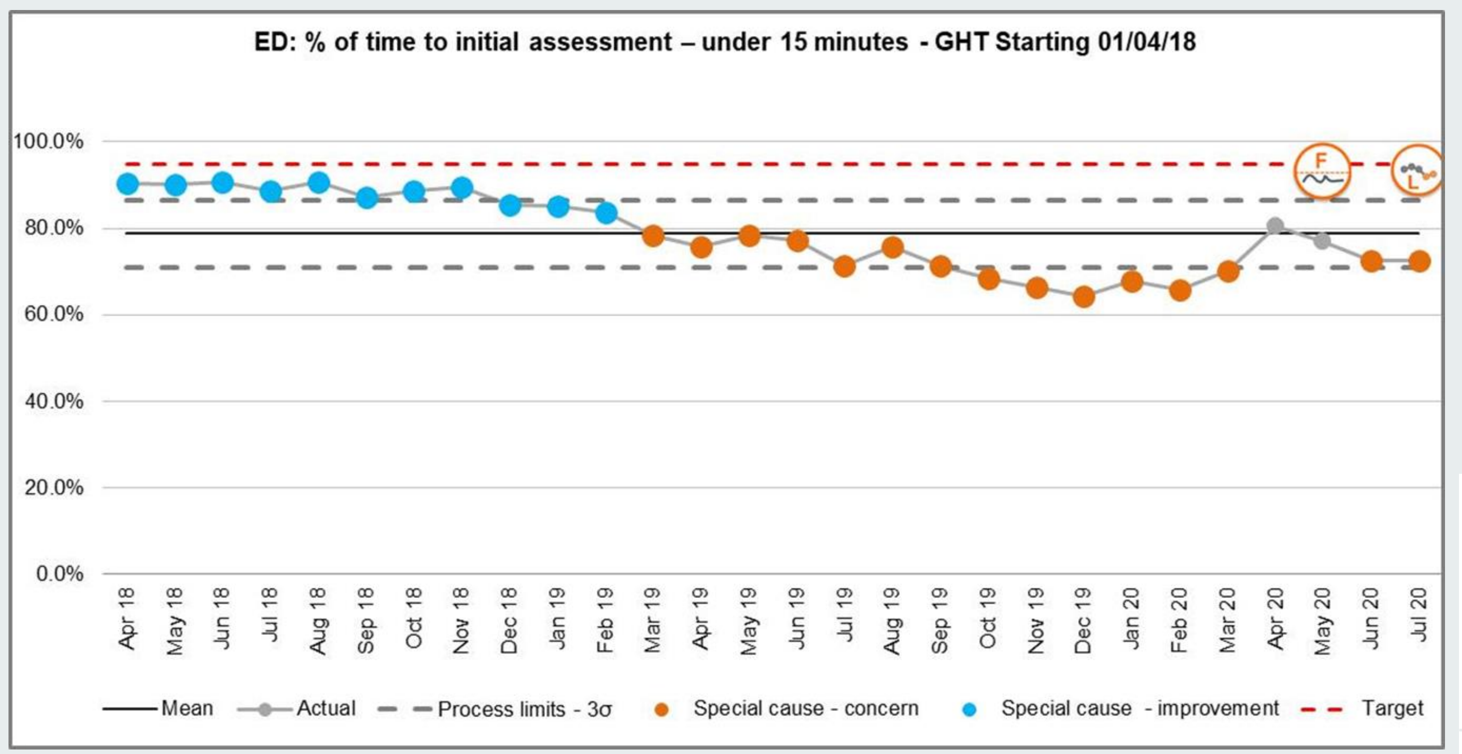

Commentary

93.32% performance for ambulances - Performance has decreased marginally in GRH compared with the previous month. Maintaining walk-in triage remains challenging due to patient numbers, space and the number of trained staff available to triage. Increased triage capacity is being reviewed in August

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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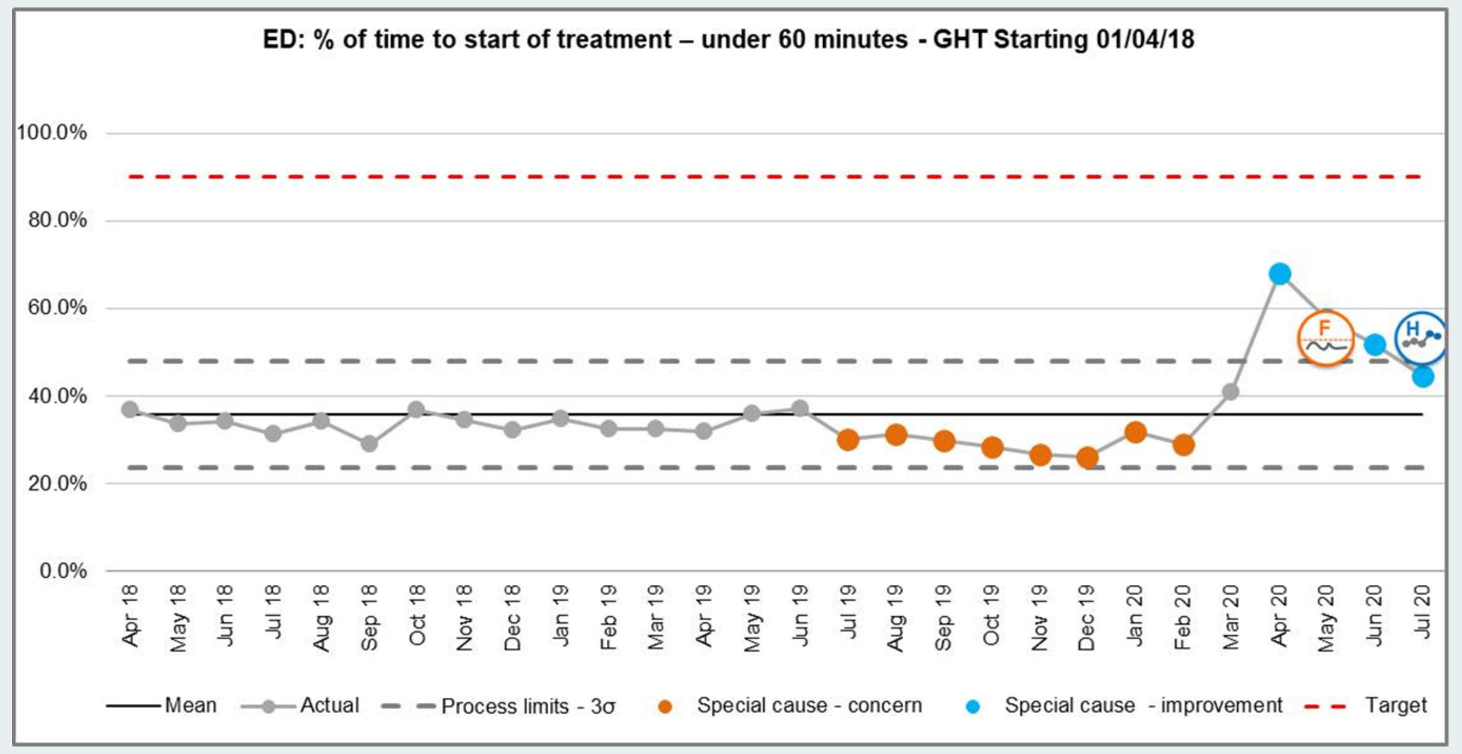

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Average doctor wait has increased in month which reflects the challenges seen in the department throughout the month. The waiting time to see a doctor has increased by 4 minutes in month.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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% of women booked by 12 weeks gestation - GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Review Underway

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

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Number of stranded patients with a length of stay of greater than 7 days - GHT Starting 01/04/18

Commentary

Work with system partners to address patients. Specific work programme for patients over 21 days.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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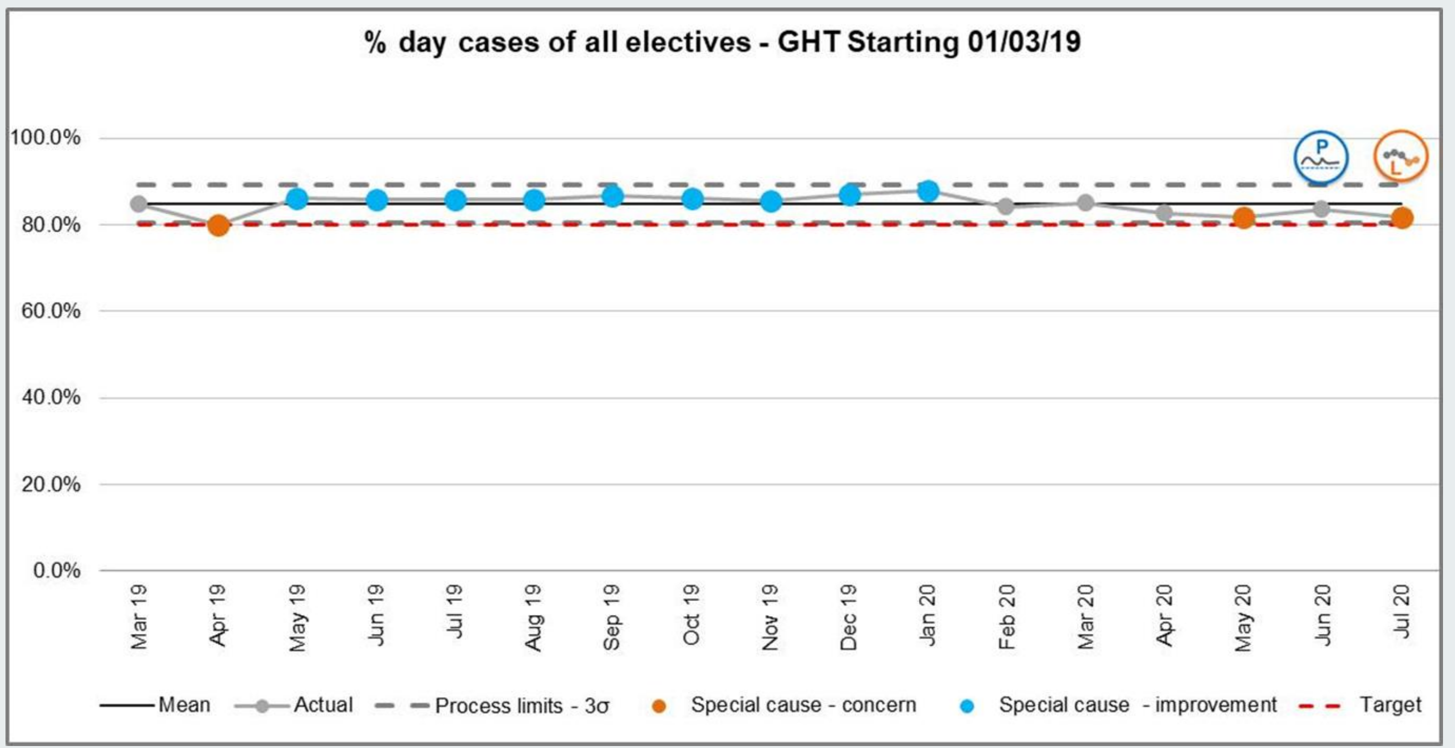

Commentary

The Trust is working to support an increase in all electives both DC and inpatient according to clinical need. We note there were some coding changes between years but still recognise the requirement to increase elective activity. We need to also include the IS data to the figures.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

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Urgent cancelled operations - GHT Starting 01/04/19

10
8
6
4
2
0

Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20

Mean Actual Process limits - 3σ Special cause - concern Special cause - improvement Target

Commentary

3 cancellations due to emergency cases which were unavoidable

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.

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Access:
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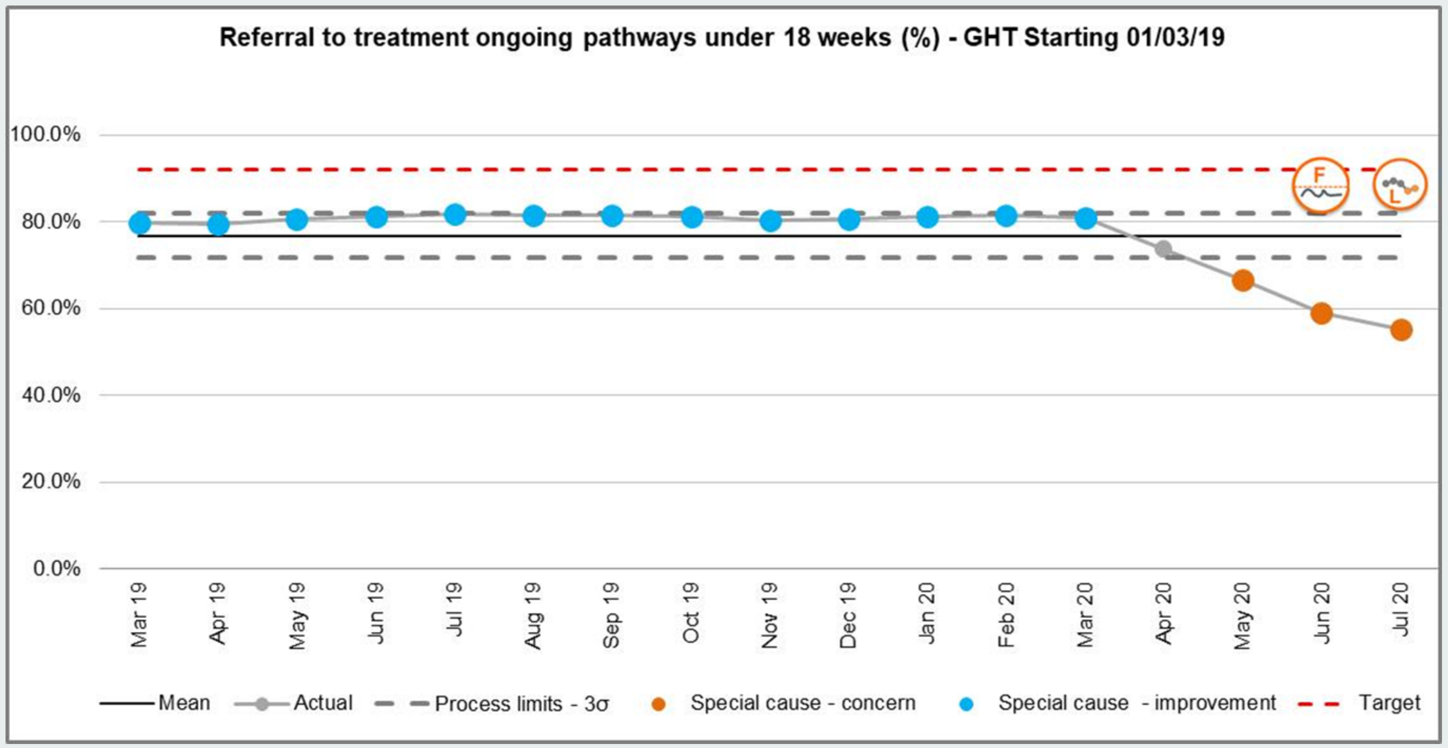

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

See planned care exception report for details. The restoration and recovery phase continues and will support clinical stratification and treatment of our most urgent patients. The long waiting cohort of patients will likely increase in coming months.

- Deputy Chief Operating Officer

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Referral to treatment ongoing pathways 35+ Weeks (number) - GHT Starting 01/03/19

6,000
5,000
4,000
3,000
2,000
1,000
0

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Recovery and restoration underway.

- Deputy Chief Operating Officer

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Access:
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Referral to treatment ongoing pathways 40+ Weeks (number) - GHT Starting 01/03/19

4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Commentary

See planned care exception report. Restoration and recovery underway.

- Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

Referral to treatment ongoing pathways over 52 weeks (number) - GHT Starting 01/04/18

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Commentary

See planned care exception report for details. The restoration and recovery phase continues and will support clinical stratification and treatment of our most urgent patients. The long waiting cohort of patients will likely increase in coming months. Additional paid sessions are being provided to address long waiting patients in addition to those urgent patients.

- Deputy Chief Operating Officer

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Quality Dashboard

This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance			Variation		
Consistently hit target	Hit and miss target subject to random	Consistently fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Jun-20	68.0%
Dementia Screening	% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic	>=90%	Mar-20	0%
Dementia Screening	% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were	>=90%	Dec-19	0%
Friends & Family Test	Inpatients % positive	>=96%	Jul-20	87.0%
Friends & Family Test	ED % positive	>=84%	Jul-20	81.8%
Friends & Family Test	Maternity % positive	>=97%	Jul-20	100.0%
Friends & Family Test	Outpatients % positive	>=94%	Jul-20	93.7%
Friends & Family Test	Total % positive	>=93%	Jul-20	91.3%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Jul-20	0
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Jul-20	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2019/20: 114	Jul-20	7
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jul-20	5
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jul-20	2
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Jul-20	30.3
Infection Control	Number of MSSA bacteraemia cases	<=8	Jul-20	1
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Jul-20	4.3
Infection Control	Number of ecoli cases	No target	Jul-20	4
Infection Control	Number of pseudomona cases	No target	Jul-20	0
Infection Control	Number of klebsiella cases	No target	Jul-20	1
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Jul-20	4

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	TBC	Jul-20	5
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	TBC	Jul-20	1
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	TBC	Jul-20	1
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	TBC	Jul-20	1
Inpatient Questions	How much information about your condition or treatment or care has been given to you?	>=90%	Mar-20	78%
Inpatient Questions	Are you involved as much as you want to be in decisions about your care and treatment?	>=90%	Mar-20	92%
Inpatient Questions	Do you feel that you are treated with respect and dignity?	>=90%	Mar-20	100%
Inpatient Questions	Do you feel well looked after by staff treating or caring for you?	>=90%	Mar-20	99%
Inpatient Questions	Do you get enough help from staff to eat your meals?	>=90%	Mar-20	67%
Inpatient Questions	In your opinion, how clean is your room or the area that you receive treatment in?	>=90%	Mar-20	100%
Inpatient Questions	Do you get enough help from staff to wash or keep yourself clean?	>=90%	Mar-20	86%
Maternity	% C-section rate (planned and emergency)	<=27%	Jul-20	26.51%
Maternity	% emergency C-section rate	No target	Jul-20	12.7%
Maternity	% of women smoking at delivery	<=14.5%	Jul-20	9.39%
Maternity	% of women that have an induced labour	<=30%	Jul-20	35.5%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Jul-20	0.42%
Maternity	% of women on a Continuity of Carer pathway	No target	Jul-20	0.0%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Feb-20	1.1
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Mar-20	108
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Mar-20	112.7
Mortality	Number of inpatient deaths	No target	Jul-20	120

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Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Mortality	Number of deaths of patients with a learning disability	No target	Jul-20	1
MSA	Number of breaches of mixed sex accommodation	<=10	Jul-20	23
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Jul-20	0
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Jul-20	7
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Jul-20	3
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Jul-20	2
Patient Safety Incidents	Medication error resulting in severe harm	No target	Jul-20	0
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Jul-20	6
Patient Safety Incidents	Medication error resulting in low harm	No target	Jul-20	8
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Jul-20	9
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Jul-20	1
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Jul-20	0
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Jul-20	4
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Jul-20	2
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Mar-20	68%
RIDDOR	Number of RIDDOR	SPC	Jul-20	3
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%
Serious Incidents	Number of never events reported	Zero	Jul-20	0
Serious Incidents	Number of serious incidents reported	No target	Jul-20	2
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Jul-20	100.0%
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Jul-20	100%
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Jul-20	93.8%

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Quality:
SPC – Special Cause Variation

% of patients who have been screened for dementia (within 72 hours) - GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 10 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Commentary

June compliance 68% shows a steady increase of 5% from May 20. The manual audit process to work around the Trac constraints has been able to respond effectively to the first of the 3 reported measures in 2019/20 and will continue for 2020/21. The ongoing remedial action is committed to improving the outcomes for patients living with dementia by early recognition and identification of delirium; in additional to continuing the manual audit, a QI project is now being established to develop, improve and test the Trust's delirium pathway which will include training as well as exploring options on Electronic Patient Records to improve the current data collection process.

- Deputy Chief Nurse

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Quality:
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Inpatients % positive - GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

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Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Our FFT rate did increase over Covid, with lower volumes of patients in our wards, and this has dropped again to pre-Covid rates. All FFT data is available by ward and specialty on the intranet area, and we are working with teams to support them to use their data for improvement

- Deputy Director of Quality

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line

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Quality:
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Maternity % positive - GHT Starting 01/04/18

140.0%
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

We are reviewing our approach for FFT in Maternity services, with a mix of survey approaches (email, paper and text) to see if we can increase our response rates and overall satisfaction score

- Deputy Director of Quality

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.

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Quality:
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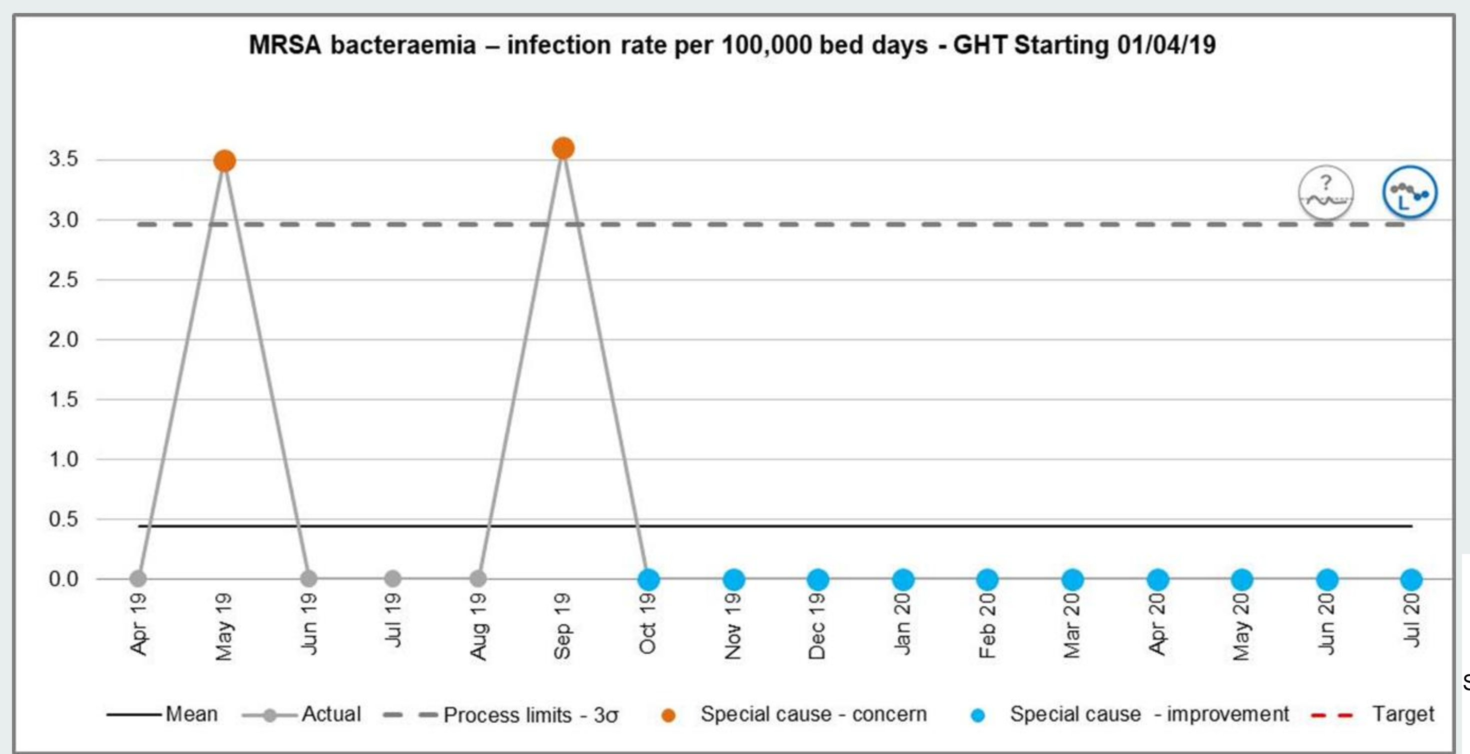

Commentary

Zero bacteraemia cases were recorded In July 2020. Gram positive bacteraemia reductions remain a priority within the IPC annual programme particularly related to improving intravenous access device care, root cause analysis of cases and MRSA screening and decolonisation.

- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
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Quality:
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Number of MSSA bacteraemia cases - GHT Starting 01/04/18

14
12
10
8
6
4
2
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

One bacteraemia case was recorded in July 2020. Gram positive bacteraemia reductions remain a priority within the IPC annual programme particularly related to improving intravenous access device care.

- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

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Quality:
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Number of klebsiella cases - GHT Starting 01/04/18

10
8
6
4
2
0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Commentary

One bacteraemia case was recorded In July 2020. Gram negative bacteraemia reductions remain a priority within the IPC annual programme; particularly related to UTI diagnosis and management and urinary catheter care and removal .

- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

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Quality:
SPC – Special Cause Variation

% of women that have an induced labour - GHT Starting 01/03/19

50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

A task and finish group has been agreed, comprising Specialty Director, labour Ward lead Consultant, Matron for Delivery Suite and Triage and Senior Registrar, to look at number of inductions undertaken for 'other' reasons. These make up 42% of all our inductions. The group will review all inductions performed in July 2020 to understand what these 'other' reasons for IOL are and will review induction of labour criteria and policy to ensure we have a consistent approach to booking of induction. Planned date for completion of review is end September 2020.

- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.

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Number of breaches of mixed sex accommodation - GHT Starting 01/04/18

20
15
10
5
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Commentary

Review Underway

- Deputy Nursing Director & Divisional Nursing Director - Surgery

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Quality:
SPC – Special Cause Variation

Number of patient safety alerts outstanding - GHT Starting 01/04/19

5
4
3
2
1
0

Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

All alerts are now closed

- Director of Safety

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

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Number of falls resulting in harm (moderate/severe) - GHT Starting 01/04/18

Month	Actual
Apr 18	10
May 18	8
Jun 18	7
Jul 18	11
Aug 18	6
Sep 18	9
Oct 18	8
Nov 18	6
Dec 18	8
Jan 19	8
Feb 19	2
Mar 19	7
Apr 19	3
May 19	4
Jun 19	2
Jul 19	7
Aug 19	1
Sep 19	5
Oct 19	7
Nov 19	1
Dec 19	4
Jan 20	5
Feb 20	5
Mar 20	0
Apr 20	2
May 20	4
Jun 20	4
Jul 20	3

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Performance is as expected with continued sustained improvement.

- Director of Safety

Data Observations

Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.

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Quality:
SPC – Special Cause Variation

Number of category 3 pressure ulcers acquired as in-patient - GHT Starting 01/04/19

10
8
6
4
2
0

Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | Jun 20 | Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Commentary

Performance is as expected with continued sustained improvement.

- Deputy Nursing Director & Divisional Nursing Director - Surgery

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Quality:
SPC – Special Cause Variation

Serious incidents – 72 hour report completed within contract timescale - GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Rule 4	When more than 15 consecutive points lie within the mean +/- 1σ this process is considered to be out of control.

Commentary

All serious incidents reported in time

- Director of Safety

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Financial Dashboard

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

This dashboard shows the most recent performance of metrics in the Financial category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend	Jul-20	33.2	
Finance	YTD Performance against Financial Recovery Plan	Jul-20	0	
Finance	Cost Improvement Year to Date Variance	Jul-20	N/A	
Finance	NHSI Financial Risk Rating	Jul-20	N/A	
Finance	Capital service	Jul-20	N/A	
Finance	Liquidity	Jul-20	N/A	
Finance	Agency – Performance Against NHSI Set Agency Ceiling	Jul-20	N/A	

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Please note that some metrics have no data available due to COVID-19

People & OD Dashboard

This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%		Jul-20	80.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Jul-20	91%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Jul-20	100.8%	
Safe Nurse Staffing	% registered nurse day	>=90%		Jul-20	100.8%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Jul-20	120.9%	
Safe Nurse Staffing	% registered nurse night	>=90%		Jul-20	100.7%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		Jul-20	131.0%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Jul-20	5.8	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Jul-20	4.2	
Safe nurse staffing	Care hours per patient day total	>=8		Jul-20	10.1	
Vacancy and WTE	Staff in post FTE	No target		Jul-20	6493.56	
Vacancy and WTE	Vacancy FTE	No target		Jul-20	358	
Vacancy and WTE	Starters FTE	No target		Jul-20	49.45	
Vacancy and WTE	Leavers FTE	No target		Jul-20	86.03	
Vacancy and WTE	% total vacancy rate	<=11.5%		Jul-20	5.14%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Jul-20	2.70%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Jul-20	8.44%	
Workforce Expenditure	% turnover	<=12.6%		Jul-20	10.2%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Jul-20	9.9%	
Workforce Expenditure	% sickness rate	<=4.05%		Jul-20	3.7%	

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People & OD:
SPC – Special Cause Variation

Trust total % overall appraisal completion - GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

F
H

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Appraisals have seen a reduction in completion since changes to working practice including more home working and service changes for staff during and post Covid.

- **Deputy Director of People and Organisational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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People & OD:
SPC – Special Cause Variation

% turnover - GHT Starting 01/04/18

14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Commentary

Non registered nursing turnover is now at its lowest level since July 19. Registered nurse retention rate is currently 89.2%, the highest it has reached over the last 2 years.

Overall Trust turnover continues to decrease; a pattern seen since April 19

- **Director of Human Resources and Operational Development**

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People & OD:
SPC – Special Cause Variation

% turnover rate for nursing - GHT Starting 01/04/19

Y-axis: 14.0%, 12.0%, 10.0%, 8.0%, 6.0%, 4.0%, 2.0%, 0.0%

X-axis: Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20

Legend: Mean, Actual, Process limits - 3σ, Special cause - concern, Special cause - improvement, Target

Commentary

Non registered nursing turnover is now below 16%, at its lowest level since July 19. Registered nurse retention rate is currently 89.2%, the highest it has reached over the last 2 years

- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.There are 2 data point(s) below the line
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

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REPORT TO TRUST BOARD – SEPTEMBER 2020

From The Quality and Performance Committee Acting Chair for meeting – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee held on 26 August 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Serious Incident Report	No further never events reported in period. Three serious incidents reported in period. Six closed action plans.	Re incident relating to oxygen cylinders, have/can technical and labelling solutions been considered together with training and reminders? Does this incident raise any wider concerns re oxygen supplies for patients being transferred between sites? Where we have a new incident that appears to repeat elements covered by previous action plans, are those original plans revisited and are different colleagues involved in such reviews? Re: Opthalmology action	Being considered. No, such matters are covered in contract with transport provider, We have not routinely done so, but have done so in the case of the never event review and yes, different colleagues are involved. The review will also involve the human factors faculty, and hence, several clinicians.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		plan, can this come back to the Cttee with more detail as to agreed timescales, numbers of cases etc so that the scale of the issue can be better understood? Does the administrative issue in this incident give rise to concern in any other speciality? More generally, are we confident of our resource levels for timely and effective reviews of incidents?	To be considered further with report back to Cttee. Yes.	Future reporting
Risk Register	One new risk added since last report: Safety (12) and Quality (16) risks arising for patients with increased waiting time for services that were reduced or which remain suspended. Four risks have been downgraded.	Discussion re falls risk and how far introduction of Electronic Patient Record and other factors are influencing falls prevention and reporting. Are the overall safety and quality scores for the new risk sensitised to the particular risks in each specialty? Is there any evidence so far that we should be splitting the risk into	To date, yes, the Trust risk is sensitised to the specialty level risks which are considered within Divisions. Not at this stage.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		lower levels of detail within the Trust's risk register?		
Implementation of Clinical Harm Policy	Update on review of clinical harm policy undertaken in May 2020 to risk stratify new, follow up and cancer patients. Divisional progress was described, together with sampling approach being undertaken. More work to do during next 6 months to embed fully within divisions.	How will Cttee be sighted on results during next six months of embedding the policy and then more routinely? Would we be sampling if it wasn't necessary, and what's the level of risk inherent in this sampling methodology? How does Executive ensure a consistent approach when the method varies by specialty?	One round of executive review has taken place. Cttee assurance frequency to be determined in agenda planning. More regular assurance reporting preferred in short term. Yes, sampling significantly assists with this activity. There is a differentiated approach according to the specialty context eg 100% of those cases delayed for 52 weeks and more. Specialties have each been invited to identify their optimum sampling strategy, which will be reviewed in light of results. Policy defines how harm is categorised; divisional executive reviews; clinical experience applied to cases; policy is being used as basis for regional policy.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		How has the policy been received? What is its impact upon morale?	Need to balance this task with need to work on backlog of cases. No pushback has been received from consultants and managers. It is known to be really important to understand the level of risk of harm in current waiting lists.	
Covid-19 update	No specific matters requiring update. Briefing re very low numbers of inpatients and no patients in critical care. Planning assumptions remain of a further rise later in year. Main impact currently likely to arise from quarantine requirements.	Are there any challenges with levels of leave being taken by colleagues? Are there concerns among staff re children returning to school?	Good evidence of leave being taken; shorter breaks; in UK rather than abroad. No evidence yet. Being monitored and the 2020 Hub remains available to assist staff.	Execs to seek assurance re detailed mapping of leave by divisions and evidence of leave being integrated into winter planning.
Winter Plan	First draft of the Trust's Winter Plan. NB This is at an early stage and not yet integrated with wider system plans in ICS. Cttee commended team on bringing such an early position.	Is the Plan credible in terms of broader workforce challenges, esp the known position within Medical Division? Is wider system's state of preparedness where it needs to be?	Demand and capacity modelling being undertaken to test this. Current system work to remodel relevant pathways was described. Whole system meeting in early Sept. to review all plans.	Further iterations and updates to Cttee as plans are refined.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Maternity Assurance Action Plan	Initial draft of plan brought to Cttee following Healthcare Safety Investigation Branch (HSIB)'s escalation of a concern. Discussion re Executive oversight of situation, including cultural dimensions.	Summary of actions being taken. What will be the Executives' source of confirmation that cultural dimensions are improving?	Action Plan developed by divisional leadership team. Maternity Assurance Task and Finish Group, chaired by Director of Quality and Chief Nurse. QandP will provide assurance on behalf of the Board. Various diagnostic and psychological safety tools are being considered. Updates in future Cttee reporting.	Not all items are yet completed. To be updated in future Cttee reporting.
Quality and performance report	Quality Delivery Group Detailed report shared with specific discussion in Cttee about deteriorating patient improvement plan; mixed sex accommodation review; friends and family test revisions currently being embedded. Cancer services 2ww and 62day performance achieved. Cttee commended team on reaching and maintaining this position and in its performance during Covid peak. Improvements in		Assurance received of level of detailed working behind high level data presented to committee. Understanding of significant issues evident.	Deep dive report on key sustained red/amber performance indicators coming to September committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	urology and adoption of a revised prostate pathway have contributed significantly. Planned care delivery group RTT performance continues to be impacted by COVID-19 Comprehensive analysis of backlog by specialty received. Urgent care Briefing received on some of the most recent challenges during August. Further improvement options being considered within a Task and Finish Group, including peer review. Demand and capacity model being re-examined to assess opportunities to review establishment. Quality and performance data/ metrics shared on ED/MIIU units.	Could Cttee have more insight into the kind of conditions that people are waiting with in the lowest performing areas? What is our specific approach to communication with these patients?		For inclusion in future reports.

Claire Feehily
Acting Chair of Quality and Performance Committee (for this meeting)
2 September 2020

TRUST BOARD – SEPTEMBER 2020

Report Title
Digital Report
Sponsor and Author(s)
Author: Nicola Davies, Digital Engagement Lead Sponsoring Director: Mark Hutchinson, Exec. CDIO
Executive Summary
<u>Purpose</u> This paper provides updates and assurance on the delivery of digital workstreams and projects within GHFT as well as business as usual functions. The progression of this agenda is in line with our ambition to become a digital leader. <u>Key issues to note</u> • The Sunrise EPR workstream updates in the report were submitted to Digital Care Delivery Group on 4 August 2020 and significant progression has been made on the delivery of order comms (requests and results) since then. • At the time of writing the order comms project is entering its final stages of testing, build and site readiness, with a planned go live date of Wednesday 26 August 2020 in all adult inpatient wards. A verbal update will be provided at the meeting. • Work continues across finance and digital teams to align benefit assumptions, opportunities and realisation. The current trajectory demonstrates that Sunrise EPR has already delivered benefits above and beyond what the business case stated. • The Trust's 2019/20 Information Governance self-assessment is on track to achieve a compliant submission by the end of September 2020; *if* we achieve the national mandatory training target of 95% of all staff trained. Work is ongoing to reach this target with the support of senior managers. <u>Conclusions</u> The importance of improving GHFTs digital maturity in line with our strategy has been significantly highlighted throughout the COVID pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, but needs to continue at pace.
Recommendations
The Group is asked to NOTE the report.
Impact Upon Strategic Objectives
The position presented identifies how the relevant strategic objectives will be achieved.
Impact Upon Corporate Risks
Progression of the digital agenda will allow us to significantly reduce a number of corporate risks.
Regulatory and/or Legal Implications
Progression of the digital agenda will allow the Trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery.
Equality & Patient Impact
Progression of the digital agenda will improve the safety and reliability of care in the most efficient and effective manner.

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

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

1.0 Sunrise EPR Progress Report

Sunrise EPR provides a much safer approach to the way we manage patient care. This report provides status updates on Sunrise EPR workstreams and interdependent digital projects, in particular the latest position on order communications (requests and results).

Workstream updates were discussed at Digital Care Delivery Group on 4 August 2020 and significant progression has been made on the delivery of order comms (requests and results) since then. A verbal update will be provided at the meeting.

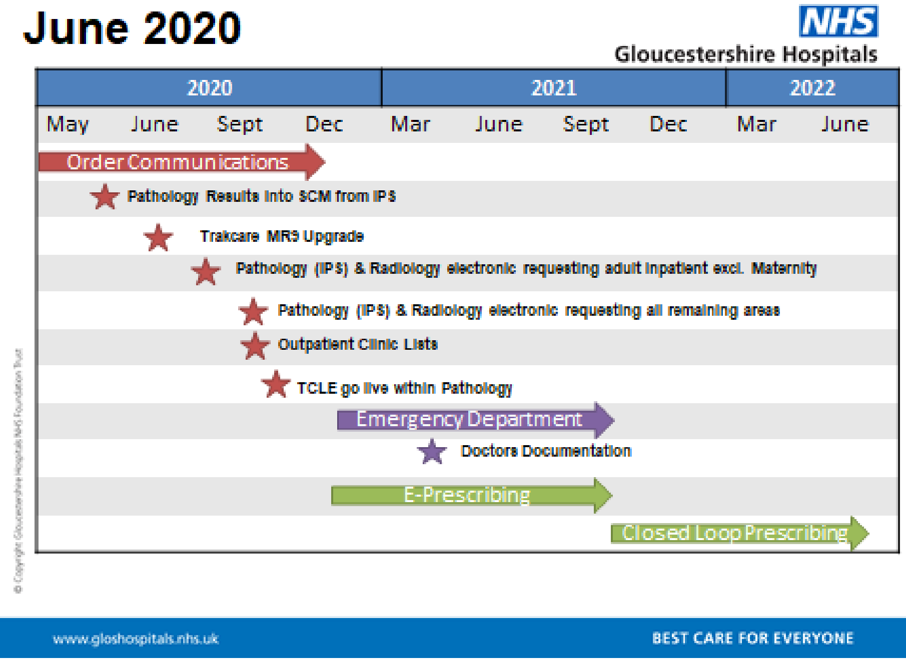
At the time of writing the project is entering its final stages of testing, build and site readiness, with a planned go live date of Wednesday 26 August 2020 in all adult inpatient wards.

Finance & Digital Committee is asked to note:

- Assurance provided by the workstream status updates
- Sunrise EPR quality and benefits process update.

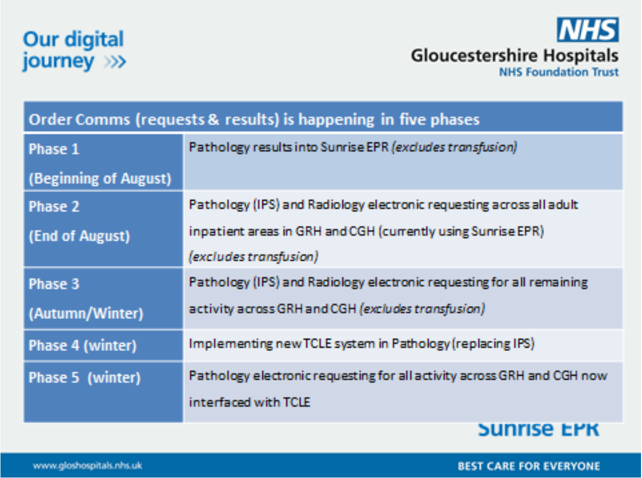
1.1 EPR High Level Programme Plan

The plan remains to deliver order comms in five phases; it is important to note that blood transfusion is excluded from phases one, two and three.



1.2 Order Comms Project Summary

Order Comms is being delivered in five phases, with results being made available to view first, following by requesting in adult inpatients in phase 2. All five phases are detailed below.



Order Comms (requests & results) is happening in five phases	
Phase 1 (Beginning of August)	Pathology results into Sunrise EPR *(excludes transfusion)*
Phase 2 (End of August)	Pathology (IPS) and Radiology electronic requesting across all adult inpatient areas in GRH and CGH (currently using Sunrise EPR) *(excludes transfusion)*
Phase 3 (Autumn/Winter)	Pathology (IPS) and Radiology electronic requesting for all remaining activity across GRH and CGH *(excludes transfusion)*
Phase 4 (winter)	Implementing new TCLE system in Pathology (replacing IPS)
Phase 5 (winter)	Pathology electronic requesting for all activity across GRH and CGH now interfaced with TCLE

Phase 1 order comms is being prepared for go live.

Phase 2 order comms build activity has advanced significantly since the July update. User testing is taking place, giving clinical staff the opportunity to see the system, commenting on the user interface. Training launched on 27 July and is being delivered using a mix of Microsoft Teams, classroom training and e-learning. The majority of staff are expected to complete e-learning and we have a compliance target of 75%.

TCLE testing plan has been reorganised and early testing move to later testing cycles. The TCLE project is currently on track.

1.3 Activity planned for next period (August)

The next reporting period will see the full testing and validation of results being sent from IPS to SCM in preparation for completion of this workstream by the 4 August. Previously this was reported to be completed in July.

Phase 2 order comms has entered user testing and the security model has been agreed but requires full implementation. Once user acceptance testing (UAT) has been completed, a full build freeze will happen. Day in the life testing will also happen within clinical settings.

Phase 2 training will take place throughout August with extensive promotion.

Additional power, network and end user devices are being rolled out in advance of go live and a Digital Super User session has taken place to explain the equipment wards will be receiving.

Go live planning is underway, including the command centre requirements, 24 hour staff cover and floor walker training.

Phase 3 order comms site readiness will start to happen, assessing all other clinical areas not included in phase 2. This will consider the requirements for phase 3, 4, 5 and next year's implementation of electronic prescribing.

A detailed implementation plan for electronic prescribing will be created during the next reporting period.

1.4 Risks

Current risks to the project timeline include:

- Pathology, Radiology and Clinical Operational capacity for validation and testing in light of the COVID-19 NHS response.

- TCLE build sign off. Although the build is complete, sign-off requires focus and dedication from pathologists.

- InterSystems delivery of MR9 due on 19 August 2020. This release has a number of system fixes that will enable TCLE. The MR9 upgrade is essential for the delivery of later phases of the order comms project. There is a genuine risk that a further upgrade might be required, as yet unknown.

- Phase 4 (TCLE) testing resources are being diverted onto phase 1 and 2 activities. Delays are being tracked through daily stand up meetings with the project team and reworking of the wider programme plan.

2.0 Digital Projects

This section provides updates on the delivery of projects within the Digital Programme Management Office (PMO).

- Projects impacted by COVID-19 pressures have been reviewed and realigned.
- The report separates projects closed this period and projects in closure, which will handover to BAU.
- Six projects are either in closure or closed during the last period.

Revised governance and project documentation being written and agreed to allow a clear process for all new projects to follow.

The current status and numbers of those projects that report to Digital Care Delivery Group are as follows:

Total Number of Projects	Number of Capital Funded	Number of Other Key Projects	Number of Primary Care /	Projects Complete or in closure	On-Hold	Number of Red Rated Projects	Number of Amber Rated	Number of Green Projects

29	Projects 8	7	CCG Projects 6	8	4	5	Projects 6	4

Red	Significant issues with the project – scope, time or budget is beyond tolerance level
Amber	Issue/s having negative impact on the project performance, project is close to tolerance level
Green	Project is on track
Blue	Complete & Closed

Since the last report one project has been completed and closed and seven projects have gone into closure to be completed by the end of July. These projects will be handed over to BAU with the relevant project closure documentation and lessons learned.

More detail on red rated projects and the reason for delays are detailed below.

Projects RAG Rated Red		
Fax Eradication	• User documentation written, document scanners all deployed. • Integration work carried out by Daisy Telecoms. • A series of supplier side delays mean that go-live in operational areas has been pushed pack for a number of successive weeks. Senior management has now become involved in order to gain some traction with the supplier. • Once technical routing work is complete faxes can be eradicated and removed. Financial benefits: <table><tr><th>Financial Year</th><th>16/17</th><th>17/18</th><th>18/19</th></tr><tr><td>**Consumables**</td><td>£2,955.40</td><td>£6,330.09</td><td>£5,842.49</td></tr><tr><td>**Machine**</td><td>£2,191.46</td><td>£1,532.30</td><td>£0.00</td></tr><tr><td>**Repair**</td><td>£1,705.44</td><td>£1,138.71</td><td>£700.00</td></tr><tr><td>**TOTAL (by Year)**</td><td>£6,852.30</td><td>£9,001.10</td><td>£6,542.49</td></tr></table>	**March 2020**
Windows 2003 Upgrade	• The seven legacy IHCS servers have now been migrated successfully away from the server 2003 OS representing a significant step forward in terms of resilience and security. • Several servers still do not have dates in place for migration or decommissioning and it is therefore not possible yet to forecast an end date.	**No end date agreed**
DOCMAN10 -Transfers of Care	• Following an extensive re-scoping, a pilot test is underway with a several GP surgeries. • Ongoing issues being worked through. The main issue is with letters being delivered to practices using the Vision GP system. This will be mitigated by all but one Vision sites being migrated to a new In-Practice system by September. Solutions are being investigated for the remaining Vision site. • Another issue has been identified with current working practice that is resulting in incomplete letters being sent from Infoflex. Advice is being circulated to managers to address with staff.	**March 2020**

SQL Migration	• 60% of migrations should be completed in August. • Ongoing weekly meeting in place to track progress. • Escalation strategy being worked on to deal with migration blockers. • Due to the complex nature of this project with hundreds of databases Trust-wide remaining to be transferred, an accurate end date cannot yet be forecast.	**July 2020**

3.0 TrakCare Optimisation

There are nine projects in the TrakCare Optimisation Programme for 2020/21. The priority for the TrakCare Optimisation Programme from April to June 2020 has been the delivery of two maintenance releases for TrakCare that are precursors for the new laboratory system, TCLE, and in turn the delivery of order communications as part of the EPR programme. The programme continues to be run remotely, which has limited some interaction with users, particularly for user acceptance testing (UAT) of the TrakCare maintenance releases.

Due to operational concerns about upgrading TrakCare on a Tuesday, the go live date for MR9 has been put back to Wednesday 19 August.

The table below presents a high-level status for each project / workstream. Several workstreams remain at Amber this month, mainly due to limited availability of operational resources during the Covid-19 pandemic. This has freed up programme resource to work on the maintenance releases and allowed these to be delivered at a faster pace than originally planned. In light of the delay of MR9, the team are working on enhancements and "deep dives", completing Ophthalmology and starting work with the Central Booking Office (CBO).

RTT/WL	Maintaining levels of data quality issues and continuing activities to prevent new issues arising. The number of news issues being generated has reduced, but the number of priority data quality issues has increased. The Trust Validation Team are returning to a weekly data quality validation process in July to stabilise the position. The Optimisation and Data Quality teams are reviewing the data quality issues to target areas.	A
Maternity	There is a risk on achieving CNST (Clinical Negligence Scheme for Trusts) submissions as not all data items can be collected on TrakCare. This is being reviewed with InterSystems but a further update from InterSystems is outstanding as at the end of May. CNST Maternity reporting is paused until 31/08/2020. This issue has formally been raised with ISC as non-compliance with a national data standard. Meeting being held on the 30/7/20 to discuss further with ISC.	A
Outpatients	Palliative Care services are due to start recording on Trak and EPR from August. Process for Interventional Radiology are under review e.g. pre-op assessment. Main focus is the deployment of virtual appointment types working with Trak Support, CBO, eRS, outpatients and clinical services. Respiratory and T&O are piloting the set-up of virtual appointments for video and telephone consultations.	G
Upgrades / Maintenance	MR9 project on hold during July as deployment date move to August 19th. Associated milestones for TCLE laboratory system continue to be met.	G

Enhancement	Whilst MR9 is on hold, enhancements that were made available during previous releases are being pursed for deployment. Demonstrations of the enhancements of interest (trauma scheduling and IP scheduling) are being held on the 29/07/20.	G
Theatres	Items delayed during Covid-19 are now being pursued for August deployment including WHO checklist, body site / laterality recording, community hospital waiting list workflow, and anaesthetic alerts.	G
Emergency Department (ED)	Handover of ED coding project to operational service being planned with ED management team but waiting for ED actions to be completed. Coding throughput is currently below expected levels, but lower levels of attendances is reducing impact of this issues. List of improvements / snag list created, but work delayed by operational staff availability due to Covid-19.	A
Deep Dives	Ophthalmology work now completing with some longer term items, e.g. vetting, to be passed to other workstreams. Urology kick off meeting held but delayed due to staff absence. Central Booking Office (CBO) project starts 14/07/2020. Other areas being considered include Community Paediatrics and Trauma and Orthopaedics.	G
BAU Transition	Ongoing delays in transitioning project work to "business as usual" due to Covid-19 pressures.	A

4.0 Sunrise EPR Quality & Benefits

Introduction

The quality review process has now been established as part of Quality Delivery Group, including monitoring of divisional improvement plans. We are working with nursing teams to maximise the data now available on Sunrise EPR. This includes using regular reporting to highlight usage and compliance by ward; reviewing audit requirements and increasing accountability.

Work continues across finance and digital teams to align benefit assumptions, opportunities and realisation. The current trajectory demonstrates that Sunrise EPR has already delivered benefits above and beyond what the business case stated. This is largely due to the drive and commitment of all to deliver go lives early and ahead of schedule.

There are no savings attributed to 19/20 due to the original Sunrise EPR implementation plan's original go live date of June 2020. This was pulled forward significantly and the trust went live at the end of November 2019.

Our next planned EPR go live is the implementation of Order Comms (requests and results) on 26 August 2020. Benefits assumptions are in place and going through an approval process.

4.1 Quality Reporting

Sunrise EPR holds a multitude of information that can be reviewed and analysed. We are working with two specialist teams as pilots (safeguarding and falls) to review the data available so that we can start to ask and answer questions, including:

- What information would be helpful to view?
- How can I use this information to support wards?
- How can I use this information to share trust activity and adherence to guidelines

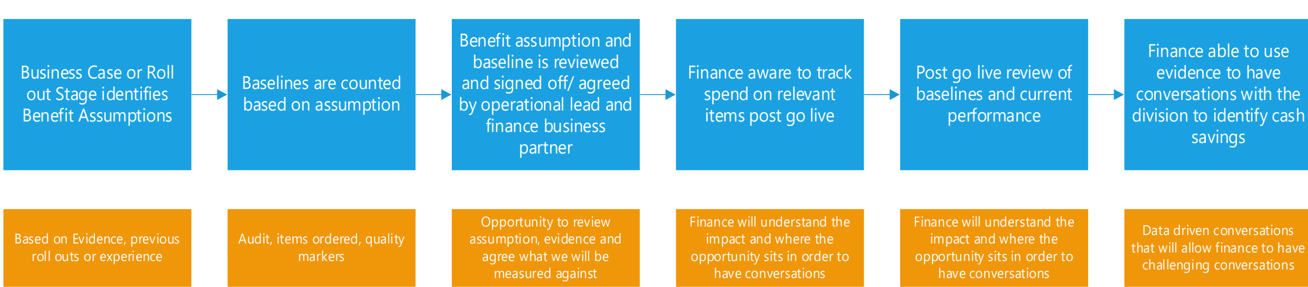
Once prioritised these audits can be built as reports that are easily refreshed and updated improving our ability to audit and review our performance; and support a move towards using data for quality improvement, research and development.

4.2 **Nursing Documentation & E-Observations Benefits**

The EPR business case clearly identifies financial and quality benefits and finance teams are considering how we turn these benefits into actual savings for reinvestment or returning to the bottom line.

The mechanism to explore the benefits available for realisation will sit with finance business partners. Keeping those partners involved, informed and engaged will help ensure that divisions and budget owners can be challenged based on benefit assumptions and the evidence provided through EPR.

Fig 1. describes the way that the digital and finance teams will work together to review and realise the benefits of digital transformation. This process is supported by monthly meetings.



The benefits from the first implementation of EPR (nursing documentation and e-observations) will largely be grouped into the following main areas:

- Non-staff savings/ cash releasing
- Staff time saving
- Clinical quality improvements
- Clinical outcomes

4.3 **Sunrise EPR - Order Comms Benefits**

Our next planned Sunrise EPR go live is the implementation of Order Comms (requests and results) on 26 August 2020. Benefits assumptions are in place and going through an agreed approval process. Benefits baselines are developed based on the benefit assumptions in the business case; as well as published evidence from other NHS hospital using order communications on Sunrise EPR. The EPR team and finance teams are meeting on 19 August 2020 to review and approve these assumptions.

We have been shadowing key staff impacted by and involved in requesting tests, reviewing results and processing samples. This has included ward-based clinicians, phlebotomists and pathology and radiology teams. We anticipate significant benefits to pathology teams, given the amount of time currently spent transcribing, processing paper requests and seeking information about patients in order to progress investigations. Initial review of the data suggests that within the Pre-Analytical areas of pathology this could account for up to 50% of a working day.

5.0 Cyber Assurance

This section highlights cybersecurity activity for the reporting period (July 2020) in relation to risk mitigation, current controls and ongoing work to protect Gloucestershire Healthcare Community information assets. In summary:

- Last 'High' audit finding closed (Domain Admin accounts)
- Three open findings remain (two Moderate and one Low)
- Two of which are dependent on technical solutions that are due to be delivered early Q3.
- There are no open High Severity CareCERT Advisories.

Focus	JUNE 2020	JULY 2020	Explanation
1. CareCERT Advisories	GREEN	GREEN	Details of all open High Severity Advisories can be found on page 2. No open high advisories.
2. CareCERT Threat Notifications	GREEN	GREEN	No threat notifications for the reporting period
3. Cyber Security Risks	AMBER	AMBER	1 High, 2 Moderate and 1 Low open findings. On track to close within Q3
4. Cyber Security Controls	GREEN	GREEN	All solutions operating normally
5. Business Risks	RED	AMBER	5 (-1) 'High' Health Community Risks – please see section 5. for more information. Domain Admin risk closed, following achievement of BDO audit target

6. Cyber Services	GREEN	GREEN	Backup Security review now in discovery phase, MTI to gather data in July, please see Section 6. For more details.

6.0 Information Governance

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

Three incidents have been reported to the ICO during the 2020/21 reporting period to date.

Data Security and Protection Toolkit (DSPT) Submission

The Trust's 2019/20 self-assessment is on track to achieve a compliant submission, with the exception of achieving the national mandatory training target. This requires that 95% of all staff complete annual refresher training.

Efforts continue to achieve the 95% target prior to publication in Sept 2020 final submission date. We are currently at 88% of all staff trained and renewed focus is on to reach to 95% compliance, the 7% equates to approximately 700 staff. The breakdown below shows our compliance by division.

Compliance Rate Highlight key:	
Less than 95%	95% and above

Breakdown by Division

Gloucestershire Hospitals

	Compliance
GHT Total	**88%**
Corporate Division	85%
Diagnostic & Specialty Division	93%
Medicine Division	90%
Non-Division	68%
Surgery Division	92%
Women & Children Division	90%

Breakdown by Staff Group

Gloucestershire Hospitals

	Compliance
GHT Total	**88%**
Add Prof Scientific and Technic	93%
Additional Clinical Services	82%
Administrative and Clerical	91%
Allied Health Professionals	93%
Estates and Ancillary	89%
Healthcare Scientists	95%
Medical and Dental	82%
Nursing and Midwifery Registered	90%

-Ends-

TRUST BOARD – 10 SEPTEMBER 2020
MS TEAMS commencing at 09:00

Report Title
Financial Performance Report **Month Ended 31 July 2020**
Sponsor and Author(s)
Author: Johanna Bogle, Associate Director of Financial Management Sponsor: Karen Johnson, Director of Finance
Executive Summary
<u>Purpose</u> This purpose of this report is to present the Financial position of the Trust at Month 4 to the Committee. <u>Key issues to note</u> The Trust will breakeven for Month 1-6, due to national income changes during the Covid-19 pandemic. At Month 4 we recorded a £3.6m deficit requiring True-Up funding. Our activity has recovered a further 20% since month 3, and this has led to additional non-pay costs of approximately £0.8m. We have been given a clear steer from the Region to maximise the use of our elective capacity over the next month (Aug) whilst we are still in this funding regime so the month 5 position is likely to be of similar or more cost, requiring a similar or increased retrospective top-up. The focus now is to ensure our Covid costs continue to reduce to compensate for the increase in normal activity and to fully understand the financial impact of recovery. For Month 4 we report a breakeven position against the NHSE/I run rate, and a £5.6m surplus against budget. Both of these numbers include the £11.94m costs of Covid-19 in our accounts. Since completing month 4 reporting there has been an emergent issue in relation to the VAT treatment of an outsourced managed service provider. The notification from HMRC impacts multiple financial years and the Trust is taking further advice in relation to its response and next steps. <u>Conclusions</u> The Trust is reporting a year to date breakeven position compared to the run rate assessment of NHSE/I. Because of block income and true-up funding, this is expected to continue until the end of Month 6. Compared to budget, the Trust is reporting a positive variance of £5.6m. <u>Implications and Future Action Required</u> To continue the report the financial position monthly.
Recommendations
The Board is asked to receive the contents of the report as a source of assurance that the financial position is understood and under control.

Impact Upon Strategic Objectives
This report updates on our progress throughout the financial year of the Trust's strategic objective to achieve financial balance.

Impact Upon Corporate Risks
This report links to a number of Corporate risks around financial balance.

Regulatory and/or Legal Implications
No issues for regulatory of legal implications.

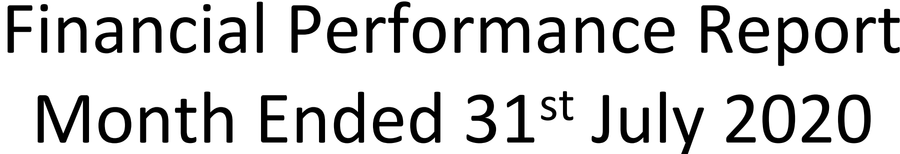
Equality & Patient Impact
None

Resource Implications			
Finance	X	Information Management & Technology	
Human Resources		Buildings	

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

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

Report to the Trust Board



Financial Performance Report
Month Ended 31st July 2020

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LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

Director of Finance Summary

Gloucestershire Hospitals NHS
NHS Foundation Trust

National Position as at Month 4

The interim funding arrangements for the Covid-19 pandemic continues until the end of month 6. Detail beyond this period still remains unclear, but we know that this year there will be no contract between Commissioners and Providers. Instead, the block arrangement will continue, but it is likely that the retrospective top up will not be available. The National Team are looking to update the block to take account of national pressures like increases in CNST charges and there will be an allocation for Covid, but the detail is unknown.

Month 4 overview

At Month 4 we recorded a £3.6m deficit requiring True-Up funding. Our activity has recovered a further 20% since month 3, and this has led to additional non-pay costs of approximately £0.8m.

We have been given a clear steer from the Region to maximise the use of our elective capacity over the next 2 months (Aug & Sept) whilst we are still in this funding regime so the month 5 position is likely to be of similar or more cost, requiring a similar or increased retrospective top-up. The focus now is to ensure our Covid costs continue to reduce to compensate for the increase in normal activity and to fully understand the financial impact of recovery.

Forecast Outturn

Work is currently ongoing to calculate the potential financial forecast position of the Trust including the following:

- Anticipated ongoing Covid-19 spend
- Recovery to ICS activity targets
- Potential for meeting national recovery targets
- Patient segregation red and green service changes
- Committed and unavoidable risks and cost pressures
- Likely delivery of efficiency savings.

This will be reported to the Group once completed.

Since completing month 4 reporting there has been an emergent issue in relation to the VAT treatment of an outsources managed service provider. The notification from HMRC impacts multiple financial years and the Trust is taking further advice in relation to its response.

Capital

The capital programme has recently been approved and work has begun to deliver the various schemes.

Balance Sheet

In order that the national NHS cash position was secure, all Trusts have received five months' of commissioner block income payments so far this year. This means that our cash balance is £62m higher than anticipated in planning.

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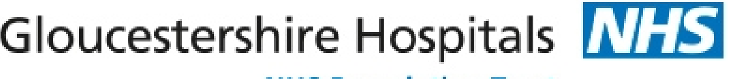
M04 Group Position vs NHSE Average Run Rate Position



Including the £11.94m of Covid-19 costs that the Trust has incurred year to date in Month 4, we are reporting a breakeven position. This is because NHSE/I have committed to additional true-up income as long as it is deemed reasonable.

Consolidated Run Rate Position - incl Covid Spend and True-Up Income	Run Rate 20/21 budget £'000		
	YTD Run Rate Calc	YTD Actual	YTD Variance
Income	199,457	195,247	(4,210)
Income True-Up	0	10,964	10,964
Pay	128,580	133,801	(5,221)
Non Pay	67,601	68,696	(1,095)
Capital Financing	3,272	3,863	(591)
Total Surplus / (Deficit)	4	(149)	(153)
Remove impact of Donated Asset Depreciation	0	149	149
Grand Total Surplus / (Deficit)	**4**	**0**	**(4)**

Excluding the year to date Covid-19 costs to date in Month 4, and associated true-up income of £10.96m, we are reporting a surplus position of £0.98m. This means that the Trust contributed a total of £0.98m of baseline funding to offset some of its Covid-19 costs. Due to the associated costs from increased activity, the year to date value of this decreases each month and is expected to be below zero in Month 5.

Consolidated Run Rate Position - excl Covid Spend and True-Up Income	Run Rate 20/21 budget £'000		
	YTD Run Rate Calc	YTD Actual	YTD Variance
Income	199,457	195,247	(4,210)
Pay	128,580	127,504	1,076
Non Pay	67,601	63,049	4,552
Capital Financing	3,272	3,863	(591)
Total Surplus / (Deficit)	4	831	827
Remove impact of Donated Asset Depreciation	0	149	149
Grand Total Surplus / (Deficit)	**4**	**980**	**976**

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M04 True-Up Funding agreed by NHSE

The Trust has spent £11.94m of Covid-19 costs so far this year. This means that the Trust has contributed £0.98m of baseline funding towards these Covid-19 costs, because it has only applied for True-Up funding of £10.96m.

NHSE require Trusts to report a breakeven position, on the assumption that the deficit before the True-Up income will be approved by NHSE. The Month 1, 2 and 3 True-Up value of £1.76m, £1.77m and £3.81m has been paid by NHSE. The Month 4 True-Up value of £3.63m will be validated by NHSE over the next fortnight.

The month 3 and 4 true-up requirements have increased since the early months. This is driven by the increase in activity, predominantly around non pay.

Payments for agreed True-Up income are made on the 15th of the following month. This means that we have received £7.34m, and expect to receive a further £3.63m on September 15th.

NHSE True-Up Income Position	Value (£'000)
True-Up M01 Paid	1,757
True-Up M02 Paid	1,769
True-Up M03 Paid	3,811
True-Up M04 Anticipated	3,627
Grand Total True-Up YTD	**10,964**

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M04 Group Position vs Budget

The Trust is currently focusing on its costs compared to run rate in months 8, 9 and 10 of 2019/20, because this is what the current funding regime is based on.

The below tables are shown for reference to the Trust's original plan only.

Including the £11.94m of Covid-19 costs and the associated income flows that the Trust has incurred year to date to Month 4, we are reporting a breakeven position. This includes true-up income from NHSE totalling £10.96m. We had budgeted for a deficit of £5.65m year to date to month 4, so we currently report a positive variance to budget of £5.65m.

Consolidated Budget Position - incl Covid Spend and True-Up Income	Budget 20/21 £'000		
	YTD Budget	YTD Actual	YTD Variance
Income	199,927	195,247	(4,680)
Income True-Up		10,964	10,964
Pay	130,545	133,801	(3,256)
Non Pay	72,216	68,696	3,520
Non-Operating Costs	2,968	3,863	(895)
Total Surplus / (Deficit)	(5,802)	(149)	5,653
Remove impact of Donated Asset Depreciation	148	149	1
Grand Total Surplus / (Deficit)	(5,654)	0	5,654

Including the Covid-19 costs but removing the impact of the NHSE True-Up income that the Trust has seen year to date to Month 4, we are reporting a deficit actuals position of £10.96m. Compared to the budget of £5.65m deficit we are therefore £5.31m worse than expected.

Consolidated Budget Position - incl Covid Spend and excl True-Up Income	Budget 20/21 £'000		
	YTD Budget	YTD Actual	YTD Variance
Income	199,927	195,247	(4,680)
Pay	130,545	133,801	(3,256)
Non Pay	72,216	68,696	3,520
Capital Financing	2,968	3,863	(895)
Total Surplus / (Deficit)	(5,802)	(11,113)	(5,311)
Remove impact of Donated Asset Depreciation	148	149	1
Grand Total Surplus / (Deficit)	(5,654)	(10,964)	(5,310)

The second half of the financial year will undoubtedly require a level of CIP to breakeven or minimise the financial year end position. The original target for 20/21 was to deliver £15.76m. At month 4 we have delivered £2.2m, but only £0.66m of this is recurrent. The Trust has struggled over the last couple of years to make recurrent CIPs so this will need to be a focus over the coming months.

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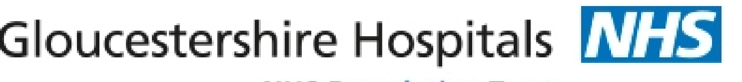
Month by Month Trend



Consolidated Run Rate Actuals	20/21 £'000				
	M01	M02	M03	M04	YTD
Pay	31,304	32,153	32,248	31,799	127,504
Non Pay	16,407	13,843	15,572	17,227	63,049
Covid	2,125	3,847	3,408	2,564	11,944
Non-operating Costs	856	990	1,072	945	3,863
Remove impact of Donated Asset Depreciation	(38)	(37)	(37)	(37)	(149)
Total Cost	50,654	50,796	52,263	52,498	206,211
Run Rate Funding, plus billable income	(48,897)	(49,027)	(48,452)	(48,871)	(195,247)
Total Deficit	**1,757**	**1,769**	**3,811**	**3,627**	**10,964**
True-up Funding	(1,757)	(1,769)	(3,811)	(3,627)	(10,964)
Grand Total Deficit	**0**	**0**	**0**	**0**	**0**

Covid Pay / Non-Pay Costs	20/21 £'000				
	M01	M02	M03	M04	YTD
Pay	1,217	1,683	1,991	1,406	6,297
Non-Pay	908	2,164	1,417	1,158	5,647
Total	**2,125**	**3,847**	**3,408**	**2,564**	**11,944**

Looking at the trend of costs each month, it is clear that non-pay is steadily growing month on month. This is in line with additional activity performed month on month, and is expected to be at a similar or higher level for Month 5, as we try to accelerate our recovery while we can claim any costs beyond our block income.

Covid costs are coming down month on month, with forecasts currently being reviewed for the full year.

Since completing month 4 reporting there has been an emergent issue in relation to the VAT treatment of an outsourced managed service provider. The notification from HMRC impacts multiple financial years and the Trust is taking further advice in relation to its response due to the material nature of the issue – this may include accepting the notification, appealing it (via a re-review) or requesting a judicial review. The impact will be reflected in month 5.

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M04 Group Position versus Budget

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Trust has not yet submitted a final plan for 2020/21. The below table is based on the current year's draft plan.

The financial position as at the end of July 2020 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity.

In July the Group's consolidated position shows a year to date breakeven position due to the current funding regime. This is £5.65m favourable against budget.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 04 Cumulative Financial Position	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	171,387	168,509	(2,878)	0	0	0	171,387	168,509	(2,878)
PP, Overseas and RTA Income	1,328	1,024	(304)	0	0	0	1,328	1,024	(304)
Other Income from Patient Activities	428	228	(200)	0	0	0	428	228	(200)
Operating Income	24,929	35,140	10,211	16,847	16,596	(251)	26,784	36,450	9,666
Total Income	**198,072**	**204,901**	**6,829**	**16,847**	**16,596**	**(251)**	**199,927**	**206,211**	**6,284**
Pay	123,749	126,987	(3,238)	6,796	6,891	(96)	130,545	133,801	(3,256)
Non-Pay	78,097	75,965	2,132	9,110	7,940	1,171	72,216	68,696	3,520
Total Expenditure	**201,846**	**202,952**	**(1,106)**	**15,906**	**14,831**	**1,075**	**202,760**	**202,496**	**264**
EBITDA	**(3,774)**	**1,949**	**5,724**	**941**	**1,765**	**824**	**(2,834)**	**3,714**	**6,548**
EBITDA %age	**(1.9%)**	**1.0%**	**2.9%**	**5.6%**	**10.6%**	**5.1%**	**(1.4%)**	**1.8%**	**3.2%**
Non-Operating Costs	2,028	2,098	(70)	941	1,765	(824)	2,968	3,863	(894)
Surplus/(Deficit) with Impairments	**(5,802)**	**(149)**	**5,654**	**0**	**0**	**0**	**(5,802)**	**(149)**	**5,654**
Less Fixed Asset Impairments	0	0	0	0	0	0	0	0	0
Surplus/(Deficit) excluding Impairments	**(5,802)**	**(149)**	**5,654**	**0**	**0**	**0**	**(5,802)**	**(149)**	**5,654**
Excluding Donated Assets	148	149	1	0	0	0	148	149	1
Control Total Surplus/(Deficit)	**(5,654)**	**0.00**	**5,654**	**0**	**0**	**0**	**(5,654)**	**0**	**5,654**

* Group Position excludes £16.7m of intergroup transactions including dividends

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Month 04 Financial Position	M04 Budget £000s	M04 Actuals £000s	M04 Variance £000s	M04 Cumulative Budget £000s	M04 Cumulative Actuals £000s	M04 Cumulative Variance £000s	Passthrough Variance £000s	Net Variance £000s
SLA & Commissioning Income	43,776	42,131	(1,645)	171,387	168,509	(2,878)	634	(2,245)
PP, Overseas and RTA Income	332	401	69	1,328	1,024	(304)		(304)
Other Income from Patient Activities	107	64	(43)	428	228	(200)		(200)
Operating Income	5,947	9,903	3,957	26,784	36,451	9,667		9,667
Total Income	**50,162**	**52,499**	**2,337**	**199,927**	**206,212**	**6,285**	**634**	**6,919**
Pay								
Substantive	30,195	30,338	(144)	121,633	122,361	(728)		(728)
Bank	1,299	1,507	(208)	5,197	6,763	(1,566)		(1,566)
Agency	929	1,357	(428)	3,715	4,677	(962)		(962)
Total Pay	**32,423**	**33,202**	**(779)**	**130,545**	**133,801**	**(3,256)**	**0**	**(3,256)**
Non Pay								
Drugs	6,331	6,044	287	25,325	22,955	2,370	(521)	1,849
Clinical Supplies	3,715	3,298	417	14,860	11,221	3,639	(112)	3,527
Other Non-Pay	8,002	9,042	(1,041)	32,031	34,520	(2,489)		(2,489)
Total Non Pay	**18,048**	**18,384**	**(336)**	**72,216**	**68,696**	**3,520**	**(634)**	**2,886**
Total Expenditure	**50,470**	**51,586**	**(1,116)**	**202,760**	**202,497**	**264**	**(634)**	**(370)**
EBITDA	**(309)**	**913**	**1,222**	**(2,834)**	**3,715**	**6,549**	**(0)**	**6,549**
EBITDA %age	**(0.6%)**	**1.7%**	**2.4%**	**(1.4%)**	**1.8%**	**(3.2%)**	**(0.0%)**	**94.7%**
Non-Operating Costs	742	950	(208)	2,968	3,863	(895)		
Surplus/(Deficit)	**(1,051)**	**(37)**	**1,014**	**(5,802)**	**(149)**	**5,654**	**(0)**	**5,654**
Fixed Asset Impairments	0	0	0	0	0	0		0
Surplus/(Deficit) after Impairments	**(1,051)**	**(37)**	**1,014**	**(5,802)**	**(149)**	**5,654**	**(0)**	**5,654**
Excluding Donated Assets	37	37	0	148	149	1		1
Surplus/(Deficit)	**(1,014)**	**(0)**	**1,014**	**(5,654)**	**0**	**5,654**	**(0)**	**5,654**

SLA & Commissioning Income – Most of the Trust income is covered by block contracts. With the volume of activity happening within the Trust significantly down, the surplus position showing can be explained by the fact that the plan is profiled for peaks and troughs in the year, while the current NHSE run-rate funding is in twelfths.

PP / Overseas / RTA Income – This is significantly down on plan due to Covid-19.

Other Operating income – Includes additional income associated with services provided to other providers, and is below plan due to Covid-19. The value of the NHSE True-Up at £10.96m year to date is included here.

Pay – Cumulatively there is an overspend of £3.26m, reflecting a £1.57m overspend on bank budgets, as well as a £0.73m overspend on substantive and a £0.96m overspend on Agency. The in-month and year to date overspend predominantly reflects the £5.87m additional pay costs of Covid-19 activity above our original budgeted levels. Further detail on pay expenditure is provided on page 16.

Non-Pay – expenditure is showing a £3.52m year to date underspend, predominantly reflecting the impact of reduced activity in most clinical areas, Surgery being the biggest contributor. Unbudgeted Covid-19 spend offsets £5.65m of the business-as-usual underspend on non-pay.

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SLA and Commissioning Income – by Commissioner (Group)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commissioner Income Analysis	Annual Budget £000s	M04 Cumulative Budget £000s	M04 Cumulative Actuals £000s	M04 Cumulative Variance £000s
NHS Gloucestershire CCG	368,470	121,692	120,684	(1,008)
Specialised Commissioning Group	109,688	36,210	34,272	(1,938)
Herefordshire & Worcestershire CCG	14,945	4,950	4,768	(182)
Welsh Commissioners	5,417	1,790	1,702	(88)
Other Commissioner Income	20,821	5,209	6,198	989
Non Contractual Agreements (NCAs)	4,626	1,536	885	(651)
Total	**523,967**	**171,387**	**168,509**	**(2,878)**

The table above shows the income position at Month 4.

The block contracts continue to support the Trust although activity is still down significantly. This creates a positive financial position against a standard activity times price calculation. This block contract adjustment at the end of Month 4 is £46m. However as the level of activity rises with the diminishing of Covid-19 this adjustment reduces and has gone from Month 1 £17.2m, Month 2 £13.8m, Month 3 £9.5m and Month 4 £5.5m. A continued risk to the income position is that income normally received outside of contracts on a more ad hoc basis, most of which have currently ceased.

The Annual Budget column represents the Trust's plans for commissioners prior to the suspension of the contracting round for 2020/21 as a result of Covid-19. These numbers were not agreed with commissioners but represent the baseline of "normal" activity going forward. The Cumulative Actuals largely reflect the imposed NHSE block contracts for the month 1-4 of 2020/21. The clear steer is that after September some form of block contracting will continue. The exact nature of these agreements is still unknown. It is likely that although contracts will be blocked to protect core income additional requirements will be placed on the Trust to manage the RTT and utilise other elective capacity including the contracts with the independent sector.

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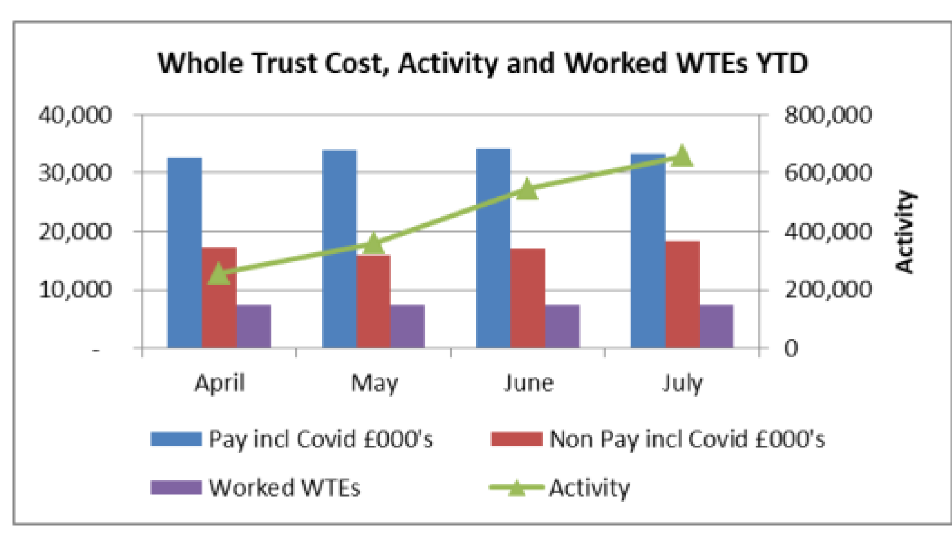
Cost, Activity and Worked WTE for the Trust

Total Trust Costs	M1	M2	M3	M4	YTD
Pay	31,304	32,153	32,248	31,799	127,504
Non Pay	16,407	13,843	15,572	17,227	63,049
Total Pay and Non Pay	47,711	45,996	47,820	49,026	190,553
Covid Costs	**M1**	**M2**	**M3**	**M4**	**YTD**
Pay	1,217	1,683	1,991	1,406	6,297
Non Pay	908	2,164	1,417	1,158	5,647
Total Pay and Non Pay	2,125	3,847	3,408	2,564	11,944
Total Costs					
Pay	32,521	33,836	34,239	33,205	133,801
Non Pay	17,315	16,007	16,989	18,385	68,696
Total Pay and Non Pay	49,836	49,843	51,228	51,590	202,497
Activity	**M1**	**M2**	**M3**	**M4**	**YTD**
Activity	**256,751**	**359,164**	**546,802**	**656,996**	**1,819,714**
WTEs					
WTE Worked Non-Covid	7,171	7,070	7,171	7,260	
WTE Worked Covid	195	272	269	163	
Total	7,366	7,342	7,440	7,424	



This slide brings together the Trust's costs and worked WTE's, alongside Covid costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs. Trust activity has increased 20% month on month, and 156% since the start of the year.

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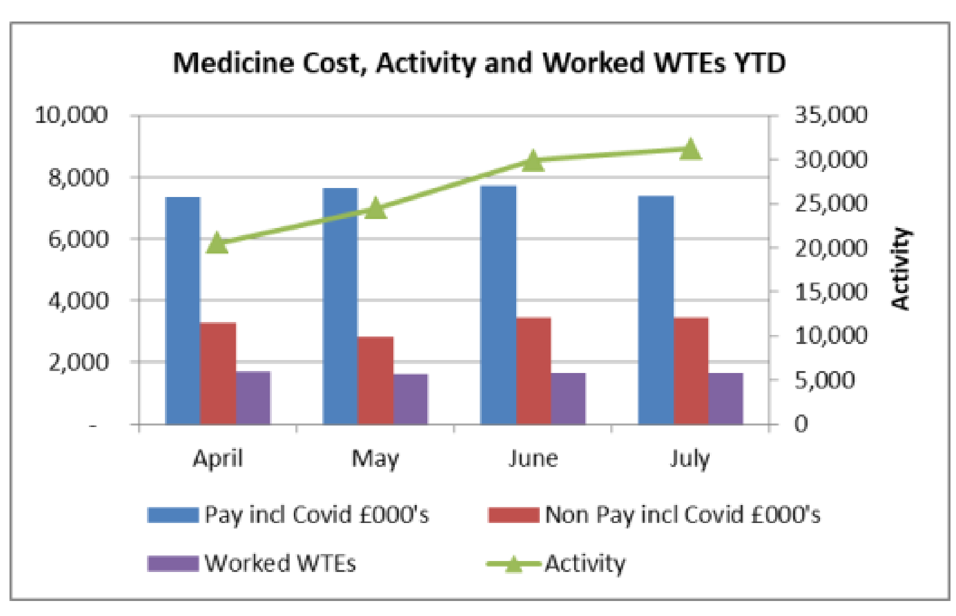
Cost, Activity and Worked WTE by Division - Medicine

Medicine Costs	M1	M2	M3	M4	YTD
Pay	6,907	7,051	7,318	7,166	28,442
Non Pay	3,257	2,807	3,441	3,454	12,960
Total	10,164	9,858	10,760	10,621	41,402
Medicine Covid Costs	**M1**	**M2**	**M3**	**M4**	**YTD**
Pay	449	606	401	219	1,675
Non Pay	29	34	2	- 5	60
Total	478	640	404	214	1,735
Total Medicine Costs					
Pay	7,355	7,657	7,720	7,385	30,117
Non Pay	3,286	2,841	3,444	3,450	13,020
Total	10,641	10,498	11,163	10,835	43,137
Medicine Activity	**M1**	**M2**	**M3**	**M4**	**YTD**
Elective Spells	604	614	823	1,083	3,124
Emergency Spells	2,142	2,557	2,955	3,272	10,926
Outpatient attendances/procedures	7,039	8,268	11,943	11,393	38,642
A&E attendances	6,810	8,869	9,761	10,919	36,359
Renal Dialysis	3,835	3,777	3,697	3,779	15,088
Excluded drugs/devices	1	3	82	77	163
Misc non-PbR activity	144	417	665	711	1,937
	20,575	**24,505**	**29,926**	**31,234**	**106,239**
Medicine WTEs					
WTE Worked Non-Covid	1,627	1,529	1,608	1,632	
WTE Worked Covid	86	85	68	45	
Total	1,713	1,613	1,676	1,677	



This slide brings together the core divisional costs and worked WTE's, alongside Covid costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs. Medicine activity has increased 4% month on month, and 52% since the start of the year.

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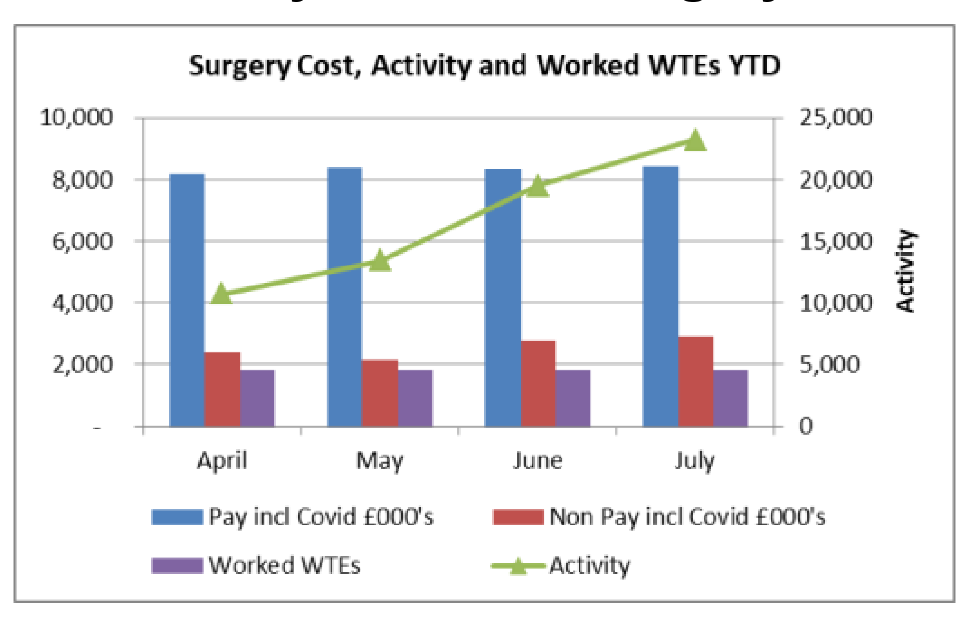
Cost, Activity and Worked WTE by Division - Surgery

Surgery Costs	M1	M2	M3	M4	YTD
Pay	7,951	8,104	7,891	7,834	31,780
Non Pay	2,275	2,071	2,792	2,906	10,044
Total	10,226	10,175	10,683	10,740	41,824
Surgery Covid Costs	**M1**	**M2**	**M3**	**M4**	**YTD**
Pay	220	297	477	622	1,615
Non Pay	143	87	- 16	4	218
Total	363	384	461	626	1,834
Total Surgery Costs					
Pay	8,171	8,401	8,368	8,456	33,396
Non Pay	2,419	2,158	2,776	2,910	10,262
Total	10,589	10,559	11,144	11,366	43,658
Surgery Activity	**M1**	**M2**	**M3**	**M4**	**YTD**
Non F2F Op's New	1,958	1,898	2,009	1,844	7,709
Non F2F OP's Follow-up	2,731	3,399	4,766	3,716	14,612
F2F OP's New	1,747	3,019	4,803	6,846	16,415
F2F OP's Follow Up	3,157	3,474	5,727	8,020	20,378
Assessments	73	111	137	196	517
Non Elective (1 day +)	504	691	754	769	2,718
Non Elective (zero stay)	132	165	196	232	725
In Patients (routine and urgents)	143	230	317	481	1,171
Day Cases (routine and urgents)	299	432	788	1,135	2,654
ED attendences	0	0	0	0	0
	10,744	**13,419**	**19,497**	**23,239**	**66,899**
Surgery WTEs					
WTE Worked Non-Covid	1,781	1,768	1,789	1,833	
WTE Worked Covid	34	56	26	14	
Total	1,815	1,824	1,814	1,846	



This slide brings together the core divisional costs and worked WTE's, alongside Covid costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs. Surgery activity has increased 19% month on month, and 116% since the start of the year.

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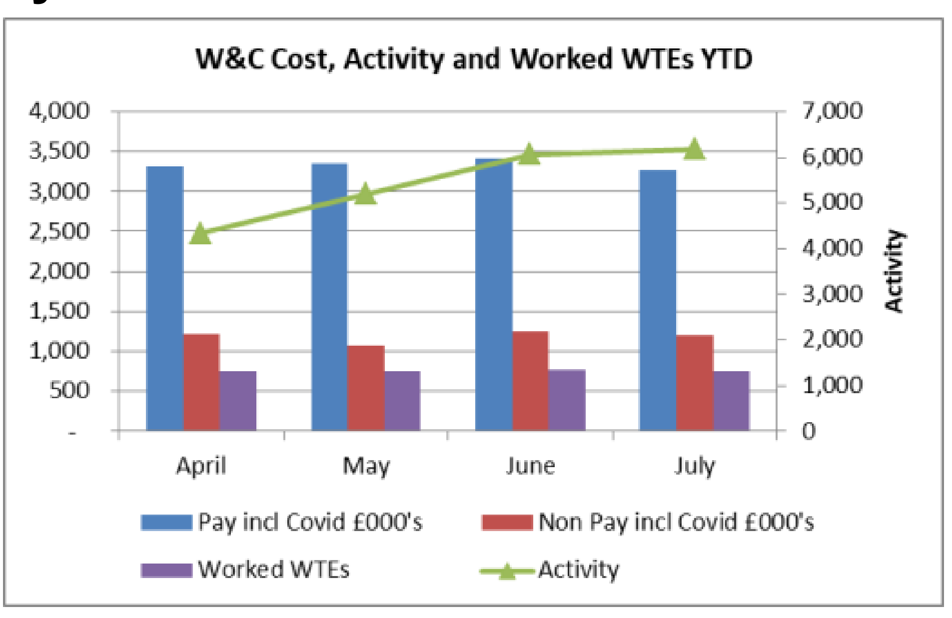
Cost, Activity and Worked WTE by Division – Women and Children

Women & Children Costs	M1	M2	M3	M4	YTD
Pay	3,150	3,211	3,242	3,102	12,704
Non Pay	1,210	1,079	1,252	1,203	4,744
Total	4,360	4,290	4,494	4,305	17,449
Women & Children Covid Costs	**M1**	**M2**	**M3**	**M4**	**YTD**
Pay	172	134	174	162	642
Non Pay	0	0	-	-	0
Total	172	134	174	162	642
Total Women & Children Costs					
Pay	3,322	3,344	3,416	3,264	13,346
Non Pay	1,210	1,079	1,252	1,203	4,744
Total	4,532	4,424	4,668	4,466	18,090
Women & Children Activity	**M1**	**M2**	**M3**	**M4**	**YTD**
Elective Inpatient Spells	63	86	91	92	332
Daycase Spells	40	77	145	98	360
Non-elective Spells	73	89	80	60	302
Emergency Spells	530	627	740	781	2,678
Outpatient Attendances	1,742	2,121	2,443	2,579	8,885
Non face to face outpatients	119	173	147	103	542
Outpatient Procedures	443	622	815	918	2,798
Radiology Unbundled	1	0	0	2	3
Critical Care	1,113	1,175	1,117	1,158	4,564
Other Non PBR	221	218	490	383	1,311
	4,345	**5,188**	**6,068**	**6,174**	**21,775**
Women & Children WTEs					
WTE Worked Non-Covid	726	732	720	726	
WTE Worked Covid	28	19	49	34	
Total	754	751	768	760	



This slide brings together the core divisional costs and worked WTE's, alongside Covid costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs. Women's and Children's activity has increased 2% month on month, and 42% since the start of the year.

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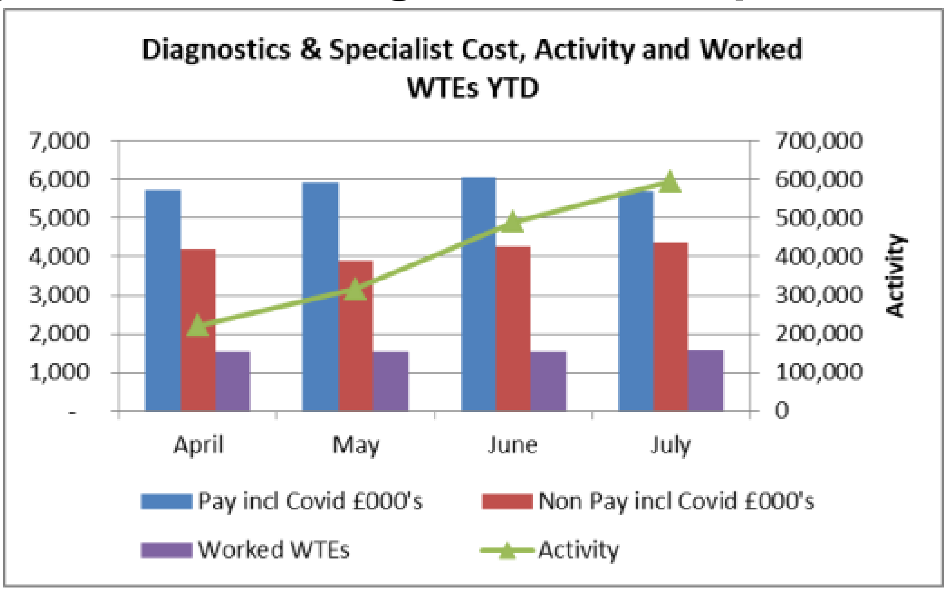
Cost, Activity and Worked WTE by Division – Diagnostic and Specialist

Diagnostics & Specialist Costs	M1	M2	M3	M4	YTD
Pay	5,595	5,719	5,848	5,612	22,774
Non Pay	4,076	3,804	4,243	4,376	16,499
Total	9,671	9,523	10,091	9,987	39,273
Diagnostics & Specialist Covid Costs	**M1**	**M2**	**M3**	**M4**	**YTD**
Pay	127	211	229	85	652
Non Pay	113	99	18	- 0	230
Total	240	310	247	85	881
Total Diagnostics & Specialist Costs					
Pay	5,721	5,929	6,078	5,697	23,425
Non Pay	4,189	3,903	4,261	4,375	16,728
Total	9,911	9,833	10,338	10,072	40,154
Diagnostics & Specialist Activity	**M1**	**M2**	**M3**	**M4**	**YTD**
Daycase Spells	203	307	336	498	1,344
Elective Inpatient Spells	34	27	50	52	163
Non-elective Spells	0	1	4	2	7
Emergency Spells	96	102	111	101	410
Outpatient Attendances	5,038	5,367	6,291	6,357	23,053
Outpatient Procedures	58	56	122	149	385
Non Face to Face Outpatients	1,681	1,721	2,429	3,187	9,018
Radiology Direct Access	2,339	3,301	4,874	6,611	17,125
Radiology Unbundled	698	810	1,126	1,243	3,877
Pathology Direct Access	107,204	170,896	293,529	371,881	943,510
Other Non PBR	4,235	4,060	4,768	5,306	18,369
	121,586	**186,648**	**313,639**	**395,387**	**1,017,260**
Radiology Exams	18,445	23,865	28,876	31,849	103,035
Pathology Requests	79,733	104,271	147,205	167,296	498,505
Chemo Activity	1,323	1,269	1,592	1,817	6,001
	99,501	**129,405**	**177,673**	**200,962**	**607,541**
	221,087	**316,053**	**491,312**	**596,349**	**1,624,801**
Diagnostics & Specialist WTEs					
WTE Worked Non-Covid	1,536	1,537	1,541	1,555	
WTE Worked Covid	3	4	5	3	
Total	1,539	1,541	1,546	1,558	



This slide brings together the core divisional costs and worked WTE's, alongside Covid costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs. Diagnostics and Specialist activity has increased 21% month on month, and 170% since the start of the year.

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Pay Expenditure – Group Totals

Pay	M04 Budget £000s	M04 Actuals £000s	M04 Variance £000s	M04 Cumulative Budget £000s	M04 Cumulative Actuals £000s	M04 Cumulative Variance
Substantive	30,195	30,338	(144)	121,633	122,361	(728)
Bank	1,299	1,507	(208)	5,197	6,763	(1,566)
Agency	929	1,357	(428)	3,715	4,677	(962)
Total	**32,423**	**33,202**	**(779)**	**130,545**	**133,801**	**(3,256)**

At the end of July the reported year to date pay position is £3.26m adverse to budget, driven by Covid spend year to date of £6.30m.

Total Pay Expenditure
M04 2020/21

£m	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Legend: 20/21 Budget; 2020/21 Actual; 19/20 Run-Rate

Y-axis: 25.0 – 35.0

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Non-Pay Expenditure (Group)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Non Pay Analysis	M04 Budget £000s	M04 Actuals £000s	M04 Variance £000s	M04 Cumulative Budget £000s	M04 Cumulative Actuals £000s	M04 Cumulative Variance £000s	Passthrough Variance £000s	Net Variance £000s
Drugs	6,331	6,044	287	25,325	22,955	2,370	(521)	1,849
Clinical Supplies	3,715	3,298	417	14,860	11,221	3,639	(112)	3,527
Other Non-Pay	8,002	9,042	(1,041)	32,031	34,520	(2,489)		(2,489)
Total Non Pay	18,048	18,384	(336)	72,216	68,696	3,520	(634)	2,886

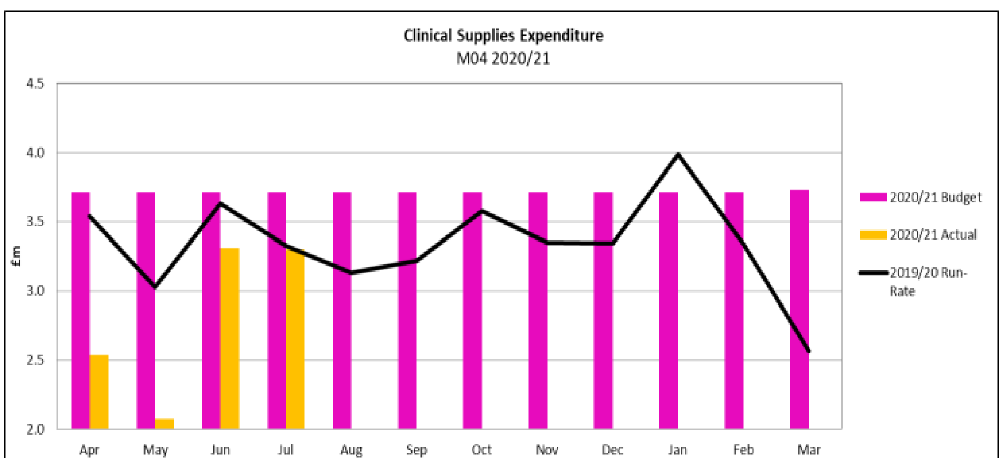
The table shows the split of non-pay expenditure between the main cost categories.

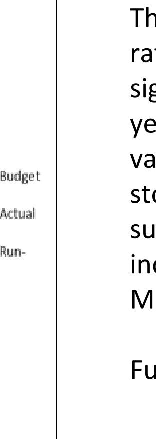
Overall non-pay year to date is £2.89m underspent against budget, predominantly reflecting the reduced activity in clinical divisions, although including Covid-19 non-pay spend.

Total Non Pay Expenditure
M04 2020/21

20.0
18.0
16.0
14.0
12.0
10.0
£m
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2020/21 Budget
2020/21 Actual
2019/20 Run-Rate

The graph for Total Non Pay shows the monthly run rate on expenditure alongside the budget. The month 4 increase is due to an average increase in activity of 20% from Month 3, and is expected to increase again in Month 5.





The graph for Clinical Supplies shows the monthly run-rate on expenditure alongside the budget. The significant drop compared to the same period last year for the early months of 2020/21 relates to variable costs that dropped with the activity that was stopped as a result of Covid-19, for example theatre supplies. Expenditure on Clinical Supplies has increased as activity has started to recover, and in Month 4 is on par with last year.

Further detail on Covid-19 costs start at slide 29.

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Balance Sheet (1)

Trust Financial Position	Opening Balance 31st March 2020 £000	GROUP Balance as at M4 £000	B/S movements from 31st March 2020 £000
Non-Current Assests			
Intangible Assets	5,851	6,054	203
Property, Plant and Equipment	257,352	257,364	12
Trade and Other Receivables	5,889	5,847	(42)
Investment in GMS	0	0	
Total Non-Current Assets	**269,092**	**269,265**	**173**
Current Assets			
Inventories	9,121	8,877	(244)
Trade and Other Receivables	31,268	28,367	(2,901)
Cash and Cash Equivalents	37,385	72,968	35,583
Total Current Assets	**77,774**	**110,212**	**32,438**
Current Liabilities			
Trade and Other Payables	(79,872)	(70,048)	9,824
Other Liabilities	(3,401)	(46,093)	(42,692)
Borrowings	(132,582)	(132,894)	(312)
Provisions	(170)	(170)	0
Total Current Liabilities	**(216,025)**	**(249,205)**	**(33,180)**
Net Current Assets	**(138,251)**	**(138,993)**	**(742)**
Non-Current Liabilities			
Other Liabilities	(6,484)	(6,359)	125
Borrowings	(40,609)	(39,960)	649
Provisions	(2,850)	(2,850)	0
Total Non-Current Liabilities	**(49,943)**	**(49,169)**	**774**
Total Assets Employed	**80,898**	**81,103**	**205**
Financed by Taxpayers Equity			
Public Dividend Capital	179,302	179,655	353
Reserves	29,891	29,891	0
Retained Earnings	(128,295)	(128,443)	(148)
Total Taxpayers' Equity	**80,898**	**81,103**	**205**

The table shows the M4 balance sheet and movements from the 2019/20 closing balance sheet, supporting narrative is on the following pages.

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The commentary below reflects the Month 4 balance sheet position against the 2019/20 outturn

Non-Current Assets

- Trade and other receivables are detailed in the table below

	Opening Balance £000	Movement £000	Closing Balance £000
Hereford Linac	3,167	-58	3,110
CRU	1,945	0	1,945
Residential Accomodation	(571)	15	(556)
Pension Provision	1,348		1,348
	5,889	(43)	5,847

- The Hereford Linac debt relates to the building of the unit. The value of this reduces as it becomes the property of Wye Valley at the end of the contract.
- CRU debt relates to what used to be known as RTA income and we are supplied with the likelihood of recovery and the aging of the debt.
- Residential Accommodation relates to the sale of the residential accommodation to the housing association. When the residences were sold there was a clause in the contract to buy back at a point in time. When IFRS accounting first came started in 2008 this entry was created and is decreasing over the lifetime of the contract.
- The pension provision relates to an NHSI provision which is offset by a provision liability.

Current Assets

- Inventories have decreased in year by £0.2m reflecting a decrease in pharmacy stock.
- Trade and other receivables has decreased by £2.9m to a balance of £28.3m this is made up of £18.4m accrued debt and £9.9m of invoices. Aged debt is analysed on slide 18.
- Cash has increased by £35.5m since the year-end, the increase in cash reflects the receipt of two block payments in month 1.

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Better Payment Practice Code (BPPC)

	Cumulative for Financial Year		Current Month July	
	Number	£'000	Number	£'000
Total Bills Paid Within period	33,238	80,695	6,808	17,804
Total Bill paid within Target	29,453	72,079	6,611	17,132
Percentage of Bills paid within target	89%	89%	97%	96%

BPPC performance currently only includes those invoices that are part of the creditors ledger balance. Performance reflects invoices processed in the period (both cumulative and in-month) rather than the invoices relating to that period.

It should be noted that whilst driving down creditor days as far as possible the Trust are not compliant with 30 day terms across all suppliers.

Liabilities – Borrowings

Analysis of Borrowing	As at 31st July 2020 £000
<12 months	
Loans from ITFF	2,498
Capital Loan	21,691
Distress Funding	106,826
Obligations under finance leases	1,360
Obligations under PFI contracts	519
Balance Outstanding	**132,894**
>12 months	
Loans from ITFF	19,091
Capital Loan	0
Distress Funding	0
Obligations under finance leases	3,597
Obligations under PFI contracts	17,272
Balance Outstanding	**39,960**
Total Balance Outstanding	**172,854**

The Trust has two major loans outstanding with the Independent Trust Financing Facility (ITFF).

The first loan was to facilitate improvements related to backlog maintenance and the second was for the build of the Hereford Radiotherapy Unit. These are included within the balance sheet within both current liabilities (for those amounts due within 12 months) and non -current liabilities (for balances due in over 12 months).

There are also borrowing obligations under finance leases and the PFI contracts.

NHSI have now confirmed that £127,860k of loans will convert to PDC in September. These loans were reclassified as due within 12 months at the beginning of the year.

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Cash flow: July

Cashflow Analysis	Apr-20 £000s	May-20 £000s	Jun-20 £000s	Jul-20 £000s	Forecast Movement August 20 to March 21 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**818**	**954**	**1,035**	**908**	**6,661**	**9,468**
Adjust for non-cash items:						
Depreciation	1,509	1,509	1,509	1,509	13,461	**17,988**
Other operating non-cash	0	0	0	0	(1,000)	**(1,000)**
Operating Cash flows before working capital	**2,327**	**2,463**	**2,544**	**2,417**	**19,122**	**26,456**
Working capital movements:						
(Inc.)/dec. in inventories	221	232	(57)	(152)	(533)	**(137)**
(Inc.)/dec. in trade and other receivables	(4,178)	10,065	(797)	(7,991)	(4,905)	**185**
Inc./(dec.) in current provisions	0	0	0	0	0	**0**
Inc./(dec.) in trade and other payables	35,152	(5,229)	(44,038)	7,110	1,228	**(12,887)**
Inc./(dec.) in other financial liabilities	7,099	(4,559)	41,320	(1,168)	(43,710)	**150**
Net cash in/(out) from working capital	**38,294**	**509**	**(3,572)**	**(2,201)**	**(47,920)**	**(12,689)**
Capital investment:						
Capital expenditure	(1,667)	(1,667)	(1,729)	(882)	(29,672)	**(34,735)**
Capital receipts	0	0	0	0	0	**0**
Net cash in/(out) from investment	**(1,667)**	**(1,667)**	**(1,729)**	**(882)**	**(29,672)**	**(34,735)**
Funding and debt:						
PDC Received	0	0	0	353	139,930	**139,930**
Interest Received	11	0	0	0	0	**11**
Interest Paid	0	0	0	0	(1,841)	**(1,841)**
DH loans - received	0	0	0	0	0	**0**
DH loans - repaid	0	0	0	0	(130,045)	**(130,045)**
Finance lease capital	(95)	(95)	(95)	(488)	(4,392)	**(4,677)**
Interest element of Finance Leases	(17)	(17)	(17)	(12)	(114)	**(165)**
PFI capital element	(43)	(43)	(43)	(68)	(612)	**(741)**
Interest element of PFI	(182)	(182)	(182)	(38)	(342)	**(888)**
PDC Dividend paid					(5,770)	**(5,770)**
Net cash in/(out) from financing	**(326)**	**(337)**	**(337)**	**(253)**	**(3,186)**	**(4,186)**
Net cash in/(out)	**38,628**	**968**	**(3,094)**	**(919)**	**(61,656)**	**(25,154)**
Cash at Bank - Opening	**37,385**	**76,013**	**76,981**	**73,887**	**72,968**	**37,385**
Closing	**76,013**	**76,981**	**73,887**	**72,968**	**11,312**	**12,231**

The cash flow for July 2020 is shown in the table opposite

Cashflow Key movements:

The Cash Position – reflects the Group position.

Two months of block income was received in month 1.

The year end forecast cash position reflects the conversion of £127,860k of loans to PDC .

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Capital Cash and Working Capital

The Trusts financial plan (balance sheet and cash flow) reflects the borrowing of working capital to meet operational commitments, revenue borrowings to repay previous revenue debt due for repayment, and capital borrowing to fund the capital programme (after allowing for internally generated funds and repayment of previous borrowings that are due for repayment).

The borrowing is approved via the annual Operational Plan submission and Capital Financing applications, and the Trust is able to draw down borrowing in year from the Department of Health in line with the approved monthly profile.

Recognising that capital cash is utilised to fund capital expenditure commitments this can not be considered when the Trust reviews the draw down requirement of revenue borrowing on a monthly basis.

Capital Summary	Internal YTD Plan £k	YTD Spend £k	YTD Var £k	20/21 Full Year Plan £k	FOT 20/21 Spend £k	Forecast Variance £k
Estates/Lifecycle	416	574	158	5,280	5,280	0
IT	1,237	1,172	(65)	3,950	3,951	1
IT TrakCare	237	528	291	993	993	0
Divisional Schemes	848	647	(201)	11,045	11,064	20
Contingency	0	0	0	2,251	2,230	(21)
Donated/Leases	0	0	0	1,500	1,500	0
IFRIC12/PFI	304	304	0	911	911	0
COVID19	1,599	1,599	(0)	1,599	1,599	0
Strategic Site Development	1,502	1,424	(78)	3,717	3,717	0
Urgent/Emergency Care	0	0	0	4,400	4,400	0
Overspend/(Underspend)	**6,143**	**6,248**	**105**	**35,646**	**35,646**	**(0)**

The Trust is forecasting a breakeven position on capital expenditure.

We are still awaiting confirmation of the reimbursement of the £1.6m of COVID19 spend from M1 and M2.

The Trust is awaiting approval from the national team for COVID19 bids amounting to £886k. This is not reflected in the forecast position as prior approval is required before any COVI19 related schemes can commence.

The Trust has been successful in securing £2.7m for critical infrastructure risk work to improve its backlog maintenance. This is reflected within the Estates forecast. Additionally, £4.4m has been secured for urgent and emergency care to improve access and flow within the Emergency Department over winter. The Trust is working with NHSE/I to agree the schemes and timescales.

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Covid-19
Additional Expenditure
FY21 M03 (July 2020)

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Introduction

Reporting additional costs incurred by the Trust in addressing the Covid-19 pandemic now forms part of the Trust's monthly monitoring return to NHSE/I.

Divisional cost returns have been reviewed, summarised and aligned to ledger information to define the additional costs incurred. In line with NHSE/I requirements costs have been assessed to fall into the following categories:

- Backfill for higher sickness absence
- COVID-19 virus testing (NHS laboratories)
- Enhanced PTS
- Existing workforce additional shifts
- Expanding medical / nursing / other workforce
- Increase ITU capacity
- Other
- Remote management of patients
- Remote working for non patient activities
- National procurement areas
- Segregation of patient pathways

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Additional Costs Incurred : July 2020

The tables below show the additional cost incurred for the year to date and month of July (second table). Costs stated represent ”completed’ costs and recorded in the general ledger, they include items paid (payroll and invoices); bank/agency known to have occurred and accrued and, for non pay orders placed where goods have been received and receipted.

Description	Pay £000s	Non Pay £000s	Income £000s	Total £000s
Month 4 GHT Ledger As At 14th Aug 2020 (Cum)	5,867	5,173		11,040
GMS Position	431	234	240	904
Month 4 Cumulative Report	**6,298**	**5,407**	**240**	**11,944**

Description	Pay £000s	Non Pay £000s	Income £000s	Total £000s
Month 4 GHT Ledger As At 14th Aug 2020	1,366	968		2,334
GMS Position	86	39	27	152
Month 3 Ledger	**1,452**	**1,007**	**27**	**2,486**

To 31st July total additional costs of £11.9m have been incurred.

In July the additional costs were £2.5m

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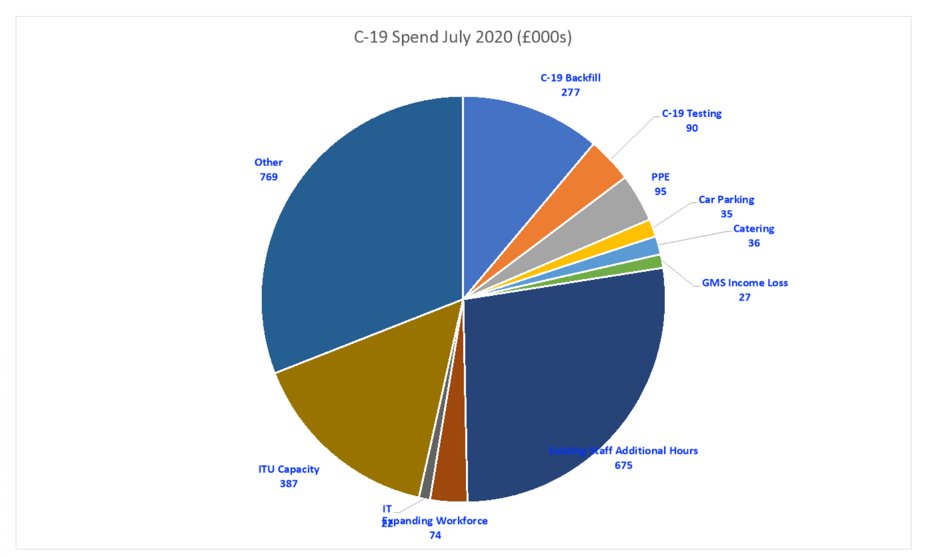
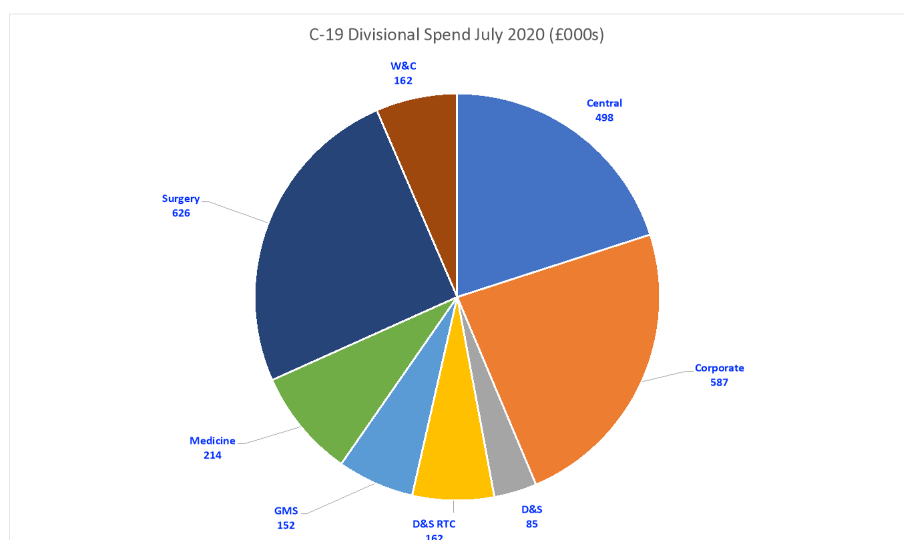
Additional Costs Incurred : July 2020 : Analysis

The charts below show a more detailed distribution of the £2.5m additional expenditure incurred for July.

Senior Finance Business Partners have confirmed that the costs reported are additional costs incurred as a result of dealing with Covid-19 and that Divisions are sighted on and have authorised the spend.

Guidance on Covid-19 cost management and authorisation has been issued to Divisions and published on the Trust intranet.





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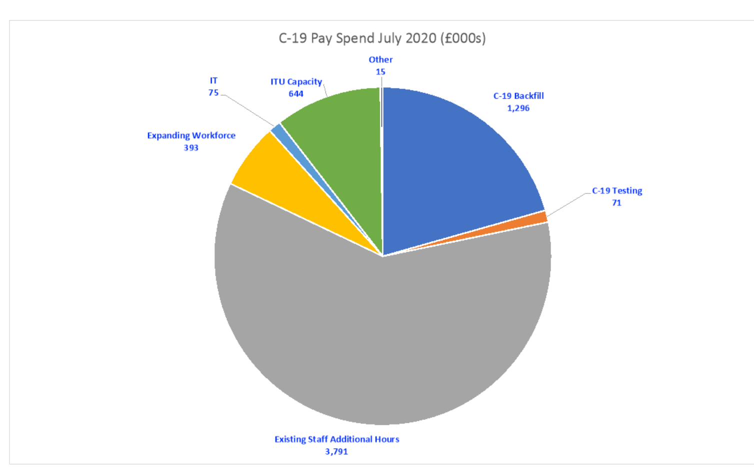
Additional Costs Incurred : July 2020 : Analysis : Pay

The chart below shows the distribution of the £1.5m additional Pay expenditure incurred in July



Pay costs reflect additional hours worked by existing staff; bank, agency and locum backfill; IT additional working and costs of new staff and contractual changes.

Divisions have implemented local processes for authorisation of **additional hours worked** by existing staff. Examples: additional shifts covered by ED consultants; IT overtime supporting internal needs and homeworking arrangements; nursing to cover critical care capacity demands; AHP covering additional therapies, home enteral feeding, radiology

Backfill Bank, agency and locum costs are gathered from weekly reports from the Temporary Staffing team.
When booking additional support managers are required to enter a reason code for the booking. Specific reason codes were introduced for Covid-19 these identify where shifts have been booked for C-19 Backfill (where existing staff have been redeployed), Increased Capacity to deal with C-19, cover for C-19 related sickness and cover for self-isolation

Expanding workforce costs reflect additional staff employed by Divisions to meet C-19 demands and contractual changes for existing staff. Examples include

- Extending temporary contracts for "winter pressures" staff and re-assigning them to C-19 wards
- Specialist nurses in Critical Care
- Senior management project support in Surgery
- Microbiology support
- Increasing physician contracted hours in Gastro and ED to provide C-19 support
- HEE Students given student contracts to provide support to clinical areas

Divisional VCP processes are followed when making such appointments

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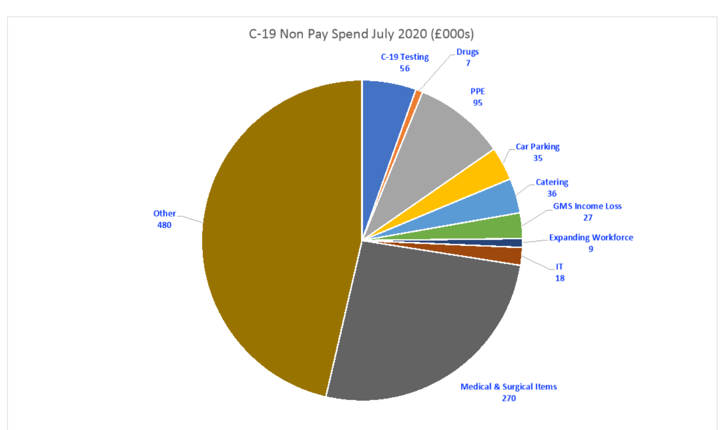
Additional Costs Incurred : July 2020 : Analysis : Non Pay

The chart below shows a more detailed distribution of the £1.0m additional Non Pay expenditure incurred in July



The majority of the non pay spend including PPE and Sanitizing products is recorded in the Central C-19 cost centre. The values are based on expenditure reports from Procurement showing items ordered for C-19.

Testing costs include test kits, reagents and other additional laboratory costs (cleaning etc

Car Parking represents the cost provision for reimbursement of staff monthly charges and recompensing the provider (SABA) for income reductions

PPE costs continue to be the largest element of spend. This includes purchase of face masks for staff, public and visitors

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Additional Costs : July 2020

The tables below summarise the YTD and Month 4 expenditure by NHSE/I category

Div	Revenue Pay / Revenue Non Pay	Backfill for higher sickness absence	COVID-19 virus testing (NHS laboratories)	Enhanced PTS	Existing workforce additional shifts	Expanding medical / nursing / other workforce	Increase ITU capacity	Int & Ext Comms	National procurement areas	Other	Remote management of patients	Remote working for non patient activites	Segregation of patient pathways	Reported Total
Trust	Revenue Pay	1,296	0	0	4,514	405	25	0	0	1	17	39	1	6,298
	Revenue Non Pay	0	523	68	0	9	201	44	3,253	504	56	123	865	5,646
Grand Total		1,296	523	68	4,514	414	226	44	3,253	505	73	163	866	11,944
Central		1	4	68	802	1	2	9	3,137	54	11	29	121	4,240
Corporate		139	0	0	238	(47)	0	35	88	171	56	133	250	1,064
D&S		4	3	0	568	80	0	0	0	0	6	0	220	882
D&S RTC		0	517	0	97	3	0	0	8	0	0	0	19	643
GMS		152	0	0	279	0	(5)	0	15	280	0	0	184	904
Medicine		558	0	0	772	345	0	0	0	0	0	0	61	1,735
Surgery		189	0	0	1,395	7	229	0	4	0	0	0	11	1,834
W&C		254	0	0	362	26	0	0	0	0	0	0	0	642
Grand Total		1,296	523	68	4,514	414	226	44	3,253	505	73	163	866	11,944

Div	Revenue Pay / Revenue Non Pay	Backfill for higher sickness absence	COVID-19 virus testing (NHS laboratories)	Enhanced PTS	Existing workforce additional shifts	Expanding medical / nursing / other workforce	Increase ITU capacity	Int & Ext Comms	National procurement areas	Other	Remote management of patients	Remote working for non patient activites	Segregation of patient pathways	Reported Total
Trust	Revenue Pay	277	0	0	1,100	68	7	0	0	0	(8)	8	0	1,452
	Revenue Non Pay	0	110	0	0	6	1	4	95	151	0	18	650	1,034
Grand Total		277	110	0	1,100	74	8	4	95	151	(8)	26	650	2,486
Central		0	0	0	154	0	0	0	1	50	0	3	290	498
Corporate		47	0	0	58	(18)	0	4	88	42	(8)	24	351	587
D&S		(5)	(6)	0	52	37	0	0	0	0	0	0	6	85
D&S RTC		0	116	0	43	0	0	0	3	0	0	0	0	162
GMS		63	0	0	24	0	0	0	0	59	0	0	7	152
Medicine		40	0	0	126	53	0	0	0	0	0	0	(5)	214
Surgery		38	0	0	576	0	8	0	4	0	0	0	0	626
W&C		94	0	0	67	1	0	0	0	0	0	0	0	162
Grand Total		277	110	0	1,100	74	8	4	95	151	(8)	26	650	2,486

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Recommendations

The Committee is asked to:

- Note the Trust is reporting a year to date breakeven position compared to the run rate assessment of NHSE/I, and that because of block income and true-up funding, this is expected to continue until the end of Month 6.
- Note that compared to budget, the Trust is reporting a positive variance of £5.66m.

Authors: **Tony Brown, Senior Finance Advisor and Johanna Bogle, Associate Director of Financial Management**

Presenting Director: **Karen Johnson, Director of Finance**

Date: **August 2020**

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REPORT TO TRUST BOARD – SEPTEMBER 2020

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

This report describes the business conducted at the Finance and Digital Committee held 27 August 2020, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital Programme Report	Comprehensive project by project update highlighting: - Continued progress with Electronic Patient Record - Initial deployment of Order Communications module - Frank assessment of the team's fatigue following intense demands Limitations of maternity reporting	How is team fatigue exhibited? Will projects be re-scheduled or will there be additional resource requirements What is the solution to this issue?	Realistically a function of current circumstances – consequence is projects "closer to the wire" than normal/desirable	Updated investment plan to be brought forward – timing to be confirmed (October?) Requires separate solution
	Review of Information Governance activity and compliance levels	How are incidents reported/monitored through the committee structure?		To be reviewed by Corporate Governance and Audit and Assurance Committee
Financial Performance Report	Review of income and expenditure by month and year to date at month 4. Overall result continues at	How long have we known about this issue? Does the ruling impact other services?	Ruling received within the last month No	Was the originally identified risk (2+ years earlier) incorrectly left off the risk register

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	break even reflecting national "true-up" regime Briefing on new issue arising from long delayed unfavourable HMRC VAT ruling on outsourced theatre services	How will this be progressed?	Working with advisers - background is that other organisations have similar arrangements that are treated differently	
Capital Programme Report	Update on in year Capital plan including confirmation of additional £2.7 Million for critical infrastructure backlog maintenance	Increments to the plan have raised the total to c. £35 million – where is this formally approved? Is there adequate resource/capacity to effectively spend the capital? Does incremental approach lead to sub optimal decisions/actions	There is strategic oversight of all projects to avoid adverse impact of piecemeal actions. Team is aware of the challenges and risks associated with the rapid turnaround times required for some bids.	Timing of formal total capital review approval needs to be reviewed.
Cost Improvement Programme	Review of current achievement at month 4 (£2.2 million actual v. £3.1 million plan) and current projection for the year indicates a significant shortfall from plan.	Latest guidance from NHSE/I indicates a return to a cost driven approach – with a tired workforce how can CIP initiatives be reinvigorated?		Requires a fresh look at how to progress with a particular emphasis on transformation work
	Updated benchmarking and Use of Resources summaries			
Third Phase of the NHS Response to	Comprehensive update on the modelling work looking at activity and associated costs	Is the current timetable involving multiple approval steps and	Executives are appropriately focussed on making realistic	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
COVID-19	to address the NHS national priorities	shifting demands realistic?	assessments of the response to the proposed priorities acknowledging that not all are achievable in the requested timeframe. The review timetable is tight and may change. High quality analysis albeit in a very dynamic situation.	
Changes to Capital and Cash Regime	Clear briefing on important technical changes to historic debt write off, and the move away from interest bearing loans to public dividend capital		Excellent analysis demonstrated this matter is being appropriately accounted for.	

Rob Graves
Chair of Finance and Digital Committee
September 2020

TRUST BOARD –SEPTEMBER 2020
Microsoft Teams at 12:30

Report Title
Provider Licence - Self-Certifications

Sponsor and Author(s)	
Author:	Natashia Judge, Corporate Governance Manager
Sponsor:	Sim Foreman, Trust Secretary

Executive Summary

Purpose

To present year-end self-certifications to the Trust Board for approval.

Key issues to note

- The Trust is required to self-certify on an annual basis the status of compliance with licensing conditions as part of the Foundation Trust Provider License. The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. Foundation trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.
    - Condition G6: the provider has taken all precautions necessary to comply with the licence, NHS Acts and the NHS Constitution.
    - Condition FT4: the provider has complied with required governance arrangements (‘Corporate Governance Statement’).
    - Condition CoS7: the provider has a reasonable expectation that required resources will be available to deliver the designated service.

- It is up to providers how they undertake the self-certification however a number of templates have been provided which the Trust has to use. Trusts are required to state either “confirmed” or “not confirmed” against each element of the licence condition. The board must sign-off the self-certification and the Trust must then publish the result on the Trust website.

- The evidence supporting the signing is contained in the Annual Report, Annual Accounts, the Quality Account and the supporting documents.

- The Trust has reviewed the statements and evidence sets and is proposing that the Trust Board responds with “confirmed” for all elements.

- For FT4, the Board is also required to consider any risks and mitigating actions for each element of the provider licence condition. While no significant risk have been identified, the comment boxes were used to provide supportive narrative.

- Normally, the Trust Board would sign off conditions G6(3) and CoS7 (3) by 31 May and conditions G6(4) and FT4(8) by 30 June 2020. However, NHS England/ Improvement have advised that in light of the current COVID-19 pandemic, they do not intend to undertake any audits of compliance against the self-certification requirements of the provider licence or to use our enforcement powers in the event of a breach in this financial year.

- As part of condition FT4, the Trust is required to certify that "the Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."

  While inevitably impacted by the COVID-19 pandemic, The Trust has reviewed the statement and is proposing that the Trust Board responds with "confirmed" for this element. The Council of Governors supported this at the recent meeting.

- As in the last year, the Board is presenting all required conditions together for single sign off.

Implications and Future Action Required

The self-certifications will be published on the Trust website, as required.

Recommendations

The Trust Board is asked to confirm that, based on the evidence provided, that to the best of their knowledge they believe that the Trust is compliant with the terms of its provider license and therefore endorses the self-certification as proposed.

Impact Upon Strategic Objectives

Good governance supports delivery of the Trust's purpose, vision and strategic objectives.

Impact Upon Corporate Risks

Outside of the current pandemic, it is worth noting that failure to certify compliance would import a significant governance risk to the Trust.

Regulatory and/or Legal Implications

The Trust is required to self-certify on an annual basis the status of compliance with licensing conditions as part of the Foundation Trust Provider License.

There is potential for reputational damage should the Trust not hold its provider license alongside monitoring enforcement action from the regulator.

Equality & Patient Impact

None.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	X	For Information	

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

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

Outcome of discussion when presented to previous Committees/TLT

oundation trusts and NHS trusts to record the self-certifications that must be made unc
ed to return your completed template to NHS Improvement unless it is requested for a

Self-Certification Temp

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS

Corporate Governance Statement - i

Certification on training of Governor

These self-certifications are set out in this templ

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates: 2019/20 — Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No significant risks identified. Detail in the Annual Governance Statement.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	No significant risks identified. Horizon scanning, work of the Audit an Assurance Committee, and the Board business cycle allows new guidance to be brought to the attention of the Board and acted on in a timely manner.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No significant risks identified. During 2019/20 the Trust continued to refine its governance arrangements in line with The NHS Foundation Trust Code of Governance which included reviewing the organisation's Standing Orders, Standing Financial Instructions and Scheme of Delegation. Other related work on governance, risk and assurance included and reviewing the efficacy and performance of Board committees against their remit, the development of the BAF and a review of the meetings within the Trust's Delivery and Assurance structure to reduce the number of groups from 17 to seven from 2020/21. The Executive and the wider management structure across the Trust, continue to apply dynamism to all aspects of risk management (identification, assessment and mitigation), with this being truly evident in the response to the threat from COVID-19. This has been greatly assisted by the continued focus on ensuring the organisational culture, alongside the governance arrangements, continues to be based on support, challenge, openness, candour and transparency. The Board has sight of timely and accurate information to assess risks to compliance with the Trust's licence. Trust performance is reviewed by the Finance and Digital Committee, the People and Organisation Development Committee and the Quality and Performance Committee and by the Board at each meeting. The Committees undertake detailed reviews of any indicators that show sustained adverse performance.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	No significant risks identified. Annual Governance Statement and Annual Report document compliance with regulatory requirements. Internal and external audit confirmed no material concern with regard to controls and processes.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Board skills assessment completed. Quality is a standing item on the Board agenda, with the Quality and Performance Committee maintaining oversight of quality issues. Quality Governance Structure operated throughout 2019/20. Governors are involved in quality through Governors' Quality Group. . Embedded approach to quality improvement acknowledged in the CQC inspection report received during 2018/19.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	No major risks identified. Fit and Proper Persons requirements are undertaken on the appointment of Board members. Regular Board and committee reporting on staffing, recruitment, retention, staff engagement, talent and leadership development in place. Regular Board Strategy and Development sessions in place. Regular meetings of the Remuneration Committee and Governors' Governance and Nominations Committee to address succession planning. Leadership capability recognised in the 2019 CQC Well-led inspection.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature | **Signature**

Name Peter Lachecki | **Name** Deborah Lee

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors" **Financial Year to which self-certification relates** Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1 The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. — Confirmed — OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Peter Lachecki	**Name**	Deborah Lee
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	torsdag 10. september 2020	**Date**	torsdag 10. september 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

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ıeed to return your completed template to NHS Improvement unless it is requested for aud

-Certification Template - Con

Insert name of organisation

Foundation Trusts and NHS trusts are required to ma

Systems or compliance with licence condi

Availability of resources and accompanyi

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.

2) Enter responses and information into the yellow data-entry cells as appropriate.

3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | | Please Respond

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust delivered an operating surplus in 2019/20 of £50k (following the receipt of additional PSF funding) and was planning for a breakeven position in 2020/21 in line with the control total offered by NHS Improvement. Financial plans were in place to support the delivery of this position with the Trust's operating and cash flow forecasts identifying the need for continued additional financial support to enable it to fund the costs of its capital programme, as the Trust does not hold historic cash reserves to draw on.

Since developing this plan the funding regime of the NHS has been disrupted due to the ongoing Covid-19 pandemic. Whilst this has provided certainty on the Trust's income for the first four months of the year (as Trusts are funded on costs incurred) guidance related to the funding from month 5 onwards has not yet been communicated. This presents an element of uncertainty to the Trust's income position, as refelcted in our 2019/20 year end audit letter.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Peter Lachecki	**Name**	Deborah Lee
Capacity	Trust Chair	**Capacity**	Chief Executive
Date	torsdag 10. september 2020	**Date**	torsdag 10. september 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

DRAFT MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 17 JUNE 2020 AT 14:30

THESE MINUTES MAY BE MADE AVAILABLE TO THE PUBLIC AND PERSONS OUTSIDE THE TRUST AS PART OF THE TRUST'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT 2000

PRESENT:

Alan Thomas	AT	Public Governor, Cheltenham (Lead)
Matt Babbage	MB	Stakeholder Appointed Governor, Gloucestershire County Council (GCC)
Tim Callaghan	TC	Public Governor, Cheltenham
Geoff Cave	GCa	Public Governor, Tewkesbury
Graham Coughlin	GCo	Public Governor, Gloucester
Anne Davies	AD	Public Governor, Cotswold
Colin Greaves	CGr	Stakeholder Appointed Governor, Clinical Commissioning Group (CCG)
Marguerite Harris	MH	Public Governor, Out of County
Nigel Johnson	NJo	Staff Governor, Other and Non-Clinical
Pat Le Rolland	PLR	Stakeholder Appointed Governor, Age UK Gloucestershire
Tom Llewellyn	TL	Staff Governor, Medical & Dental
Jeremy Marchant	JM	Public Governor, Stroud
Kedge Martin	KM	Public Governor, Tewkesbury
Sarah Mather	SM	Staff Governor, Nursing and Midwifery
Maggie Powell	MPo	Stakeholder Appointed Governor, Healthwatch
Julia Preston	JP	Staff Governor, Nursing and Midwifery

IN ATTENDANCE:

Peter Lachecki	PL	Trust Chair
Deborah Lee	DL	Chief Executive Officer
Rachel de Caux	RdC	Chief Operating Officer (left the meeting at 16:01)
Claire Feehily	CF	Non-Executive Director (NED)
Sim Foreman	SF	Trust Secretary
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Rob Graves	RG	Non-Executive Director
Steve Hams	SH	Director of Quality & Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital & Information Officer
Simon Lanceley	SL	Director of Strategy & Transformation
Mike Napier	MN	Non-Executive Director
Alison Moon	AM	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director

APOLOGIES:

Pat Eagle	PE	Public Governor, Stroud

ACTION

001/20 DECLARATIONS OF INTEREST

There were none.

002/20 CHAIR'S UPDATE

The Chair welcomed all to the Committee and highlighted changes to working practices due to the current situation. The Chair and all NEDs had been completely clear of the hospitals in accordance to guidance, but despite this were still working effectively and efficiently. All Board Committees had been maintained which had enabled NEDs to execute their roles well, understanding challenges, giving challenge and support to executive colleagues. The frequency of NED only meetings had increased to monthly, although the format had changed a little with the use of MS Teams. The Chair formally thanked the NEDs for their support during this time to provide Governors with assurance.

The Chair confirmed that it had been agreed to continue with virtual meetings for the next three months at least and highlighted a 'silver lining' from the current situation had been an increase in the number of Governors observing the Trust Board (eight at the last meeting).

RESOLVED: The Council NOTED the update.

003/20 REPORT OF THE CHIEF EXECUTIVE

Paper presented by the CEO, with the following highlights:

- The dynamic in the hospital was changing dramatically for a number of reasons; COVID activity had reduced and the final patient had been 'clapped' out of critical care. This patient was also a staff member and the most unwell of 12 members of staff affected. DL thanked the critical care team for what they had accomplished. Overall in terms of COVID, the hospitals were now quiet with only 11 inpatients COVID+ confirmed compared to the peak when there were close to 200 patients.
- Regular activities and services were being resumed and increased. Along with social distancing, the wearing of masks in public areas for staff and visitors, screens between patients on wards were in place. Although this phase of transition would settle, DL advised that things were still frequently changing causing the feel to be very dynamic.
- Focused attention was being given to the environment away from clinical areas as more staff return from home working. There was a significant reduction in the number of desks in areas with attention also given to shared environments, i.e. telephones and keyboards, where policies and protocols had been shared to apply infection control standards.
- The approach to reducing transmission through testing continued for patients and staff. National guidance was still awaited regarding the routine testing of asymptomatic staff.
- Guidance had been received regarding cancer services where if capacity was available in laboratories, it was prudent to start routine testing of staff working in non-surgical cancer services i.e. chemotherapy, radiotherapy.
- The "Test and Trace" system had not particularly impacted the Trust and Gloucestershire as a county had one of the lowest rates of take up for this programme.
- A Zoom meeting was held with BAME colleagues and non-BAME

colleagues to discuss how staff were feeling in response to the George Floyd incident and Black Lives Matter. DL felt it was a positive and engaged discussion, but may have benefited from more time. The main point raised was that actions needed to bring about step change for what had been known for a long time; a number of minority groups, who were marginalised in society, had a less favourable time working for the Trust which was not right. The Trust had tried to improve this, but a big enough change had not been brought about. This would be taken forward as a Board and Executive team working hand in hand with the Diversity network.

In response:

NJ questioned if antibody testing would be rolled out for staff shielding. DL responded that for staff who had been shielding, the likelihood was extremely low. Discussions had been had nationally and locally with the outcome that this was not going to be offered at the moment, but may change. SH and Emma Wood, Director of People and OD and Deputy CEO (EW), were looking into how this could best be communicated.

MPo asked about social distancing in outpatient areas. DL responded that changes began in an adhoc manner, but in the last ten days approach was now Trust wide. All areas should now have the same posters and the same system of works. MPo also added with regard waiting areas and over running clinics, how would social distancing be managed. DL assured that clinics were now being booked differently to pre-COVID and waiting rooms were marked out and shouldn't encounter crowding. RdC echoed that there were blocks between face to face appointments to hold virtual/telephone consultations and waiting areas were marked out and included perspex screens to ensure safety.

NJ asked if BAME staff would get the opportunity to share their experiences with the wider staff and or public in the future. DL added that important to note that this started on Monday with a Zoom meeting and going forward had to be driven by the evidence base. It was known for the last ten to 15 years nothing had changed. The main highlight from the meeting was that staff wanted action that made a difference.

AD questioned if attendance at the hospital had decreased due to telephone consultations and if this would continue. DL responded that she had been delighted to hear patients talk about virtual first, although some care was still being delivered face to face. RdC and team were looking at scenarios on what things would look like if we return to normal. Colleagues had received feedback that virtual consultations were quite draining and could take as long as a face to face consultation. RdC added that in terms of outpatient data, activity was back up to 90% on last year and was very encouraging. Virtual was helping to prevent delays and improve activity.

RESOLVED: The Council NOTED the report.

004/20 CHAIRS' REPORTS

Finance and Digital Committee (FDC):

Paper presented by RG. Paper taken as read with the following highlights:

Finance:

- The focus in most recent finance meetings had been on the approach to the numbers in the 2020/2021 year, which had been complicated. For assurance the Finance Team had been interrogated on the methodology applied and how the Trust was complying with the unusual rules in this pandemic. The Committee was satisfied that the Finance Team were handling things appropriately and acknowledged the way that the Trust was going to be monitored later in the year would cause significant issues with budgetary control. This had all happened alongside work to record the exceptional costs resulting from the COVID situation.
- At the beginning of June an extraordinary FDC meeting was held to discuss temporary service changes as part of the Phase Two response to the pandemic. A comprehensive analysis was presented to show the financial implications and under the charge of the Board, it was deemed that the financial impact was reasonable and affordable within the guidelines from NHS England and Improvement (NHSE/I).

Digital:

- The Committee had recently been presented with a brief account regarding the digital work for the pandemic i.e. remote consultations, which represented things that would be sustained into the future.
- There had been operational consequences on the original programme plan that the organisation was being prepared for i.e. order communications which was important for future extended applications of the electronic record systems, with more information to follow in the coming months.

Estates and Facilities Committee (EFC):

MN presented the paper following the EFC on the 28 May 2020, with the following highlights from significant NED challenge:

- The COVID-19 update highlighted that the senior GMS (Gloucestershire Managed Services) team felt integrated and part of the team. Likewise, the Trust team had been equally complimentary.
- GMS had awarded a 5% cost of living increase to staff on GMS terms and conditions; the first pay increase since the start of GMS. Concern was expressed regarding the level and how it would be received by other GMS staff groups and communicated to both GMS and wider Trust staff. Assurance was given that a team had been established to work with the Trusts HR department to ensure communication was effective.
- Contract Management Group updates were provided by RdC and to note KPIs were being met, cleaning was still a key area of focus, although the EFC had deemed cleaning a topic for the Quality and Performance Committee to ensure standards were complied to by GMS.
- PFI (Private Finance Initiative) lifecycle costs and parking costs were of particular interest to NEDs with plans for reports to come to

Committee in the future.

- The outlying business case for the strategic site development programme had been approved by the Board in January and submitted to NHSE/I. SL had hoped that it would've been discussed in May, but had been deferred to June. In light of COVID-19 and changes to working practices, reflection had been given to whether or not the scope or design could be done differently, although changes at this stage would incur additional costs.
- In conjunction with the Gloucestershire ICS (Integrated Care System) and the estates strategy as a whole, a review was underway of office space that may be needed in the future. Should the digital and virtual solutions that had been applied during COVID become normal working practices, this could indicate that less space was needed.

In response:

AD questioned what the implications for the Trust and patients were if national cleaning standards were not met. RdC responded that the national cleaning standards were not currently mandated and were being discussed nationally. Earlier in the year discussions were held with GMS to highlight level of resource and investment required to deliver against contractual cleaning standards, which the improvement programme had focused on. Further commentary would go back to the Quality and Performance Committee (QPC) from the Infection Control Committee. AD added that she would like to know the differences. SH agreed with RdC's comment and highlighted that the improvement work started 18 months ago. Key to note was the outcome for patients and over the last six months there had been improvement with clostridium difficile rates, good hand hygiene and other transmission based precautions. Cleaning was important, but only one part of a wider process for patients.

People and Organisational Development Committee (PODC)

Paper taken as read. Presented by BH with the following highlights:

BH firstly wished to thank DL for the BAME Zoom call which was very insightful and emotional to hear the personal experiences of colleagues.

- At the last PODC the risk relating to BAME staff and COVID-19 was reviewed and work had started to identify actions to be taken. A Freedom to Speak Up guardian role had been introduced.
- The disproportionate effect of COVID on BAME staff had been reviewed and MP had updated on studies noting that in this county there was no proportional impact. Out of nine staff members admitted to hospital, two were BAME. EW had provided a letter of support to BAME staff during this time. The Committee were assured that BAME staff needs had been met and further work continued. The Zoom call highlighted a significant number of actions that would be reviewed.
- The COVID risk to mental health was to be reviewed by HR and the PODC before adding to the risk register and more information on this would follow in coming weeks.

- Assurance had been provided that GMS colleagues were engaged by the Trust and GMS Management.
- A review of building on working in non-COVID times had commenced.
- The staff survey had highlighted the need for more medical and dental engagement, understanding of why staff felt that they were being bullied and harassed, what the term civility means and what staff do not want to experience in the work place.

Quality and Performance Committee (QPC):

Paper taken as read. Presented by AM with the following highlights.

- The QPC had received assurance that the internal process to identify new and existing risks was robust.
- Serious Incident reporting had reduced during COVID to which the confidence in the reporting system was challenged. MP had already commenced work looking at mid-February to mid-May incidents and would report back to QPC.
- The risk to patients whose care or treatment had been delayed had been reviewed through the clinical harm review policy. The definition of harm was discussed and the decision was taken to add mental health. MP would present an updated paper to the July QPC noting how changes had been embedded and implemented.
- The QPC had received assurance regarding the COVID governance temporary changes and impact assessment of the first phase along with the clinical validation process. A recovery paper had also been received which provided good assurance that the Executives had a good grip on issues and what was to be achieved.
- Last year the numbers of patients waiting improved dramatically, this had now declined. RdC had outlined realistically that recovery this time would be slower and based on clinical need over length of time patients were waiting. Timelines and trajectories had been requested to track progress.
- The Quality & Performance Report highlighted that longstanding indicators need to be re-reviewed and in turn the QPC meeting length extended.
- The Quality Account annual report and Annual Screening report were very good reads and showed good performance from the Trust.

In response:

PLR questioned what was learnt from planning ahead with regard patient discharge. AM responded that the patient association had done a survey looking at patient discharge. SH to review and take forward, but to note that when presented with data and statics, discussions were held at Committee in terms of taking things forward. PLR asked if the Committee had had time to consider what they would do again and what they would not do to impact on the community; had the silver linings been grasped. AM responded that the Trust was very focused on silver linings and had kept a log through the pandemic which would be brought back to the QPC and Board in the future. SH added that the onward care team who support discharge had started the process to look at what had gone well to develop the process in the future. DL assured that

despite rumours relating to patients returning to care homes, the Trust had followed all guidance and a review of the approach, undertaken by GCC, shown that the Trust had followed guidance and good practice ahead of that.

JM questioned the actual numbers of care home patients involved and challenged the nature of the care given. DL responded that the Trust had followed the guidance based on the science at the time and what was done was absolutely good enough, although it was recognised that the support for care homes was not comprehensive enough, but was not the responsibility of the Acute Trust. JM thanked DL for her honesty. JM also questioned how sophisticated was the recording of silver linings. SL responded that from the first phase of COVID a team member had joined all meetings and captured details. Four areas had already been prioritised which include home working, virtual outpatients, seven day working and staff health and wellbeing support.

GC asked if the reduction in cancer referrals had been assessed during the COVID period and RdC replied that in April there was a dramatic reduction by 75%. Levels had started to return in May and were now starting to return to normal, but to note that there was reluctance from patients to come in to hospital for treatment or surgery (including cancer patients) due to the fear of COVID. GC further asked what steps had been taken to highlight that things were as safe as possible. RdC confirmed that the work focusing on temporary service change included assurance for patients on both sites and assured that safety of patients was paramount.

Audit and Assurance Committee (AAC):

Paper taken as read. Paper presented by CF with the following highlights:

- Assurance had been gained that counter fraud activity was continuing well and across the system. The risk of procurement fraud was heightened at the moment.
- The framework in which risks were considered and managed in the Trust had highlighted variability with some divisions with the quality of data. The AAC would keep oversight of the action plan.
- The internal auditors were happy with consistency of evidence of improvement and the Trust was not far off the highest level of reporting.
- The Annual Report and external audit progress was encouraging, with plenty of assurance that this was a much better year.

RESOLVED: The Council NOTED the assurance reports from the Committee Chairs.

005/20 ANNUAL QUALITY ACCOUNT 2019/20

SH presented the final draft of the annual Quality Account for Governors to add any final comments while it goes through its final stages of engagement. The account demonstrates all the work undertaken for the last 12 months. Any additional comments would be welcomed and sent

to Suzie Cro by the 25 June 2020 to be finalised ahead of Board approval in August.

RESOLVED: The Council NOTED the draft Annual Quality Account 2019/20.

006/20 DIGITAL QUALITY AND BENEFITS REPORT

Paper presented by MH highlighting the benefits from the implementation of Sunrise EPR (electronic patient record).

The EPR system successfully went live seven months ahead of schedule. The system had replaced the need for paper notes and could be accessed from anywhere in the hospital and from home. This allowed Matrons to keep track of patients from anywhere. The system could be updated in real time and was able to trigger interventions in the right timescales.

Over the last couple of weeks EPR had been able to implement the News2 score, electronic observations, allowing for the sickest patients in the hospital to be identified instantly and staff assigned accordingly in either hospital.

EPR had also helped with the deployment of staff, the instant ability to provide reports for the Department of Health and many national returns the Trust had to submit.

In the main, EPR had significantly afforded significant additional time for nurses to focus on patients and although the Trust would not be able to eradicate paper from the hospital for now, as time goes on less and less paper would be needed and this was the first step of the journey.

In response:

AT praised DL and MH’s team for the speed of realising benefits from the EPR system. AT raised with regard safeguarding and videoconferencing, how was safeguarding going to be dealt with for the vulnerable. MH reassured that currently only 5% of appointments were videoconferencing, appointments were more telephone conferencing, but work was underway to support videoconferencing and the adopting of new ways of working.

PLR commented that it was a really helpful report, particularly on the impact of the EPR. This was echoed by NJ who felt it looked like a real time saver and commended the team.

JM asked if GPs were able to see patients’ records from outside the Trust. MH responded that across Gloucestershire there was a system joining up your information (JUYI) where partners entered a summary of the primary care record, community trust record and mental health record into one system, but due to the Trust mainly having records on paper, things were delayed.

JP raised concern that the access for logging into EPR could sometimes be time consuming and can also keep logging you out. MH replied that

future investment would include the provision of Ipads for staff to ease access, but to note that compared to obtaining paper records from file, EPR was a much better use of time. Also in the near future some users would be issued with a card that can be tapped onto the side of a screen which would take the user back to where they were last in the system. JP expressed concerns around security risk if the card was lost. MH agreed that some form of education would be important.

AD questioned if TrakCare was still in use. MH confirmed that TrakCare was a patient administration system which was still being used for administrative purposes. Sunrise EPR was a system for the clinical team funded by monies negotiated out of the TrakCare contract when these elements were removed from it.

NJ questioned if there was any training for healthcare professionals undertaking virtual clinics. MH assured that work was underway to support staff.

DL informed all that MH had been nominated for the Health Tech Leader of the year award, highlighting that he was the only non-clinician nominated and delighted he had been recognised. The Chair echoed the support and wished MH well.

RESOLVED: The Council NOTED the report.

007/20 COVID-19 TEMPORARY SERVICE CHANGE UPDATE

SL presented the paper with the following highlights:

- The Trust Board had decided, based on work from MP, to centralise vascular services to Gloucestershire Royal Hospital (GRH), although daycase would still remain at Cheltenham General Hospital (CGH).
- The urology emergency pathway would go to GRH and depending on swab results the patient may then be transferred to CGH.
- Internally work to improve communication had been undertaken for teams and to understand the impact for them.
- Externally with a range of partners, communication had gone out over social media, the radio, posters around the towns, signage changes internally and soon there would be changes to the external signage of the Cheltenham Minor Injuries Unit.
- This was the first week and despite teething problems, things were getting better.

In response:

In response to a Governor question, SL explained that the three key objectives was to limit transmission between patients and staff, the second to restore services i.e. planned care, cancer services and diagnostics and the third to give confidence to the population that both of our hospitals were safe to visit.

The service changes around separating COVID and non-COVID were to give patients, their families and carers the confidence to come and receive care.

PL questioned if there was anything causing concern from the teething problems. SL assured that there was nothing that couldn't be fixed so far and Task and Finish groups were still in place to resolve issues in real time.

RESOLVED: The Council NOTED the report.

008/20 GOVERNOR'S LOG

AT commented that during the Governor's pre-meet it had been discussed about the usefulness of the system. Looking through there had been valuable questions and comprehensive answers. Difficulty accessing the website had been raised which AT would discuss and resolved with SF.

RESOLVED: The Council NOTED the Governor's Log.

009/20 ANY OTHER BUSINESS

There was none.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 19 August 2020.

Signed as a true and accurate record:

Chair
19 August 2020