PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Thursday 08 October 2020 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies (RdC)	Chair		12:30	
1.	Patient story	Suzi Cro			
2.	Declarations of interest	Chair		13:00	
3.	Minutes of the previous meeting	Chair	Approval		YES
4.	Matters arising	Chair	Approval		YES
5.	Chief Executive Officer's report	Deborah Lee	Information	13:05	YES
6.	Trust risk register	Emma Wood	Approval	13:15	YES
7.	Compassionate leadership	Emma Wood	Approval	13:25	YES
	BREAK			13:45	
	FINANCE AND DIGITAL				
8.	Finance report	Karen Johnson	Assurance	13:55	YES
9.	Digital report	Mark Hutchinson	Assurance	14:05	YES
10.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	14:15	YES
	ESTATES AND FACILITIES				
11.	Assurance report of the Chair of the Estates and Facilities Committee	Mike Napier	Assurance	14:20	YES
	QUALITY AND PERFORMANCE				
12.	Quality and Performance report	Steve Hams / Mark Pietroni / Felicity Taylor-Drewe	Assurance	14:25	YES

13.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	14:35	YES
	AUDIT AND ASSURANCE				
14.	Assurance report of the Chair of the Audit & Assurance Committee	Claire Feehily	Assurance	14:40	YES
	ADDITIONAL PAPERS				
15.	Annual report and acccounts	Sim Foreman	Information	14:45	YES
	STANDING ITEMS				
16.	Governor questions and comments	Chair		14:50	
17.	New risks identified	Chair			
18.	Any other business	Chair			
CLOSE				15:00	

Date of the next meeting: Thursday 12 November 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

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MS TEAMS ON THURSDAY 10 SEPTEMBER 2020 AT 10:15

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
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
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
IN ATTENDANCE:		
Coral Boston	CB	Engagement/ Equality, Diversity and Inclusion BAME Lead (Staff story)
Sim Foreman	SF	Trust Secretary
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Abigail Hopewell	AH	Head of Leadership Development (staff story)
Craig MacFarlane	CM	Head of Communications
Noel Peter	NP	Consultant in Trauma and Upper Limb Surgery and Major Trauma Lead (Staff story)
APOLOGIES:		
Mark Hutchinson	MH	Chief Digital and Information Officer
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were five governors, three staff and three members of the public present.		

ACTION

147/20 STAFF STORY

EW introduced AH, NP and CB. NP and CB shared their personal experiences as BAME colleagues and reinforced the need for real changes to tackle the poorer experiences encountered by BAME colleagues compared to their non-BAME counterparts. NP delivered a presentation on eradicating systemic racism and championing diversity and inclusion, but advised that sadly he had been discouraged by colleagues from attending the Board. The Chair expressed deep concern that NP had been discouraged from attending, but said he was very pleased that he had ignored their advice and that he was "leading the charge" to drive and champion change. The Chair thanked both NP and CB for sharing their moving and very personal stories.

Board members in turn thanked CB and NP for their authenticity,

honesty and bravery in telling their stories. The Black Lives Matter movement had brought into focus a situation that had continued for too long and there was recognition that the Board and organisation need help to make the changes. Discussion took place on different ways this could happen and NP felt the most important issue was addressing unconscious bias and combatting the silence that existed amongst colleagues and friends when they knew something was wrong and thus colluded with the negative culture. The concept of "allyship" was supported although more work was needed to identify what this meant in practice. EW stated it was vital that people were able to tell their story in order to make changes.

RdC asked how NP and BAME colleagues had managed anxieties about COVID and whether the Trust could have done more to support them. NP advised there was potential for improvement on many fronts and opportunities to reflect and learn. He recounted that when shielding for over 70s was introduced, two white consultant colleagues were told to do this but a third BAME staff grade doctor was told to keep working and continued to do for weeks until NP spoke out. NP advised that as a BAME person he often "felt lucky to have a job" rather than recognising that he had earned it, and felt others may feel the same. BH recognised this and shared personal experiences from her own family. BH felt the real challenge was encouraging and supporting an environment for those who don't want to speak up, to feel safe to do so and that we would only be effective in tackling discrimination when this happened. NP commented that diversity only works with inclusion and that there was hunger for people to speak to others and for them to be listened to.

CF commented, as the NED lead for Freedom To Speak Up, that she was humbled by the stories of CB and NP and the vulnerability they had demonstrated as they spoke. CF advised that by sharing their stories, CB and NP had prompted, and could help, the Trust to stage conversations that recognise vulnerability and align to compassionate leadership.

MP echoed comments of others that NP and CB had set the tone for future staff stories and defined a moment of decision for the Trust. MP recognised the need for white people to lead this work alongside BAME colleagues, but shared a personal view that he worried in his own case that this could be perceived as lacking authenticity. NP assured that "you being you" is all that was needed. CB supported this, citing EW and AH as allies wholly behind this and stated the importance of people knowing what you stand for.

The Chair invited DL to sum up who said she had been deeply moved by the experiences shared, and that as a Board we have many roles to play but most importantly that we must all be "impatient for change and intolerant of things that are not aligned to our values". She went on to say that that whilst diversity was a fact, inclusion was a choice and the right cultural landscape was needed to bring these things together and deliver high impact change. DL stressed the importance of examining the support available for BAME colleagues who speak up and identifying changes needed. DL added that support was also need for colleagues such as NP and CB acting as "lightning conductors" for others to

channel their views through and asked EW to give thought to this.

The Chair once again thanked NP and CB and stated the Board would look back to the meeting as a defining moment for the Trust.

RESOLVED: The Board NOTED the staff story.

148/20 DECLARATIONS OF INTEREST

There were none.

149/20 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meetings held on Thursday 13 August 2020 as a true and accurate record for signature by the Chair.

150/20 MATTERS ARISING

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

151/20 UPDATE FROM THE CHAIR

The Chair sought approval for meetings to continue to be held virtually until the end of December 2020 and this was agreed.

RESOLVED: The Board APPROVED that Board, Committee and Governor meetings continue to be held virtually until 31 December 2020.

The Board also NOTED that the Council of Governors had re-appointed AM as a Non-Executive Director (NED) for a second term until 3 September 2023 and that it has been agreed that RG would serve a full second NED term until 28 February 2023.

152/20 CHIEF EXECUTIVE OFFICER'S REPORT

DL presented the report and highlighted that COVID testing and track and trace was not yet serving the public as intended. It was confirmed that there was good access for local Pillar I testing (Gloucestershire health and care staff) but wider community testing, as in other areas, was impacted by pinch points as a consequence of demands for tests exceeding the capacity available; this was further compounded by capacity serving areas such as Gloucestershire with a low incident of cases being diverted to areas with high prevalence such as the north west of England.

DL was delighted to report that the 62 day cancer standard had been achieved in July for the first time since June 2014 and this had been sustained in August. DL described that whilst many specialities had been achieving the standard for a year or more, poor performance in urology had meant that the Trust's aggregate performance was below the national standard. She went on to commend the cancer team for their forensic approach to this issue and to the many teams who had

come together to redesign care including urology, pathology and radiology. She concluded by saying the evidence of embedded change was hopefully the start of a trend and not a blip and confirmed that achievement was not a reflection of low demand during the pandemic. AM commented that this was phenomenal having sat on Quality Committee for a number of years and seen the challenges first hand with respect to improving performance.

The Board noted also the progress on the Electronic Patient Record (EPR) programme as a positive milestone with a very successful deployment of "Order Comms". In response to a question DL outlined the next steps in the programme.

AM asked in relation to the external review by Dr Matthew Cooke, former National Clinical Director for Urgent and Emergency Care, of Emergency Department (ED) performance, if there was an indication of the improvements that could be made. RdC advised Dr Cooke had huge experience and credibility and a trial of new ways of working to reduce time to triage were seeing key benefits. The next step was to share activity demand and workforce capacity plans with Dr Cooke and this was in hand. She went on to say that the "Pit Stop" trial had reduced average waits for senior clinical review from 61.9 minutes to 38.2 minutes with the longest waits going from 3 hrs 54 minutes to 1 hr 38 minutes. She concluded by saying that performance was still not where it needs to be but the whole hospital was focussed on supporting improvement.

RESOLVED: The Board NOTED the Chief Executive Officer's report.

153/20 TRUST RISK REGISTER

EW presented the report and confirmed there were no changes to the register since the last meeting. EW explained the role of the Risk Management Group (RMG) as the eighth executive Delivery Group reporting into the Trust Leadership Team in managing and reviewing the approach to risk management. In response to a question from MN as to whether RMG would exception report to the Audit and Assurance Committee (AAC), it was advised a report would go to each meeting covering the monthly RMG meetings.

In relation to query from RG on whether exit from EU should be on the register, RdC explained this is due to be revisited in October 2020 as part of emergency planning response and resilience work and the previous governance and decision making arrangements would be stepped up. Nationally this was yet to be re-established as a distinct programme and would form part of the winter plan nationally and locally.

AM referenced the risk to clinically vulnerable and BAME staff and sought assurance that the personalised risk assessments were being carried out properly. EW confirmed that risk assessments were in place for all BAME staff and those defined within the government criteria and we had achieved 100% of those known to us. The employee system data had been interrogated in the first instance with follow up via managers to identify any other individuals in their teams that might have

been omitted resulting in 100% compliance. EW went on to describe that those who flagged up to be at higher risk via this self-assessment would then be offered a more detailed face to face risk assessment. EW advised she would investigate the issue described by NP related to a BAME colleague aged over 70 being required to work when shielding was advised.

RESOLVED: The Board NOTED the Trust Risk Register as a source of assurance and information.

154/20 BOARD ASSURANCE FRAMEWORK

SF presented the report which showed the Board Assurance Framework (BAF) as at the end of quarter 1 2020/21 (Q1). Board committees had received reports detailing the risk they were responsible for and SF updated that a number of risk had been merged or closed following the review process. This challenge process would be ongoing to ensure principal risks to the strategic objectives were captured and remained relevant. SF also advised the Audit and Assurance Committee had supported a revised BAF format and this would be implemented over the next quarter.

CF endorsed SF's comments and added that the work would help to ensure principal risks became more targeted and properly defined, so that assurance could be attained in the right committee.

MN stated this had been a big step forward but queried some of the assurance ratings of the objectives given the risk ratings of the principal risks. Discussion took place on the difference between the risks to the objectives and progress of the objectives. It was felt this would be clearer in future iterations of the BAF and in the review process.

The Chair reported he was content that following review, board agendas aligned with the risks and issues in the BAF.

RESOLVED: The Board:

- REVIEWED the controls and assurances in place for those principal risks allocated to the Board and assured that these are adequate.
- APPROVED the BAF and NOTED the updates and assurance ratings for Q1 2020/21.
- AGREED and ASKED Committees to further reduce principal risks as appropriate as per Audit and Assurance Committee recommendation.
- ASKED for further thought be given to the distinction and reporting of risks to strategic objectives and progress against their delivery.

155/20 EQUALITY, DIVERSITY & INCLUSION (EDI) ACTION PLAN

EW advised the report had been previously reviewed by the People & Organisational Development Committee (PODC) and provided an update on progress against a two year action plan based on staff survey

results and equality, diversity and inclusion data from the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WRES). It was felt that a two year timeframe could deliver sustainable change.

EW advised that consultants had been appointed to lead the Widening Participation Review and work was underway to understand the data and trends, develop and implement action plans to improve inclusion and diversity. Terms of Reference for the Review had been widely shared.

MN commended the report and direction of travel it conveyed but commented that some of the priorities felt open ended and vague. He also felt that as there were no discernible improvements, that he did not feel assured the Trust was hitting the right areas and would prefer "hard targets". EW assured targets with quantifiable metrics were in place and being used, but this level of granularity and detail did not go to PODC. EW accepted that PODC had not spent as much time on the information due to COVID, but felt that the Trust was doing the right things now, although cultural changes could take up between three to five years to become embedded change was seen.

EWa, asked in the context of being "inpatient and intolerant" as DL had expressed earlier, given the size of the data and action plan, what was the biggest challenge faced by the Board. EW felt it is this work being viewed as a "thing on the *To Do* list" rather than what it should be. SH supported this and commented it should be creating opportunities for inclusion and identifying game changers.

DL commented on the new national target that required the Trust to demonstrate that c15% of senior leadership roles were being held by BAME colleagues but noted that whilst this would result in greater diversity it would not alone guarantee greater inclusion. There was a need to address the perceived acceptance of racism in some areas and tiers of more junior management. DL summarised some of the things she would like to see including mandated training in this area; immersion events for bands 4-7 so they were better informed of the data, staff experience and their role in ensuring inclusive practise and behaviours in their teams and zero tolerance approach to those whose behaviour was not aligned to our expectations.

MAG stated that she had seen a huge difference in addressing this agenda since she joined the organisation, but agreed with MN that smart targets were needed. In relation to cultural change, MAG felt the Board were aligned and there were grass roots advocates such as NP and CB in post, but the mid-level appeared "stuck". EW explained that the executive review process looked at EDI actions and targets and this had led to good conversations and individuals taking responsibility for improvements. EW also confirmed this "squeezed middle" had been identified pre-COVID and work was underway to support them. DL updated that EW had shared her thoughts on leadership development for these staff including competency checks and 360 appraisals. EW stressed this should be mandatory so that support can be targeted to areas of concern.

The cover sheet for the paper was identified as an exemplar of good practice for other report authors.

RESOLVED: The Board NOTED the WRES Comparison report and associated next steps and was ASSURED of the Trust's plans to improve the experience of colleagues working across our Trust.

156/20 PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

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

157/20 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE & OD COMMITTEE

RESOLVED: The Board RECEIVED the report as assurance of the scrutiny and challenge undertaken by the People and Organisational Development Committee.

158/20 SAFEGUARDING ANNUAL REPORT

SH presented the report and advised in relation to COVID specific incidents, nothing had been seen as yet however during and post-lockdown there had been an increase in the number of domestic violence cases affecting women and children. This was seen and monitored by the Safeguarding Operational Group on a monthly basis.

AM said that the report had been reviewed at Quality and Performance Committee (QPC) and that she, as NED lead for safeguarding, could see an improvement in both approach and outcomes. AM commented on the lack of an EPR for children as a barrier to further improvements and in relation to learning disabilities felt some patients may not find virtual consultations helpful.

SH updated on good progress in respect of EPR and added that maternity services were identified as a key area also. The Trust was looking at a range of options to bring real value and benefits from bringing the family together. Some systems were being tested alongside considering a solution with AllScripts (the current EPR provider). BH stated that getting to a single record for children was the biggest challenge faced by the NHS and local authorities and asked if there were ICS plans to do this. DL and SH advised plans were in place across health but did not yet extend to education or social care but work was underway to share risk assessments. MP shared details for information of the partners engaged in the Joining Up Your Information (JUYI) project.

RESOLVED: The Board NOTED the Safeguarding Annual Report and those recommendations implemented as quality improvements to Trust services.

159/20	**QUALITY AND PERFORMANCE REPORT**

SH, RdC and MP presented the report.

SH advised that COVID transmission was low and that whilst mixed sex accommodation breaches had peaked in July, they had fallen during August 2020.

MP had no specific points to raise but reinforced, for context, that recovery and performance work was focused on safety and quality. RdC seconded this and wished to highlight again the tremendous work on cancer performance.

RG asked about progress related to stroke care and an update that was due to be presented at QPC. RdC reminded the Board that changes had been enacted linked to the Temporary Service Changes (TSC) and further work would take place. DL added that the TSC metrics captured stroke care and there was evidence of reduced performance with respect to two measures and an increase in one; the team were addressing the former which linked to retaining the acute stroke direct admission bed at GRH.

MN referenced the EPR update related to nurses having more time with patients leading to a reduction in falls and commented that he could not see this flowing through in the data. SH advised it had been discussed at Quality Delivery Group and agreed to review the data source. SH added that visiting had a positive effect on falls reduction and the COVID restrictions on visiting had contributed to a slight increase. RG requested that the Board receive an update in future on early indications of EPR progress on patient care i.e. falls etc. **SH**

RESOLVED: The Board RECEIVED the report as assurance that the Executive Team and Divisions fully understood 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.

160/20	**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.

161/20	**DIGITAL REPORT**

DL presented the Digital Report in the absence of MH and highlighted good progress on the implementation of the order communications project (Order Comms) and positive work on information governance standards delivery. DL also updated on the timeline and priorities in the forward agenda, that included further roll out of Order Comms as part of a wider outpatient programme.

The Board extended thanks to MH and his team for their successful

implementation of the order comms system.

AM advised the report referenced five red projects but only detailed four and asked for details of the fifth. MP updated from discussions at the Digital Care Board that this was an oversight and there were only four red projects as detailed. He added the impact of the rollout of order comms should not be underestimated, especially during a global pandemic.

MN welcomed the report and asked if the replacement of the Datix risk management system was a digital project. DL confirmed that the replacement of the system had been identified as a priority in the 2020/21 planning round but had not made the final list of funded priorities affordable within the money available. The cost was reported as c£360k revenue over five years. The Chair commented that Finance and Digital Committee (FDC) did not have sight of these projects and DL advised it was due to them being unfunded as F&D had oversight of projects in hand. EW updated that the upgraded Datix version did not meet the needs of the Trust, and conscious of NED concerns about the system, the Digital team and Risk team were working together to look at potential alternative options. CF assured there had been regular updates on Datix replacement at AAC.

MN asked if the Board could be made aware of all those things put forward for funding which had been prioritised and not ultimately funded. DL explained that a risk assessment was completed for all priorities not funded and residual high risk issues would be visible to the Board through Board and Committee risk registers. DL asked SL to give thought how best to ensure visibility of this issue as part of the preparation for the 2021/22 planning round.

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

162/20 FINANCE REPORT

KJ presented the report for Month 4 (M4) and confirmed the Trust was still operating in the current funding regime based on block contracts and top up payments. The position of £3.6m “true up” payment was £200k lower than M3 due to a reduction in COVID spend and accruals on medical pay. KJ had received confirmation the £3.6m had been approved and funding would flow through to the Trust.

There had been a 20% increase in activity affecting direct non-pay costs but the cash position remained strong with two months of block payments in the bank.

KH updated the Board on an emerging issue related to VAT treatment of the outsourced provision and advised that the Trust was working closely with its VAT advisors and an update would go to F&DC as the potential current worst case position would be significant for the Trust. She also advised that the impact of a decision against the Trust had been included for prior months in this month’s NHSI “true up” submission.

Overall the balance sheet was good and the cash position strong and KJ

drew attention to supporting information in the pack on cost/activity/staff correlations. The Board were also pleased to note a remarkable performance related to payment of invoices (95% +).

The Board noted that deadlines remained in place for financial planning submissions but that information on the regime was likely to come in late. KJ advised she would raise these concerns with regional colleagues.

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

163/20 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.

164/20 PROVIDER LICENSE: SELF-CERTIFICATIONS

SF presented the paper and explained the links to the Trust's provider licence and the reason for these not being presented alongside the annual report and accounts related to process changes due to COVID.

RESOLVED: The Board CONFIRMED that, based on the evidence provided, that to the best of their knowledge they believed that the Trust was compliant with the terms of its provider license and therefore ENDORSED the self-certification as proposed.

165/20 REVIEW OF THE MINUTES OF THE COUNCIL OF GOVERNORS

RESOLVED: The Board NOTED the minutes of the Council of Governors held on Wednesday 17 June 2020.

166/20 GOVERNOR QUESTIONS AND COMMENTS

AT recognised his feedback was focused on comments as governor questions were being answered through the log. AT thanked KJ and her team for leading the external audit services tender exercise, the outcome of which would be approved by the Council of Governors and also thanked SL and his team for a governor briefing session on Fit For the Future which had been very informative.

AT referenced the staff story and felt that having such a powerful expression of changing culture at the board demonstrated how much the Trust had developed in recent years and that as someone who had been part of the governing body both before and after the leadership changes, he found the Trust to be open and transparent, rather than defensive.

AT thanked AM and RG for their continued service as NEDs, and all staff involved in delivering the 62 day cancer target. He referenced the work in the Safeguarding report to bring together adults and children IT systems together and also advised that governors had welcomed sight

of the self-certifications which had not been shared previously, to his knowledge.

The Board heard that it was the last board meeting before the Annual Members' Meeting for some staff governors, and potentially some public governors and AT thanked all governors for their time and contributions. AT recognised the reasons for continuing with virtual meetings but repeated his previous request for governors to meet in person when permitted to do so. DL advised this last request had been well in hand but the recent announcement of the "rule of six" had put a pause on this again.

145/20 NEW RISKS IDENTIFIED

There were none.

146/20 ANY OTHER BUSINESS

There were no items of any other business.

[Meeting closed at 15:07]

Date of the next meeting: Thursday 8 October 2020 at 12:30 via Microsoft Teams.

Signed as a true and accurate record:

Chair
8 October 2020

Public Trust Board – Matters Arising – October 2020

Minute	Action	Owner	Target Date	Update	Status
10 SEPTEMBER 2020					
159/20	**QUALITY AND PERFORMANCE REPORT:**				
	Provide update in future on early indications of EPR progress on patient care i.e. falls etc.	SH	October 2020	Proposed joint paper from Digital and Quality/Nursing is prepared for the Finance and Digital Committee in future (*date to be finalised and reported at Board*). In addition, whilst the number of people falling has not reduced (as seen in the QPR), patients experiencing harm as a result of falling has reduced (statistically significantly), the reasons for this are likely to be multifactorial, such as completion of ePR risk assessments, visiting, deployment of nursing staff and implementation of the falls bundle.	**OPEN**

PUBLIC BOARD OCTOBER 2020

CHIEF EXECUTIVE OFFICER'S REPORT

1 Operational Context

1.1 The operational context for the Trust remains largely unchanged from last month with a continued focus on restoration of services, preparations for winter (which feels like it is very much on its way) and the expected increase in the number of patients with suspected and confirmed COVID-19.

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 positive place relative to other areas. Higher levels of COVID-19 remain present in the 15-24 years age group and we now have evidence that rates are increasing in the 25-59 age group although rates in the most vulnerable age groups remain low. The latter is especially importance given it is illness amongst this group that is most likely to lead to hospitalisation. The national picture serves to remind us of the importance of being prepared for the winter ahead and the now inevitable increase in cases.

1.3 One important service development which was established in response to the learning from the initial phase of the pandemic is the provision of a C*ovid virtual ward*. This service is a response to the cohort of patients who were managed at home, under the care of their GP, whose outcomes could be improved by earlier detection of any deterioration in their condition and particularly those who present with "silent" symptoms at the onset of their deterioration. The service enables up to 500 patients, at any time, to have their oxygen levels monitored whilst remaining at home and thus, in the absence of their deterioration manifesting through worsening visible symptoms, can be identified and admitted to hospital sooner than might otherwise be the case. This will not only improve overall outcomes but is expected to reduce the number of patients who require admission to critical care services.

1.4 Similarly, we are increasingly aware of the impacts of what is now being referred to as "Long COVID"– a wide range of symptoms including breathlessness, fatigue, depression and exercise intolerance that remain present three months beyond the original illness. We are awaiting a national specification for the respiratory symptoms service and continue to work with partners on the model for those with broader symptoms. As updated last month, all patients with COVID-19 who required critical care have been offered follow up with a resulting high take up rate. It is clear that the legacy of COVID on health – physical and psychological – is considerable. Positively, there are a number of national research studies looking into the diagnosis, treatments and management of Long COVID.

1.5 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 particularly with respect to elective activity which in the most recent week was 72% of last year's activity level (for the same period) compared to 64% last month with inpatients having reach 100% of last year's activity levels. Positively, we are one of the strongest performers regionally and nationally for diagnostic recovery at 85% of previous activity levels for CT and MRI imaging and we

have the lowest number of patients waiting over six weeks for their diagnostic procedure in the South West. Within this positive picture on diagnostics, pressures and long waits do continue to affect patients who are awaiting endoscopy and work continues to improve activity levels and waiting times in this area; clinical prioritisation of these patients continues to determine who is offered the available capacity.

1.6 This month we commenced sending more than 12,000 letters to patients who are waiting for care to confirm they remain on our waiting list and advise of next steps and importantly, how they can contact the Trust for further information. We have received very high volumes of call backs from patients and will be phasing our approach to ensure those that call can easily access advice.

2 Key Highlights

2.1 This month, the Trust Leadership Team received and endorsed the eagerly awaited Engagement and Involvement Strategy which has been developed under the leadership of Helen England with huge contributions from colleagues in the patient experience and organisational development team. The timing couldn't be better given the recent arrival of James Brown as our first ever Director of Engagement, Involvement and Communication. James joins us from the North West where he has held a number of appointments in this area and, just two weeks in, is already making a positive impact in the organisation.

2.2 In keeping with our research ambitions we remain very active with respect to research studies in the area of COVID-19, both staff and patient participation. In the newly established urgent COVID related public health studies (which comprises 61% of all research activity in the Local Clinical Research Network this year) Gloucestershire Hospitals is the highest recruiting centre in the Network accounting for 59% of all recruits. Truly outstanding performance and especially appreciated given my role as Chair of the West of England LCRN! Recruitment of colleagues into the Siren study, aimed at developing our understanding of the immunity associated with previous COVID-19 infection continues to go well with around 300 staff now participating. Finally, and very importantly, research in non-COVID areas is also now picking back up, with trials recently opened in the areas of ophthalmology, cancer, cardiovascular, trauma and orthopaedic, stroke and paediatrics

2.3 Following the Trust's declaration of a *climate emergency,* Gloucestershire Hospitals was invited to join a national group of likeminded organisations to progress this agenda together working in partnership with the National Sustainability Unit. The inaugural meeting, chaired by Dame Jackie Daniels the Chief Executive of Newcastle University Hospitals Foundation Trust (the first Trust to declare a climate emergency) took place this month and it was clear from this meeting that there are many opportunities to "steal with pride" a number of initiatives being progressed by others. The recent appointment of Jen Cleary as our first Head of Sustainability provides new capacity and focus for this important agenda. Importantly, all Trusts celebrated some of the positive impacts on carbon emissions arising from different ways of working and delivering care during the pandemic but it remains clear that sustainable procurement of goods remains one of the biggest opportunities for the NHS. Perhaps inevitably, there was much talk about the impact on the environment from the significantly increased use of Personal Protective Equipment.

2.4 The long awaited financial regime and funding envelopes for months 7-12 of the remaining year have now arrived and teams have been working across the system to interpret the guidance and understand the implications for our system. The Board will

consider the most recent iteration of the plan at an extraordinary board meeting on the 2 October. Final submissions are now expected on the 21 October 2020. The Regional Review meeting which took place on the 30 September was positive although it is clear that all systems in the Region have considerable progress to make to achieve a balanced submission.

2.5 *One Gloucestershire* achieved a huge milestone in its journey to realising our vision for future care as set out in the *Fit For the Future Programme* with the NHSI assurance team confirming that they will be recommending final approval of our Pre Consultation Business Case to the Regional Director, having been assured on all five of the required tests. A final position is expected ahead of the Board meeting on the 8 October.

2.6 My personal involvement in the reverse mentoring programme established by the local NHS with Val Simms, Diverse City lead and a group of eight community advocates from Gloucestershire's Black, Asian and Minority Ethnic (BAME) communities kicked off this month with my inaugural meeting with my paired mentee. It was an incredibly valuable session providing new and powerful insights for me, into life in Gloucestershire through the eyes of a Jamaican woman who came to Gloucester as a child in the 1960s. These sessions will continue for the next six months with the aim of developing mutual understanding of the issues affecting the black community and those of us seeking to provide increasingly personalised care that is culturally sensitive and easily accessible, especially to this at risk of experiencing health inequalities in their life. Session two is in the diary!

2.7 Last month and I updated the Board on four entries shortlisted in this year's national patient experience awards #PENNA and I am absolutely delighted to announce that two of the four nominees were winners! Huge congratulations to Jean Tucker, national PALS Manager Of The Year and nurse Shona Duffy for her work on developing guidelines for the care of our patients who are homeless.

Deborah Lee
Chief Executive Officer

1 October 2020

TRUST PUBLIC BOARD – 08 OCTOBER 2020
Microsoft Teams, Commencing at 12:30

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							
<u>Purpose</u> The Trust Risk Register enables the Trust Leadership Team to have oversight, and be assured of, the active management of the key risks within the organisation. <u>Key issues to note</u> • No changes have been made to the Trust Risk Register since the last report as RMG is not scheduled to convene until a day prior to October's Board • The business cycle for RMG will be realigned to improve the flow between RMG and Board							
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 – OCTOBER 2020

Trust Risk Register

1. Revised Risk Escalation Process

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	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	Diagnostics and Specialties, Medical, Surgical, Women's and	Safety	Major (4)	Possible -	12	8 -12 High risk	Director of Quality and	30/09/2020	Trust Risk

	of falls	6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	Children's			Monthly (3)			Chief Nurse		Register
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	Environmental	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
		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.									

C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	3. Nutritional assistants on several wards where patients are at 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.	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/08/2020	Trust Risk Register

TRUST PUBLIC BOARD – 08 OCTOBER 2020
Microsoft Teams, Commencing at 12:30

Report Title

Compassionate Leadership Update

Sponsor and Author(s)

Author: Emma Wood, Deputy CEO and Executive Director of People and Organisational Development
Sponsor: Emma Wood, Deputy CEO and Executive Director of People and Organisational Development

Executive Summary

Purpose
To provide the Board with an update on the Trust's journey to develop and support a compassionate culture.

Key issues to note
Values and behaviours
Through collaboration with stakeholders and Prof. Michael West the behaviours which underpin the Values have been finalised and a compassionate leadership framework devised.

Compassionate leadership programme
The Trust has developed a compassionate leadership programme with a core mandatory module for Leaders and Managers followed by a longer 6 month development programme. The programme introduces the elements of compassionate leadership as framed by Prof. Michael West and with the assistance of a 'critical friend' experienced in this agenda. The core module commences with an Immersion into the Trust's equality data and references to the links between compassionate behaviour, staff health and wellbeing and patient outcomes.

Progress summary
Progress has been made across the compassionate culture agenda including the development of the behavioural and compassionate leadership frameworks. The Trust has commissioned a Widening Participation Review which seeks to conduct a deep-dive review of the experiences of BAME colleagues. Further the People and OD team have commenced the programme of work approved by the Board in July 2020 including:

- Reciprocal mentoring;
- Introduction of a BAME Freedom to Speak Up Guardian;
- Introduction of new Health and Wellbeing support and resources to support compassionate behaviours;
- ICS commitment to assist in the design (and fund) of a Stepping Up programme and conduct batch interviews;
- Securing funding from Health Education England to assist in the development of a number of programmes aimed to support our BAME registrant colleagues.

Implications and Future Action Required
Next steps include the roll out of the behavioural framework and finalising the design of the compassionate leadership programme. Progress against the agreed actions will continue to be reviewed by the People and OD committee sub group with particular focus on the commencement of the Widening Participation Review. Board members will be invited to meet the consultancy commissioned to undertake this review as part of an initial 'strategic conversation' to understand members view of the culture of the organisation and their views

on the problems staff may face in its current culture.

Further, the Board are asked to consider how they can incorporate the elements of the Trusts compassionate leadership framework in their committees and practice as Chairs.

Recommendations

It is recommended the Board are **assured that progress is being made** and the Board are asked to **approve the ongoing direction** in terms of our culture change programme.

Impact Upon Strategic Objectives

The programme of work relating to compassionate leadership links to three strategic objectives in particular; Outstanding Care, Compassionate Workforce and Quality Improvement.

Impact Upon Corporate Risks

The programme of work aims to mitigate risks relating to poor staff experience which appear on the People and OD Divisional risk register and risks relating to patient care as connected with staff behaviour which appear on the Quality and Nursing risk register.

Regulatory and/or Legal Implications

The ambition of our compassionate leadership programme links to our Equality, Diversity and Inclusion agenda. This agenda is monitored through national reporting requirements associated such as Workplace Race Equality Standard and Workplace Disability Standard and Best practice and employment legislation, including the Equality Act. Patient care is monitored by both NHSEI and the CQC with leadership being reviewed under the Well Led domain.

Equality & Patient Impact

There is a known researched link between employee experience, stability, retention and patient experience.

Resource Implications

Finance	X	Information Management & Technology	
Human Resources	X	Buildings	

Action/Decision Required

For Decision		For Assurance	X	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)
			Sub group 23/09/20				

Outcome of discussion when presented to previous Committees/TLT

The People and OD committee subgroup responsible for overseeing the Board approved action plan noted the update on the priorities and were assured. Members requested:
Priorities were redefined into SMART objectives and segmented as necessary where the action was complicated and multifactorial with owners and deadlines
Consider how we may reach out to local communities to assist in our Equality agenda
Members also met the new Chair and Deputy Chair of the BAME diversity network subgroup and the provider for the Widening Participation Review. The committee were assured of the appointment of the supplier.

OUR JOURNEY TO OUTSTANDING

#J20

Compassionate Culture update

Thursday 8th October

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Contents

- A reminder of our journey to refresh our values, behaviours and embed a compassionate leadership culture;
- Progress summary;
- Appendices with further material.

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Our Journey

- In January 2018: Concentrated our values from six to three

LISTENING | HELPING | EXCELLING | IMPROVING | UNITING | CARING

CARING | LISTENING | EXCELLING

- In 2019 the People & OD team:
  - ➢ Launched and ran 'Our Journey to Outstanding' consultations with Divisions and Specialities to:
    - ➢ Understand view on what outstanding would 'look and feel like' for staff and patients and
    - ➢ Assist in the design of the 2019 -2024 strategic plan;
  - ➢ Engaged with c1200 staff in forums to consider the behaviours that might sit under the three values;
  - ➢ Triangulated data sources to understand the link between patient care and staff experiences.

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What matters to patients?

Themes	Functional	Relational
Being treated as a person, not a number		✓
Staff who listen and spend time with patient		✓
Individualised treatment and no labelling		✓
Using language that is easy to understand		✓
Finding out about the latest technologies, innovations and medications	✓	
Feeling informed, receiving information and being given options		✓
Patient involvement in care and being able to ask questions		✓
More public awareness about condition	✓	
Efficient processes	✓	
Knowledgeable health professionals		✓
Aftercare support		✓
Positive outcomes	✓	
Continuity of care		✓
Good relationships and positive attitudes among staff		✓
The value of support services		✓

- *'**Relational**' aspects of care (like dignity, empathy, emotional support) are very significant in terms of overall patient experience;*
- *alongside '**functional**' aspects (access, waiting, food, noise)."*

…**but** relational aspects of care are harder to measure as they are behavioural in nature and to change requires a more open discussion about our culture (how we do things around here).

Dept. Health/NHSI (2010)

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What matters to colleagues?

- A consistent theme when discussing values is the importance of these lies in the **behaviour** of colleagues and these can impact morale and a sense of belonging;
- The majority of ‘values’ complaints and feedback from staff surveys (2018 and 2019 results) and through the Freedom to Speak Up Guardians relate to levels of incivility in the workplace;
- The experiences of BAME, disabled and LGBTQ+ staff groups is consistently less positive than their counterparts and these groups of colleagues are more likely to experience bullying, harassment and discrimination.

OUR JOURNEY TO OUTSTANDING

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Linking experiences and outcomes

Three of our new objectives **Outstanding care, Quality improvement** and **Compassionate workforce** recognise the link between staff skills, knowledge, attitude and experiences and patient outcomes.

With the help of Michael West and the Kings Fund we commenced a conversation about Compassionate Leadership behaviours and Civility Saves Lives (a vehicle to approaching a dialogue with clinicians) with staff linking to our survey results.

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Developing compassionate behaviours

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- Having engaged staff on ‘behaviours’ at formal forums, bespoke workshops and by survey throughout 2019 and into 2020 acceptable and unacceptable behaviours were defined collaboratively;
- Board engagement on early drafts took place in December 2019 and again as linked to Compassionate Leadership with Michael West in February 2020;
- COVID-19 paused any further development but during the pandemic staff demonstrated considerable levels of compassion in their practice.

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Developing Compassionate behaviours

- COVID-19 also placed a spot light upon the social injustices and health inequalities faced by BAME colleagues. This drove a desire to do more to eliminate the experience differential between BAME and White colleagues;
- In July 2020 the Board agreed a new set of actions to address inequity and created a sub group of the People and OD committee to ensure delivery (appendix 1);
- A key element of the action plan is to conduct a Widening Participation Review to explore the Trusts culture and the experience of our BAME colleagues.

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Progress Summary

1. Co- designed a compassionate leadership framework with Michael West to describe our ambitions as linked to our values (Appendix 2);
2. Updated the behavioural framework based on all sources of feedback (Appendix 3);
3. Incorporated the compassionate leadership framework and behaviours into appraisal and recruitment and selection material;
4. Designed and piloted Compassionate Leadership Core module for Leaders and Managers as a new mandatory offer (Appendix 4);
5. Commissioned the Widening Participation Review (Appendix 5);

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6. Successfully bid for Health Education England CPD funding to assist in our positive action agenda; mentoring(including reciprocal), leadership development, funds for BAME registrants to develop their skills via specific leadership courses, mentoring and coaching;
7. ICS support and funding to develop a BAME stepping up and 'batch interview' programme across the system;
8. Community and NHS Leadership Academy Board level reciprocal mentoring programme commencing;
9. First BAME Freedom to Speak Up Guardian in post;
10. New health and wellbeing solutions devised to support Compassionate culture including Peer Supporters (Appendix 6)

OUR JOURNEY TO OUTSTANDING

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Compassionate culture: next steps

- Commencement of the Widening Participation Review starting with a strategic conversation with the Board;
- Continued delivery of the action plan;
- Focused rollout of the behaviours and framework throughout October;
  - Announcement and discussion in Deborah's vlog;
  - Threading references through other campaigns during October:
    - Black History Month and Widening participation review launch;
    - World Mental Health Day and launch of Peer Support Network;
    - Staff Survey 2020;
    - Freedom to Speak Up Month;
  - Pilot 2 of core module;
  - Dedicated section on intranet with access to resources.
  - Continued development of our colleague wellbeing services

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Appendices

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Appendix 1 – Board approved action plan

3-4 month priorities:

- Establish BAME Freedom to Speak up guardian;
- Identify means to strengthen joint decision making and problem solving and co design solutions;
- BAME mentoring;
- Career progression and development;
- Recruitment and selection improvements;
- Improved training commencing with managers and leaders;
- Opportunities to connect and speak out;
- Improved Health and wellbeing.

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4-8 month priorities (end financial year)

- Improved communication and communication channels;
- BAME recruitment events;
- Compassionate leadership collaboration opportunities with Kings Fund;
- Inclusion Hub.

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Compassionate Leadership Culture

Caring
Develop safe, trusting and engaging cultures where all can deliver Best Care for Everyone

Listening
Manage conflict positively, openly, courageously and ethically

Excelling
Work collectively towards an inspiring vision of the best care for the people we serve

Caring
Value and ensure inclusion and diversity and remove barriers and boundaries

Listening
Support colleagues to reflect, learn and innovate

Excelling
Promote supportive and effective team and inter-team working

Caring
Nurture colleagues and encourage colleagues to help one another

Listening
Strengthen 'voice', influence and control for all colleagues

Excelling
Promote everyone's growth, development and leadership

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Appendix 2: Compassionate Leadership Framework
– co-created with Professor Michael West

Appendix 3: Concertina and behaviour framework

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Our values:

- Caring
- Listening
- Excelling

Our behaviours:

Our behaviours demonstrate the way in which we aim to do things in our Trust. In summary, these are:

- **Attending** to others' needs
- **Understanding** one another
- Showing **empathy** and compassion
- **Helping** by taking action

Remember that, occasionally, despite our best efforts we can sometimes get things wrong. Be kind to yourself, and others, when this happens. In doing so, we can give one another the opportunity to learn, and to become the best version of ourselves.

I am
attentive

#hello my name is...

- I am welcoming and introduce myself to everyone I meet
- I give you my full attention when we communicate with one another, and I acknowledge your perspective
- When you explain, challenge or ask me something, I will listen and respond accordingly
- I say thank you and I recognise everyone's contributions

our behaviours

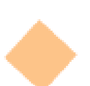
I am
understanding

- I check we both understand one another, and that you know I have listened to you
- I invite feedback on what could be better. I am open to discussion and other views
- I respond flexibly to different communication needs and give you time to express yourself
- I seek to understand what matters to others and respect when their priorities are different from my own

our behaviours

I am
empathetic

- I am respectful, kind and treat all others fairly
- I am caring towards others and try to understand without judgement
- I encourage and support all colleagues to make suggestions on how we can improve our work
- I always try to make a positive difference to my colleagues and our patients



our behaviours

I am
helpful

- I offer support and encouragement to colleagues and patients
- I can be trusted to take action whenever someone needs help, or when something needs putting right
- I take responsibility and reflect on my actions and behaviours to help me to improve
- I call out wherever I witness unlawful discrimination, bullying or harassment; and I support those who experience it

Unacceptable behaviours

- I will never bully, harass or unlawfully discriminate against others
- I will never lie, deceive or act dishonestly
- I will never disrespect or ignore your right to privacy, confidentiality and ability to make your own choices
- I will never behave rudely, aggressively or dismissively towards you with my body language, tone of voice or words

- I will never knowingly let someone fail or make a mistake if it may cause harm to themselves or others

These behaviours undermine our compassionate culture and reduce our ability to create and maintain a happy, healthy workplace. Research also shows that civility, kindness and compassion save patients' lives.

If you see something wrong, you can speak to:

- Your line manager
- The 2020 Staff Advice and Support Hub
- The HR Advisory team or your Trade Union representative
- Freedom to Speak Up Guardian
- Peer Support Network

Find out more by visiting the Intranet and searching for 'behaviour framework'.

our values

Our **values** demonstrate the way in which we aim to act at GHNHSFT. They are as follows:

caring

We care for our patients and colleagues by showing respect and compassion

listening

We listen actively to better meet the needs of our patients and colleagues

excelling

We are a learning organisation and we strive to excel.
We expect our colleagues to be and do the very best they can.

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Appendix 4: Compassionate Leadership programme

- **½ day core module** – compulsory for all Leaders and Managers
- **6 x ½ day modules over 6 months.** Standalone programme plus embedded into existing programmes e.g. IManage
- **Online resource/reference guide** – signposting to tools, videos, research etc.

A provider with experience within the NHS Leadership Academy and with Michael West is acting as a 'critical friend' reviewing the content and design.

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Compassionate Leadership programme

Core module

- First Pilot 23rd September 2020, 2nd Pilot 19th Oct;
- Rollout of core module October 2020.

6 month programme

- Pilot cohort to commence late October 2020 (complete March 2021);
- Subsequent cohorts to commence late 2020/early 2021.

Online resource/reference guide

- Piloted alongside core module and pilot cohort. Ongoing refining and updating.

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Overview of Compassionate Leadership Content – High Level

SESSION CONTENT

Core Session Content

- Immersion of data - Equality, Diversity & Inclusion
- What does compassionate leadership mean?
- Component parts of compassionate leadership.
- Compassionate leadership in the NHS context
- Benefits of compassionate leadership
- Myths of compassionate leadership
- Practicalities of compassionate leadership
  - Self
  - Team
  - Organisation/ environment
- Psychological safety
- Privilege
- Action and development
- Learning partners

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Compassionate Self

- Why self- compassion?
- Types of self care
- Understanding yourself
- Emotional Intelligence and how to use it
- Mindfulness
- Self resilience
- Development planning

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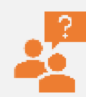
How do you develop your authentic leadership practice?

Leading with kindness

Leading with empathy

Emotional bank account

Acting with integrity.


What will you do?

Compassionate Team

- How does my team operate
- What reputation does it have and how?
- Psychological safety – a deeper exploration
- Trust in teams
- Dysfunctions of Teams- Lencioni
- Equality, Diversity and inclusion – a deeper exploration
- Development planning

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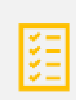
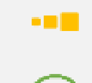
Compassionate Organisation



Development planning



Mid-staffs

Behaviours that don't support compassion

Empathy and compassion at organisational level

What happens without empathy & compassion

Winterbourne view etc.

Longer term benefits of compassion

Having the right environment that you develop.

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Appendix 5: Widening Participation Review

DWC have been commissioned to undertake a review into our culture and provide feedback to the Trust on how it may succeed in its ambitions

Terms of reference (edited)

1. To conduct a deep-dive review of the experiences of BAME colleagues. To go underneath/behind the existing data/evidence to better understand and identify any organisation-specific structural, systemic, cultural and behavioural reasons behind this inequity.

2. To review the existing and newly emerging/evolving governance and decision-making structures and processes in terms of BAME representation;

3. Advise whether our current priorities/action plans are the correct ones, and/or whether any of these can be modified/updated. Advise of any additional recommendations for the Trust to consider.

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Appendix 6

Caring for those who care

Covid-19 Pandemic Recovery phase at
Gloucestershire Hospitals NHS Foundation Trust

Everyone

In-house support

- Vivup EAP telephone counselling **0330 380 0658**
- Staff Support service (121 psychological therapy)
- Occupational Health
- Peer Support Network
- Wellness check-in tool
- Chaplaincy team
- Freedom to Speak Up Guardians
- Sanctuary areas
- Discounts for NHS staff
- *Salary Finance – education; loans; savings*

Learning resources

- Working from home toolkit
- Online guides, tips and videos
- Wellbeing books from GHT Library

NHS national support

- NHS virtual staff common rooms
- National Staff Support Line 7am-11pm. **0300 131 7000**. Text **FRONTLINE** to 85258 (available 24/7)
- NHS Bereavement and Loss Support Line 8am-8pm. **0300 303 4434**
- Project5 – 2 free coaching sessions or 3 mental health support sessions from trained volunteers.
- NHS short learning guides

Free apps

- Unmind
- Headspace
- Silvercloud
- Sleepio
- Daylight
- Movement for modern life
- #StayAlive – suicide prevention resource

Teams

In-house support

- Psychology Link Worker
- Decompression/Schwartz/ wellbeing sessions
- Team diagnostics/ development (Leadership & OD)
- *Mediation service*

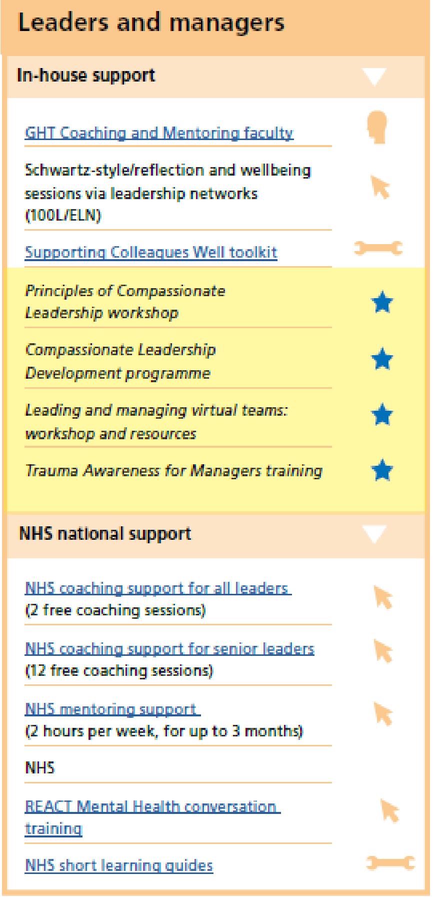
NHS national support

- NHS short learning guides

Ways to show you care

- Gem thank you postcards
- Random acts of kindness
- 5 minutes pause at 11am
- Every Name is a Person Care toolkit

Currently unavailable, coming soon



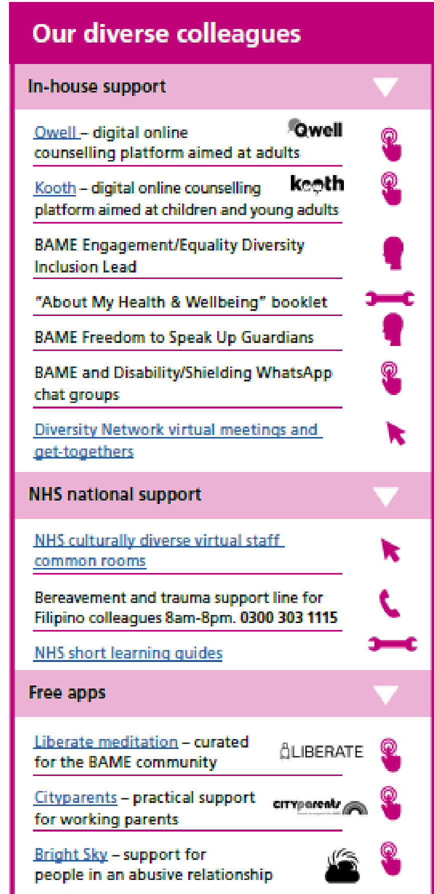
Leaders and managers

In-house support

- GHT Coaching and Mentoring faculty
- Schwartz-style/reflection and wellbeing sessions via leadership networks (100L/ELN)
- Supporting Colleagues Well toolkit
- *Principles of Compassionate Leadership workshop*
- *Compassionate Leadership Development programme*
- *Leading and managing virtual teams: workshop and resources*
- *Trauma Awareness for Managers training*

NHS national support

- NHS coaching support for all leaders (2 free coaching sessions)
- NHS coaching support for senior leaders (12 free coaching sessions)
- NHS mentoring support (2 hours per week, for up to 3 months)
- NHS
- REACT Mental Health conversation training
- NHS short learning guides



Our diverse colleagues

In-house support

- Qwell – digital online counselling platform aimed at adults
- Kooth – digital online counselling platform aimed at children and young adults
- BAME Engagement/Equality Diversity Inclusion Lead
- "About My Health & Wellbeing" booklet
- BAME Freedom to Speak Up Guardians
- BAME and Disability/Shielding WhatsApp chat groups
- Diversity Network virtual meetings and get-togethers

NHS national support

- NHS culturally diverse virtual staff common rooms
- Bereavement and trauma support line for Filipino colleagues 8am-8pm. **0300 303 1115**
- NHS short learning guides

Free apps

- Liberate meditation – curated for the BAME community
- Cityparents – practical support for working parents
- Bright Sky – support for people in an abusive relationship

For more information:

For help with accessing any of these services, contact the 2020 Staff Advice and Support Hub by email **ghn-tr.2020@nhs.net** or call **0300 422 2020**

The 2020 Hub is open: Monday - Friday, 8.00am - 8pm

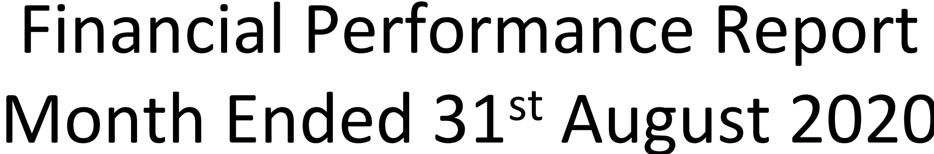
TRUST PUBLIC BOARD – 08 OCTOBER 2020
Microsoft Teams, Commencing at 13:30

Report Title
Financial Performance Report **Month Ended 31 August 2020**
Sponsor and Author(s)
Author: Johanna Bogle, Associate Director of Financial Management Sponsor: Karen Johnson, Director of Finance
Executive Summary
Purpose This purpose of this report is to present the Financial position of the Trust at Month 4 to the Committee. Key issues to note The Trust will breakeven for Month 1-6, due to national income changes during the Covid-19 pandemic. At Month 5 we recorded a £6.5m deficit requiring True-Up funding. This was predominantly as a result of an additional £4.2m provision against the VAT treatment of an outsourced managed service provider, which is progressing through an HMRC review process. Our activity has was down 1% since month 4, and this has led to a slight reduction in non-pay costs. We have been given a clear steer from the Region to maximise the use of our elective capacity over the next month (Sept) whilst we are still in this funding regime so the month 6 position is again likely to require a retrospective top-up. We continue to work through the financial impact of recovery, while awaiting confirmation of funding arrangements for the second half of the financial year. In Month 5 the Trust has been awarded additional capital funding of £8.6m and is forecasting to spend this in addition to the original plan. Conclusions 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 £8.48m. Implications and Future Action Required 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 August 2020

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National Position as at Month 5

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 5 overview

At Month 5 we recorded a £6.5m deficit requiring True-Up funding. This was predominantly as a result of an additional £4.2m provision against the VAT treatment of an outsourced managed service provider, which is progressing through an HMRC review process.
Our activity was down 1% since month 4, and this has led to a slight reduction in non-pay costs.

We continue to work through the financial impact of recovery, while awaiting confirmation of funding arrangements for the second half of the financial year.

Forecast Outturn

Work continues to refine 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.

Capital

At Month 5 the Trust has been awarded additional funding of £8.6m and is forecasting to spend this in addition to the original plan. Capital plans have incurred £8.1m to date, with a forecast spend of £38.1m for the year.

Balance Sheet

In order that the national NHS cash position was secure, all Trusts have received six months' of commissioner block income payments so far this year. This means that our cash balance is £71m higher than anticipated in planning.

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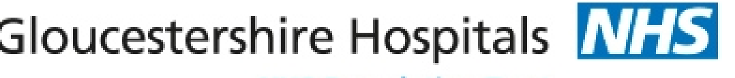
M05 Group Position vs NHSE Average Run Rate Position



Including the £13.16m of Covid-19 costs that the Trust has incurred year to date in Month 5, 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	249,321	245,265	(4,056)
Income True-Up	0	17,469	17,469
Pay	160,725	167,709	(6,984)
Non Pay	84,501	90,343	(5,842)
Capital Financing	4,090	4,868	(778)
Total Surplus / (Deficit)	5	(186)	(191)
Remove impact of Donated Asset Depreciation	0	186	186
Grand Total Surplus / (Deficit)	**5**	**0**	**(5)**

Excluding the year to date Covid-19 costs to date in Month 5 of £13.16m, and associated true-up income of £17.47m, we are reporting a deficit position of £4.30m. Month 5 was the first time this was a deficit position. Primarily, this is because of the provision against Gen Med of £4.2m, but the deficit is likely to grow next month as well, because our shortfall in income as a result of reduced activity during Covid-19 is greater than the variable costs of not delivering that activity. We have not yet had the funding envelope for M7-12 confirmed for the impact after M6.

Consolidated Budget Position - excl Covid Spend and True-Up Income	Budget 20/21 £'000		
	YTD Budget	YTD Actual	YTD Variance
Income	248,214	245,265	(2,949)
Pay	163,037	160,926	2,111
Non Pay	90,130	83,970	6,160
Capital Financing	3,711	4,868	(1,157)
Total Surplus / (Deficit)	(8,664)	(4,499)	4,165
Remove impact of Donated Asset Depreciation	184	186	2
Grand Total Surplus / (Deficit)	(8,479)	(4,313)	4,167

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M05 True-Up Funding agreed by NHSE

The Trust has spent £13.16m of Covid-19 costs so far this year. This, plus the Gen Med VAT provision equate to £17.36 of the £17.47m true-up position.

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 totalling £7.343m has been paid by NHSE. The Month 4 True-Up value of £3.63m has been agreed by NHSE and will be paid into our bank account on 15/09/2020. The Month 5 True-Up value will be validated by NHSE over the next fortnight.

The true-up requirements continue to grow. Until Month 5 this was driven by the increase in activity, but in Month 5 the major impact was as a result of the VAT provision of £4.2m.

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 Agreed	3,627
True-Up M05 Anticipated	6,505
Grand Total True-Up YTD	**17,469**

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M05 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 £13.16m of Covid-19 costs and the associated income flows that the Trust has incurred year to date to Month 5, we are reporting a breakeven position. This includes true-up income from NHSE totalling £17.47m. We had budgeted for a deficit of £8.48m year to date to month 5, so we currently report a positive variance to budget of £8.48m.

Consolidated Budget Position - incl Covid Spend and True-Up Income	Budget 20/21 £'000		
	YTD Budget	YTD Actual	YTD Variance
Income	248,214	245,265	(2,949)
Income True-Up		17,469	17,469
Pay	163,037	167,709	(4,672)
Non Pay	90,130	90,343	(213)
Non-Operating Costs	3,711	4,868	(1,157)
Total Surplus / (Deficit)	(8,664)	(186)	8,478
Remove impact of Donated Asset Depreciation	184	186	2
Grand Total Surplus / (Deficit)	(8,479)	0	8,479

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 5, we are reporting a deficit actuals position of £17.47m. Compared to the budget of £8.48m deficit we are therefore £8.99m 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	248,214	245,265	(2,949)
Pay	163,037	167,709	(4,672)
Non Pay	90,130	90,343	(213)
Capital Financing	3,711	4,868	(1,157)
Total Surplus / (Deficit)	(8,664)	(17,655)	(8,991)
Remove impact of Donated Asset Depreciation	184	186	2
Grand Total Surplus / (Deficit)	(8,479)	(17,469)	(8,989)

The second half of the financial year will undoubtedly require a level of CIP to breakeven or minimise the financial year end deficit position. The original target for 20/21 was to deliver £15.76m. At month 5 we have delivered £2.7m, but only 49% 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. The current forecast suggests a shortfall of £10.3m.

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Month by Month Trend

Consolidated Run Rate Actuals	20/21 £'000					
	M01	M02	M03	M04	M05	YTD
Pay	31,304	32,153	32,248	31,799	33,422	160,926
Non Pay	16,407	13,842	15,572	17,228	20,921	83,970
Covid	2,125	3,847	3,408	2,564	1,212	13,156
Non-operating Costs	855	991	1,072	946	1,004	4,868
Remove impact of Donated Asset Depreciation	(37)	(37)	(37)	(38)	(37)	(186)
Total Cost	50,654	50,796	52,263	52,499	56,522	262,734
Run Rate Funding, plus billable income	(48,897)	(49,027)	(48,452)	(48,872)	(50,015)	(245,263)
Total Deficit	**1,757**	**1,769**	**3,811**	**3,627**	**6,507**	**17,471**
True-up Funding	(1,757)	(1,769)	(3,811)	(3,627)	(6,507)	(17,471)
Grand Total Deficit	**0**	**0**	**0**	**0**	**0**	**0**

Covid Pay / Non-Pay Costs	20/21 £'000					
	M01	M02	M03	M04	M05	YTD
Pay	1,217	1,683	1,991	1,406	486	6,783
Non-Pay	908	2,164	1,417	1,158	726	6,373
Total	**2,125**	**3,847**	**3,408**	**2,564**	**1,212**	**13,156**

Looking at the trend of costs each month, it is clear that non-pay has been steadily growing month on month. If we remove the VAT risk of £4.2m from the M05 number, we can see that it has slightly dropped since Month 4. This is in line with activity growing between months 2-4 and then slightly dipping in Month 5. Activity is expected to grow again in Month 6, as we try to accelerate our recovery while we can reclaim any costs beyond our block income.

The VAT risk of £4.2m and associated 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 rev-review) or requesting a judicial review. The impact will increase in Month 6, once we have started to incur legal costs.

Covid costs are coming down month on month, with forecasts under review.

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M05 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 August 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 August the Group's consolidated position shows a year to date breakeven position due to the current funding regime. This is £8.48m favourable against budget.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 05 Cumulative Financial Position	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**	**Budget £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	213,299	210,685	(2,614)	0	0	0	213,299	210,685	(2,614)
PP, Overseas and RTA Income	1,660	1,304	(356)	0	0	0	1,660	1,304	(356)
Other Income from Patient Activities	535	293	(242)	0	0	0	535	293	(242)
Operating Income	30,401	48,794	18,393	21,058	20,495	(564)	32,720	50,451	17,731
Total Income	**245,895**	**261,077**	**15,182**	**21,058**	**20,495**	**(564)**	**248,214**	**262,734**	**14,520**
Pay	154,536	159,210	(4,674)	8,501	8,599	(98)	163,037	167,709	(4,672)
Non-Pay	97,481	99,168	(1,687)	11,388	9,910	1,479	90,130	90,343	(213)
Total Expenditure	**252,017**	**258,379**	**(6,362)**	**19,890**	**18,509**	**1,381**	**253,167**	**258,051**	**(4,885)**
EBITDA	**(6,122)**	**2,698**	**8,820**	**1,169**	**1,986**	**817**	**(4,953)**	**4,682**	**9,635**
EBITDA %age	**(2.5%)**	**1.0%**	**3.5%**	**5.6%**	**9.7%**	**4.1%**	**(2.0%)**	**1.8%**	**3.8%**
Non-Operating Costs	2,542	2,884	(342)	1,169	1,986	(817)	3,711	4,868	(1,158)
Surplus/(Deficit) with Impairments	**(8,664)**	**(186)**	**8,478**	**0**	**0**	**0**	**(8,664)**	**(186)**	**8,478**
Less Fixed Asset Impairments	0	0	0	0	0	0	0	0	0
Surplus/(Deficit) excluding Impairments	**(8,664)**	**(186)**	**8,478**	**0**	**0**	**0**	**(8,664)**	**(186)**	**8,478**
Excluding Donated Assets	184	186	2	0	0	0	184	186	2
Control Total Surplus/(Deficit)	**(8,479)**	**(0)**	**8,479**	**0**	**0**	**0**	**(8,479)**	**(0)**	**8,479**

* Group Position excludes £20.5m of intergroup transactions including dividends

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M05 Detailed Income & Expenditure (Group)

Month 05 Financial Position	M05 Budget £000s	M05 Actuals £000s	M05 Variance £000s	M05 Cumulative Budget £000s	M05 Cumulative Actuals £000s	M05 Cumulative Variance £000s	Passthrough Variance £000s	Net Variance £000s
SLA & Commissioning Income	41,912	42,176	264	213,299	210,685	(2,614)	567	(2,046)
PP, Overseas and RTA Income	332	280	(52)	1,660	1,304	(356)		(356)
Other Income from Patient Activities	107	66	(41)	535	293	(242)		(242)
Operating Income	5,936	14,001	8,064	32,720	50,451	17,731		17,731
Total Income	**48,287**	**56,522**	**8,235**	**248,214**	**262,734**	**14,520**	**567**	**15,087**
Pay								
Substantive	30,265	30,988	(723)	151,897	153,347	(1,450)		(1,450)
Bank	1,299	1,667	(368)	6,496	8,430	(1,934)		(1,934)
Agency	929	1,255	(326)	4,644	5,931	(1,287)		(1,287)
Total Pay	**32,493**	**33,910**	**(1,417)**	**163,037**	**167,709**	**(4,672)**	**0**	**(4,672)**
Non Pay								
Drugs	6,331	5,884	447	31,657	28,839	2,818	(451)	2,368
Clinical Supplies	3,715	3,361	354	18,576	14,581	3,995	(117)	3,878
Other Non-Pay	7,868	12,399	(4,531)	39,897	46,922	(7,026)		(7,026)
Total Non Pay	**17,914**	**21,643**	**(3,729)**	**90,130**	**90,343**	**(213)**	**(567)**	**(780)**
Total Expenditure	**50,407**	**55,553**	**(5,146)**	**253,167**	**258,051**	**(4,885)**	**(567)**	**(5,452)**
EBITDA	**(2,119)**	**970**	**3,089**	**(4,953)**	**4,682**	**9,635**	**(0)**	**9,635**
EBITDA %age	**(4.4%)**	**1.7%**	**6.1%**	**(2.0%)**	**1.8%**	**(3.8%)**	**(0.0%)**	**63.9%**
Non-Operating Costs	742	1,007	(265)	3,711	4,868	(1,158)		
Surplus/(Deficit)	**(2,861)**	**(37)**	**2,824**	**(8,664)**	**(186)**	**8,478**	**(0)**	**8,478**
Fixed Asset Impairments	0	0	0	0	0	0		0
Surplus/(Deficit) after Impairments	**(2,861)**	**(37)**	**2,824**	**(8,664)**	**(186)**	**8,478**	**(0)**	**8,478**
Excluding Donated Assets	36	37	1	184	186	2		2
Surplus/(Deficit)	**(2,825)**	**(0)**	**2,825**	**(8,479)**	**(0)**	**8,479**	**(0)**	**8,479**

SLA & Commissioning Income – Most of the Trust income continues to be covered by block contracts and this will remain the position until the end of September. The volume of activity within the Trust is significantly down which reflects the impact of Covid-19.

PP / Overseas / RTA Income – This remains 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 £17.47m year to date is included here.

Pay – Cumulatively there is an overspend of £4.67m, reflecting a £1.93m overspend on bank budgets, as well as a £1.45m overspend on substantive and a £1.29m overspend on Agency. The in-month and year to date overspend predominantly reflects the £6.78m 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 £0.78m year to date overspend. This has swung into overspend this month following the VAT provision, but the small net overspend year to date illustrates the impact of reduced activity in most clinical areas, Surgery being the biggest contributor. Unbudgeted Covid-19 spend offsets £6.37m 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	M05 Cumulative Budget £000s	M05 Cumulative Actuals £000s	M05 Cumulative Variance £000s
NHS Gloucestershire CCG	368,470	151,095	150,855	(240)
Specialised Commissioning Group	109,688	44,866	42,840	(2,026)
Herefordshire & Worcestershire CCG	14,945	6,129	5,960	(169)
Welsh Commissioners	5,417	2,220	2,126	(94)
Other Commissioner Income	20,821	7,075	7,641	566
Non Contractual Agreements (NCAs)	4,626	1,914	1,263	(651)
Total	**523,967**	**213,299**	**210,685**	**(2,614)**

The table above shows the income position at Month 5.

The block contracts continue to support the Trust although activity is still down significantly against the expected position in more normal times. However the levels are rising. This creates a positive financial position against a standard activity times price calculation. This block contract adjustment at the end of month 5 is £51.6m. Phase 3 of the Covid-19 response sets new activity targets for the Trust from Month 5 as the NHS seeks to recover to normal levels of activity and address issues relating to worsening waiting times for elective surgery and cancer. A continued risk to the income position is that normally received outside of contracts on a more ad hoc basis 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 1-6 of 2020/21. The clear steer is that after September block contracting will cease although the exact form is still unknown at the time of writing. The elective elements of the contract both inpatient and outpatient are expected to have a degree of variability with marginal additional income for over performance or reductions for under performance.

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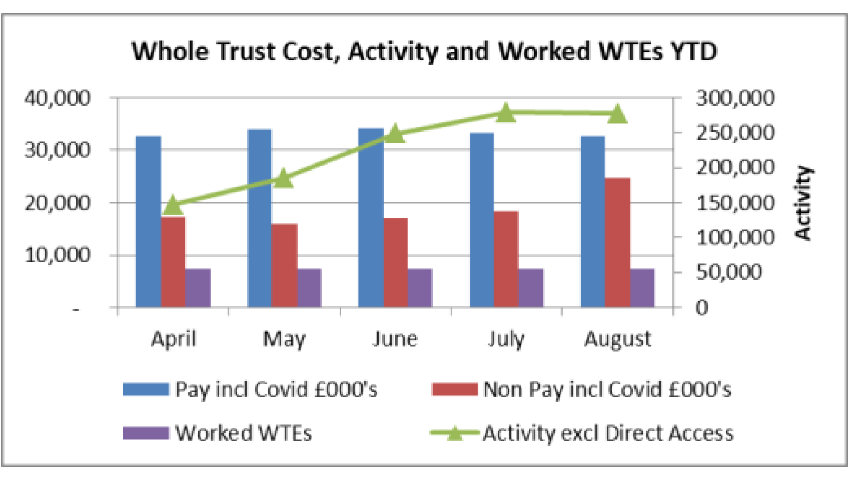
Cost, Activity and Worked WTE for the Trust

Total Trust Costs (excl GMS)	M1	M2	M3	M4	M5	YTD
Pay	31,304	32,153	32,248	31,799	32,223	127,504
Non Pay	16,407	13,842	15,572	17,228	23,990	63,049
Total	47,711	45,995	47,820	49,027	56,213	190,553
Covid Costs	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Pay	1,217	1,683	1,991	1,406	476	6,297
Non Pay	908	2,164	1,417	1,158	643	5,647
Total	2,125	3,847	3,408	2,564	1,119	11,944
Total Costs						
Pay	32,521	33,836	34,239	33,205	32,699	133,801
Non Pay	17,315	16,006	16,989	18,386	24,633	68,696
Total	49,836	49,842	51,228	51,591	57,332	202,497
Activity	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Activity	**256,757**	**359,166**	**546,829**	**657,268**	**618,297**	**1,820,021**
Activity excl Direct Access	**147,214**	**184,969**	**248,426**	**278,776**	**276,781**	**1,136,167**
WTEs						
WTE Worked Non-Covid	7,171	7,070	7,171	7,260	7,290	
WTE Worked Covid	195	272	269	163	103	
Total	7,366	7,342	7,440	7,424	7,392	



This slide brings together the Trust's costs and worked WTE's, alongside Covid-19 costs and worked WTE's, and activity. It excludes GMS data.

Note the trend of increased activity month on month compared to costs. Excluding direct access, Trust activity has decreased 1% month on month, but is up 88% since the start of the year.

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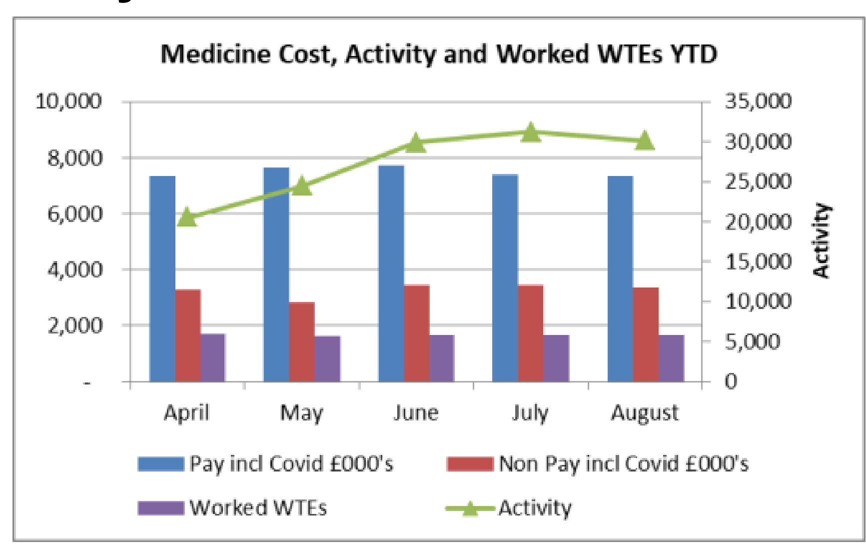
Cost, Activity and Worked WTE by Division - Medicine

Medicine Costs	M1	M2	M3	M4	M5	YTD
Pay	6,907	7,051	7,318	7,166	7,214	35,656
Non Pay	3,257	2,807	3,441	3,454	3,338	16,298
Total	10,164	9,858	10,760	10,621	10,552	51,954
Medicine Covid Costs	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Pay	449	606	401	219	148	1,823
Non Pay	29	34	2	- 5	42	102
Total	478	640	404	214	190	1,925
Total Medicine Costs						
Pay	7,355	7,657	7,720	7,385	7,362	37,479
Non Pay	3,286	2,841	3,444	3,450	3,380	16,400
Total	10,641	10,498	11,163	10,835	10,742	53,879
Medicine Activity	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Elective Spells	604	614	823	1,083	889	4,013
Emergency Spells	2,142	2,557	2,955	3,272	2,940	13,866
Outpatient attendances/procedures	7,039	8,268	11,943	11,393	9,882	48,524
A&E attendances	6,810	8,869	9,761	10,919	11,603	47,962
Renal Dialysis	3,835	3,777	3,697	3,779	3,716	18,804
Excluded drugs/devices	1	3	82	77	39	202
Misc non-PbR activity	144	417	665	711	1,113	3,050
	20,575	**24,505**	**29,926**	**31,234**	**30,182**	**136,421**
Medicine WTEs						
WTE Worked Non-Covid	1,627	1,529	1,608	1,632	1,637	
WTE Worked Covid	86	85	68	45	33	
Total	1,713	1,613	1,676	1,677	1,671	



This slide brings together the core divisional costs and worked WTE's, alongside Covid-19 costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs. Medicine activity has decreased 4% month on month, and increased 47% since the start of the year.

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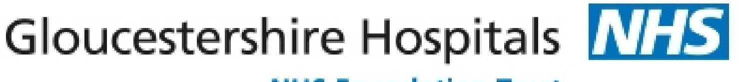
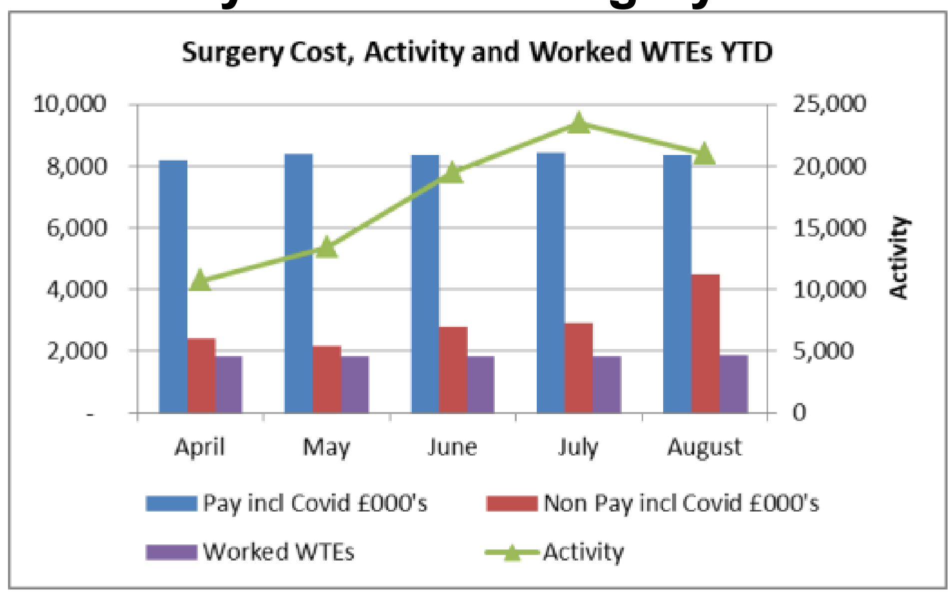


Cost, Activity and Worked WTE by Division - Surgery

Surgery Costs	M1	M2	M3	M4	M5	YTD
Pay	7,951	8,104	7,891	7,834	8,290	40,070
Non Pay	2,275	2,071	2,792	2,906	4,373	14,417
Total	10,226	10,175	10,683	10,740	12,663	54,487
Surgery Covid Costs	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Pay	220	297	477	622	48	1,663
Non Pay	143	87	- 16	4	101	319
Total	363	384	461	626	149	1,983
Total Surgery Costs						
Pay	8,171	8,401	8,368	8,456	8,338	41,734
Non Pay	2,419	2,158	2,776	2,910	4,474	14,736
Total	10,589	10,559	11,144	11,366	12,812	56,470
Surgery Activity	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Non Elective Zero Stay	132	165	198	239	218	952
Non Elective 1+ Day Stay	504	691	757	865	720	3,537
Assessments	73	111	132	191	229	736
Elective In Patients	143	230	319	511	547	1,750
Elective Day Cases	300	432	788	1,153	1,214	3,887
Out Patients Face to Face - New	1,750	3,019	4,805	6,871	6,563	23,008
Out Patients Face to Face - Follow Up	3,158	3,473	5,730	8,047	7,892	28,300
Out Patients Virtual - New	1,958	1,899	2,012	1,866	1,361	9,096
Out Patients Virtual - Follow Up	2,732	3,401	4,783	3,768	2,290	16,974
ED attendences	0	0	0	0		0
	10,750	**13,421**	**19,524**	**23,511**	**21,034**	**88,240**
Surgery WTEs						
WTE Worked Non-Covid	1,781	1,768	1,789	1,833	1,877	
WTE Worked Covid	34	56	26	14	8	
Total	1,815	1,824	1,814	1,846	1,885	



This slide brings together the core divisional costs and worked WTE's, alongside Covid-19 costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs. Surgery activity has decreased 13% month on month, and increased 96% since the start of the year.

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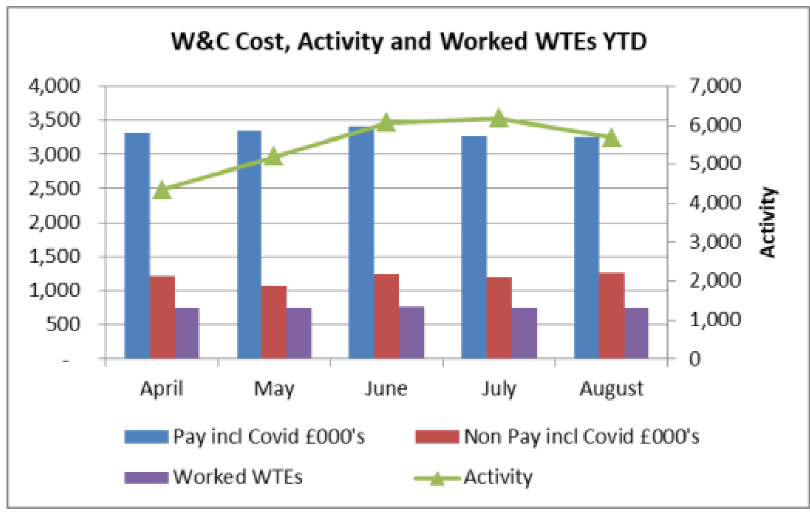
Cost, Activity and Worked WTE by Division – Women and Children

Women & Children Costs	M1	M2	M3	M4	M5	YTD
Pay	3,150	3,211	3,242	3,102	3,191	15,895
Non Pay	1,210	1,079	1,252	1,203	1,253	5,997
Total	4,360	4,290	4,494	4,305	4,444	21,893
Women & Children Covid Costs	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Pay	172	134	174	162	58	700
Non Pay	0	0	-	-	15	15
Total	172	134	174	162	73	715
Total Women & Children Costs						
Pay	3,322	3,344	3,416	3,264	3,249	16,595
Non Pay	1,210	1,079	1,252	1,203	1,268	6,012
Total	4,532	4,424	4,668	4,466	4,517	22,607
Women & Children Activity	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Elective Inpatient Spells	63	86	91	92	77	409
Daycase Spells	40	77	145	98	102	462
Non-elective Spells	73	89	80	60	100	402
Emergency Spells	530	627	740	781	807	3,485
Outpatient Attendances	1,742	2,121	2,443	2,579	1,966	10,851
Non face to face outpatients	119	173	147	103	139	681
Outpatient Procedures	443	622	815	918	884	3,682
Radiology Unbundled	1	0	0	2	3	6
Critical Care	1,113	1,175	1,117	1,158	1,140	5,704
Other Non PBR	221	218	490	383	473	1,784
	4,345	**5,188**	**6,068**	**6,174**	**5,691**	**27,466**
Women & Children WTEs						
WTE Worked Non-Covid	726	732	720	726	709	
WTE Worked Covid	28	19	49	34	35	
Total	754	751	768	760	744	



This slide brings together the core divisional costs and worked WTE's, alongside Covid-19 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 decreased 8% month on month, and increased 31% since the start of the year.

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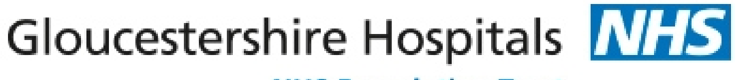
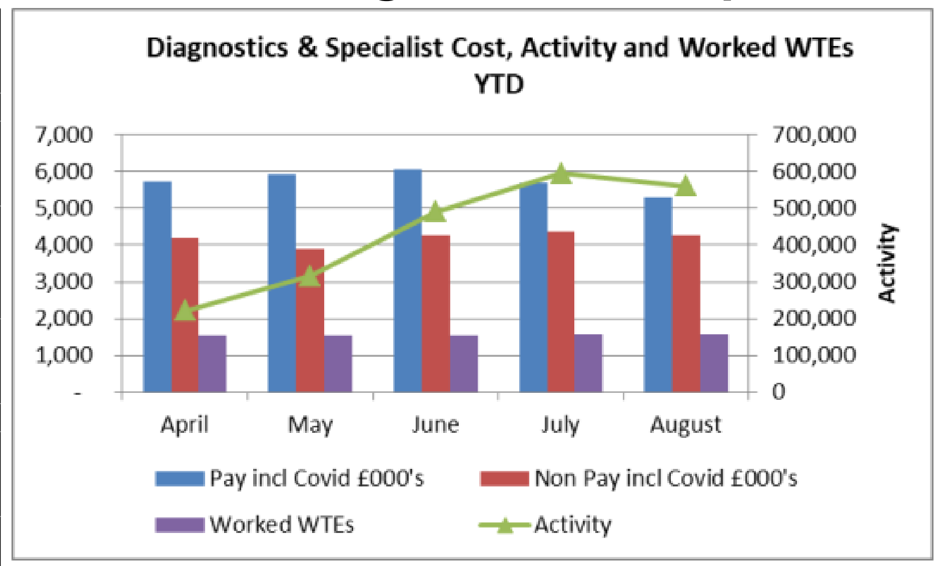


Cost, Activity and Worked WTE by Division – Diagnostic and Specialist

Diagnostics & Specialist Costs	M1	M2	M3	M4	M5	YTD
Pay	5,595	5,719	5,848	5,612	5,230	28,004
Non Pay	4,076	3,804	4,243	4,376	4,257	20,756
Total	9,671	9,523	10,091	9,987	9,487	48,760
Diagnostics & Specialist Covid Costs	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Pay	127	211	229	85	79	731
Non Pay	113	99	18	- 0	5	235
Total	240	310	247	85	84	965
Total Diagnostics & Specialist Costs						
Pay	5,721	5,929	6,078	5,697	5,309	28,734
Non Pay	4,189	3,903	4,261	4,375	4,262	20,990
Total	9,911	9,833	10,338	10,072	9,571	49,725
Diagnostics & Specialist Activity	**M1**	**M2**	**M3**	**M4**	**M5**	**YTD**
Daycase Spells	203	307	336	498	400	1,744
Elective Inpatient Spells	34	27	50	52	85	248
Non-elective Spells	0	1	4	2	2	9
Emergency Spells	96	102	111	101	91	501
Outpatient Attendances	5,038	5,367	6,291	6,357	5,874	28,927
Outpatient Procedures	58	56	122	149	156	541
Non Face to Face Outpatients	1,681	1,721	2,429	3,187	2,951	11,969
Radiology Direct Access	2,339	3,301	4,874	6,611	7,594	24,719
Radiology Unbundled	698	810	1,126	1,243	1,194	5,071
Pathology Direct Access	107,204	170,896	293,529	371,881	333,922	1,277,432
Other Non PBR	4,235	4,060	4,768	5,306	6,515	24,884
	121,586	**186,648**	**313,639**	**395,387**	**358,784**	**1,376,044**
Radiology Exams	18,445	23,865	28,876	31,849	33,787	136,822
Pathology Requests	79,733	104,271	147,205	167,296	167,296	665,801
Chemo Activity	1,323	1,269	1,592	1,817	1,523	7,524
	99,501	**129,405**	**177,673**	**200,962**	**202,606**	**810,147**
	221,087	**316,053**	**491,312**	**596,349**	**561,390**	**2,186,191**
Diagnostics & Specialist WTEs						
WTE Worked Non-Covid	1,536	1,537	1,541	1,555	1,556	
WTE Worked Covid	3	4	5	3	2	
Total	1,539	1,541	1,546	1,558	1,558	



This slide brings together the core divisional costs and worked WTE's, alongside Covid-19 costs and worked WTE's, and activity.

Note the trend of increased activity month on month compared to costs. Diagnostics and Specialist activity has decreased 7% month on month (excluding direct access it has decreased 1%), and has increased 154% since the start of the year (excluding direct access it has increased by 97%).

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Pay Expenditure – Group Totals

NHS Foundation Trust

Pay	M05 Budget £000s	M05 Actuals £000s	M05 Variance £000s	M05 Cumulative Budget £000s	M05 Cumulative Actuals £000s	M05 Cumulative Variance
Substantive	30,265	30,988	(723)	151,897	153,347	(1,450)
Bank	1,299	1,667	(368)	6,496	8,430	(1,934)
Agency	929	1,255	(326)	4,644	5,931	(1,287)
Total	**32,493**	**33,910**	**(1,417)**	**163,037**	**167,709**	**(4,672)**

At the end of August the reported year to date pay position is £4.67m adverse to budget, predominantly driven by Covid spend year to date of £6.78m.

Total Pay Expenditure
M05 2020/21

35.0
34.0
33.0
32.0
31.0
30.0
29.0
28.0
27.0
26.0
25.0
£m
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
20/21 Budget
2020/21 Actual
19/20 Run-Rate

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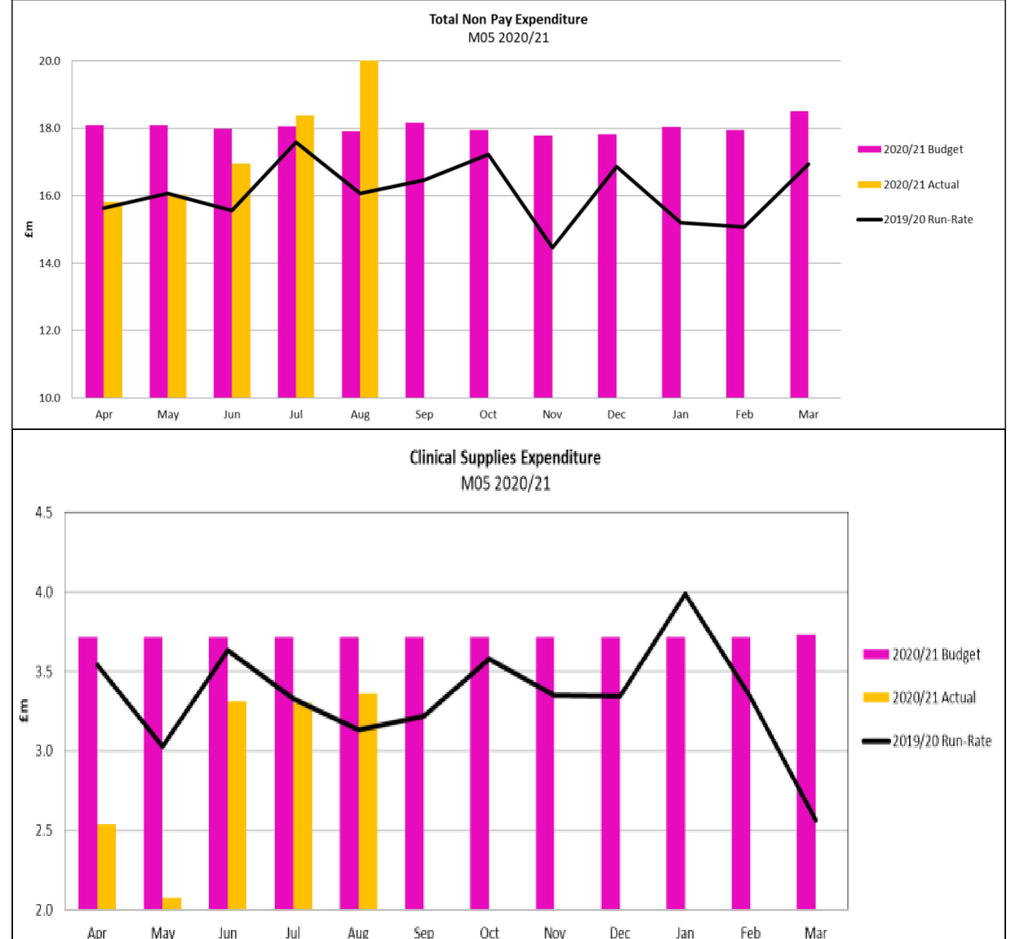
Non-Pay Expenditure (Group)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Non Pay Analysis	M05 Budget £000s	M05 Actuals £000s	M05 Variance £000s	M05 Cumulative Budget £000s	M05 Cumulative Actuals £000s	M05 Cumulative Variance £000s	Passthrough Variance £000s	Net Variance £000s
Drugs	6,331	5,884	447	31,657	28,839	2,818	(451)	2,368
Clinical Supplies	3,715	3,361	354	18,576	14,581	3,995	(117)	3,878
Other Non-Pay	7,868	12,399	(4,531)	39,897	46,933	(7,037)		(7,037)
Total Non Pay	17,914	21,643	(3,729)	90,130	90,354	(224)	(567)	(791)



The table shows the split of non-pay expenditure between the main cost categories.

Overall non-pay year to date is £0.8m overspent against budget. After accounting for the VAT provision of £4.2m, we have a run-rate underspend that reflects the reduced activity in clinical divisions, although including Covid-19 non-pay spend.

The graph for Total Non Pay shows the monthly run rate on expenditure alongside the budget. The month 5 increase is due to the VAT provision. Without this, the non-pay spend would be down month on month, reflecting the activity drop of approximately 1% in M5.

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 5 is slightly higher than 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 M5 £000	B/S movements from 31st March 2020 £000
Non-Current Assests			
Intangible Assets	5,851	6,072	221
Property, Plant and Equipment	257,352	257,650	298
Trade and Other Receivables	5,889	5,836	(53)
Investment in GMS	0	0	
Total Non-Current Assets	**269,092**	**269,558**	**466**
Current Assets			
Inventories	9,121	8,761	(360)
Trade and Other Receivables	31,268	32,420	1,152
Cash and Cash Equivalents	37,385	78,951	41,566
Total Current Assets	**77,774**	**120,132**	**42,358**
Current Liabilities			
Trade and Other Payables	(79,872)	(75,370)	4,502
Other Liabilities	(3,401)	(51,796)	(48,395)
Borrowings	(132,582)	(132,313)	269
Provisions	(170)	(170)	0
Total Current Liabilities	**(216,025)**	**(259,649)**	**(43,624)**
Net Current Assets	**(138,251)**	**(139,517)**	**(1,266)**
Non-Current Liabilities			
Other Liabilities	(6,484)	(6,328)	156
Borrowings	(40,609)	(39,798)	811
Provisions	(2,850)	(2,850)	0
Total Non-Current Liabilities	**(49,943)**	**(48,976)**	**967**
Total Assets Employed	**80,898**	**81,065**	**167**
Financed by Taxpayers Equity			
Public Dividend Capital	179,302	179,655	353
Reserves	29,891	29,891	0
Retained Earnings	(128,295)	(128,481)	(186)
Total Taxpayers' Equity	**80,898**	**81,065**	**167**

The table shows the M5 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 5 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	-72	3,096
CRU	1,945	0	1,945
Residential Accomodation	(571)	18	(553)
Pension Provision	1,348		1,348
	5,889	(54)	5,836

- 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 £0.3m reflecting a decrease in pharmacy stock.
- Trade and other receivables has increased by £1.1m to a balance of £32.4m this is made up of £24.1m accrued debt and £8.3m of invoices. Aged debt is analysed on slide 18.
- Cash has increased by £41.5m 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)

Gloucestershire Hospitals NHS

NHS Foundation Trust

	Cumulative for Financial Year		Current Month August	
	Number	£'000	Number	£'000
Total Bills Paid Within period	40,225	100,688	6,987	19,991
Total Bill paid within Target	35,765	91,274	6,312	19,195
Percentage of Bills paid within target	89%	91%	90%	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 August 2020 £000
<12 months	
Loans from ITFF	2,574
Capital Loan	21,631
Distress Funding	106,229
Obligations under finance leases	1,360
Obligations under PFI contracts	519
Balance Outstanding	**132,313**
>12 months	
Loans from ITFF	19,091
Capital Loan	0
Distress Funding	0
Obligations under finance leases	3,478
Obligations under PFI contracts	17,229
Balance Outstanding	**39,798**
Total Balance Outstanding	**172,111**

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	Aug-20 £000s	Forecast Movement September 20 to March 21 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**818**	**954**	**1,035**	**908**	**967**	5,753	10,435
Adjust for non-cash items:							
Depreciation	1,509	1,509	1,509	1,509	1,509	**11,952**	**19,497**
Other operating non-cash	0	0	0	0	0	**1,500**	**1,500**
Operating Cash flows before working capital	**2,327**	**2,463**	**2,544**	**2,417**	**2,476**	**19,205**	**31,432**
Working capital movements:							
(Inc.)/dec. in inventories	221	232	(57)	(152)	116	**(237)**	**123**
(Inc.)/dec. in trade and other receivables	(4,178)	10,065	(797)	(7,991)	1,749	**3,086**	**1,934**
Inc./(dec.) in current provisions	0	0	0	0	0	**0**	**0**
Inc./(dec.) in trade and other payables	35,152	(5,229)	(44,038)	7,110	2,503	**(14,509)**	**(19,011)**
Inc./(dec.) in other financial liabilities	7,099	(4,559)	41,320	(1,168)	2,140	**(42,542)**	**2,290**
Net cash in/(out) from working capital	**38,294**	**509**	**(3,572)**	**(2,201)**	**6,508**	**(54,202)**	**(14,664)**
Capital investment:							
Capital expenditure	(1,667)	(1,667)	(1,729)	(882)	(1,737)	**(28,790)**	**(36,472)**
Capital receipts	0	0	0	0	0	0	**0**
Net cash in/(out) from investment	**(1,667)**	**(1,667)**	**(1,729)**	**(882)**	**(1,737)**	**(28,790)**	**(36,472)**
Funding and debt:							
PDC Received	0	0	0	353	0	**139,577**	**139,930**
Interest Received	11	0	0	0	0	**0**	**11**
Interest Paid	0	0	0	0	(658)	**(1,841)**	**(2,499)**
DH loans - received	0	0	0	0		**0**	**0**
DH loans - repaid	0	0	0	0	0	**(130,045)**	**(130,045)**
Finance lease capital	(95)	(95)	(95)	(488)	(488)	**(3,904)**	**(5,165)**
Interest element of Finance Leases	(17)	(17)	(17)	(12)	(12)	**(102)**	**(177)**
PFI capital element	(43)	(43)	(43)	(68)	(68)	**(544)**	**(809)**
Interest element of PFI	(182)	(182)	(182)	(38)	(38)	**(304)**	**(926)**
PDC Dividend paid						**(5,770)**	**(5,770)**
Net cash in/(out) from financing	**(326)**	**(337)**	**(337)**	**(253)**	**(1,264)**	**(2,933)**	**(5,450)**
Net cash in/(out)	**38,628**	**968**	**(3,094)**	**(919)**	**5,983**	**(66,720)**	**(25,154)**
Cash at Bank - Opening	**37,385**	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**37,385**
Closing	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**12,231**	**12,231**

The cash flow for August 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	927	928	1	5,280	5,280	0
IT	1,409	1,998	589	5,150	5,190	40
IT TrakCare	237	628	391	993	993	0
Divisional Schemes	1,904	907	(996)	12,607	12,634	27
Contingency	0	0	0	1,051	984	(67)
Donated/Leases	0	26	26	1,500	1,500	0
IFRIC12/PFI	380	380	0	911	911	0
COVID19	1,599	1,599	0	1,599	1,599	0
Strategic Site Development	1,565	1,599	34	3,717	3,717	0
Urgent/Emergency Care	0	0	0	4,400	4,400	0
Overspend/(Underspend)	**8,021**	**8,064**	**44**	**37,208**	**37,208**	**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.

At M5, the Trust has been successful in securing the following:

- £2.7m for critical infrastructure risk work to improve its backlog maintenance. This is reflected within the Estates/Lifecycle forecast.
- £4.4m has been secured for urgent and emergency care to improve access and flow within the Emergency Department over winter.
- £1.2m from the “Adapt & Adopt” allocation to facilitate changes to support COVID compliant diagnostic services .
- £362k for mobile mammography equipment.

All of these allocations are reflected in the forecast outturn position.

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Covid-19
Additional Expenditure
FY21 M05 (August 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.

Trust guidelines and process for capturing these costs, at Divisional level, were published in the Trust in early April and further updated to reflect additional NHSE/I guidance in May.

Divisional cost returns have been reviewed, summarised and balanced to ledger information to define the additional costs incurred in August. 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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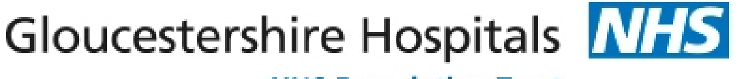
Additional Costs Incurred : August 2020



The tables below show the additional cost incurred for the year to date and month of August (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.

	£000s			
Cumulative Position	**Pay**	**Non Pay**	**Income**	**Total**
Month 5 GHT Ledger as at 14th Sept 2020	6,343.0	5,816.4		12,159.4
GMS Position	440.7	204.7	351.7	997.2
Cumulative Report	**6,783.7**	**6,021.2**	**351.7**	**13,156.6**

	£000s			
In Month Position	**Pay**	**Non Pay**	**Income**	**Total**
Month 5 GHT Ledger as at 14th Sept 2020	476.1	643.4		1,119.5
GMS Position	10.0	10.1	72.9	93.0
In Month Report	**486.1**	**653.4**	**72.9**	**1,212.4**

To 31st August total additional costs of £13.2m have been incurred.

In August the additional costs were £1.2m

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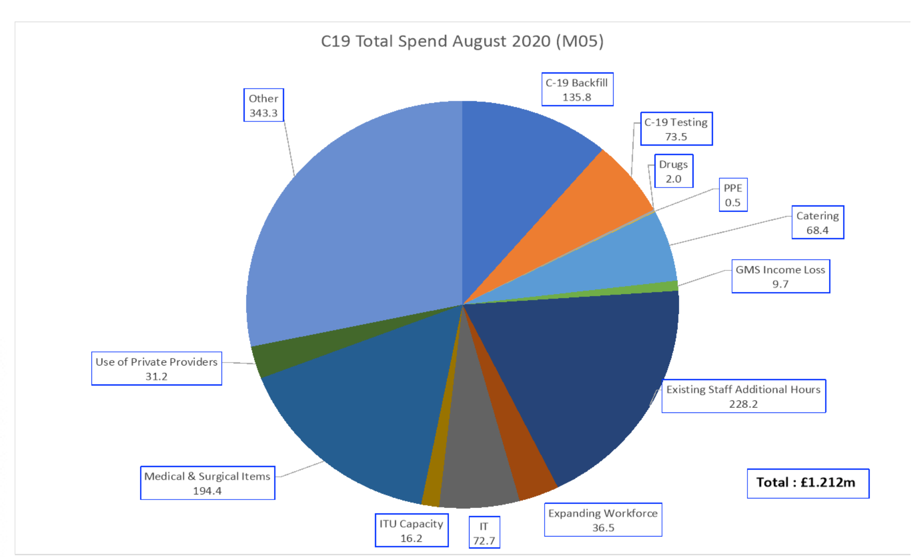
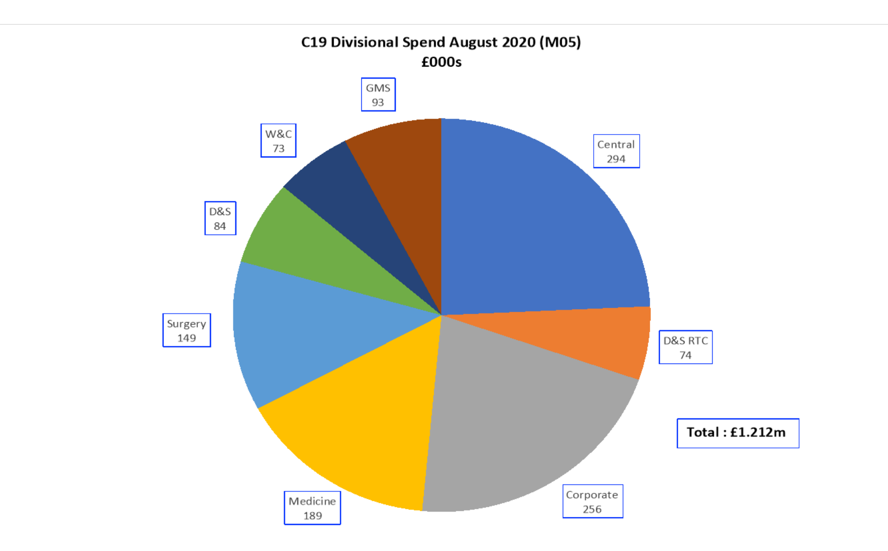
Additional Costs Incurred : August 2020 : Analysis

The charts below show a more detailed distribution of the £1.2m additional expenditure incurred for August.

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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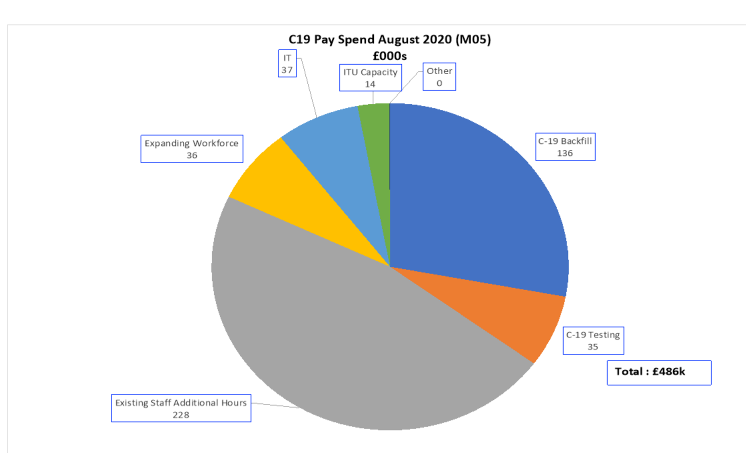
Additional Costs Incurred : August 2020 : Analysis : Pay

The chart below shows the distribution of the £0.5m additional Pay expenditure incurred in August



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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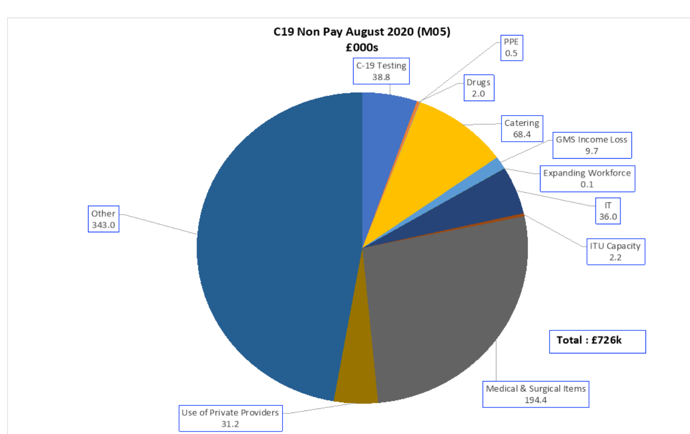
Additional Costs Incurred : August 2020 : Analysis : Non Pay

The chart below shows a more detailed distribution of the £0.7m 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

Catering and GMS income loss reflects recompense to GMS for reduced GP CSSD services, podiatry services and catering related income as staffing, patient and visitor levels reduced and a Trust subsidy for staff meals.

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 : August 2020

The tables below summarise the YTD and Month 5 expenditure by NHSE/I category

Cumulative		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
		£000s												
Trust	Revenue Pay	1,193.0	46.7	0.0	4,970.4	429.4	25.9	0.0	0.0	0.0	93.4	23.7	1.2	6,783.7
	Revenue Non Pay	0.0	559.1	222.5	0.0	9.4	198.5	55.5	3,156.4	874.3	71.6	119.9	1,105.8	6,372.9
Total		**1,193.0**	**605.7**	**222.5**	**4,970.4**	**438.8**	**224.4**	**55.5**	**3,156.4**	**874.3**	**165.0**	**143.6**	**1,107.0**	**13,156.6**
Central		1.5	3.5	222.5	879.0	1.0	2.3	26.7	3,136.4	332.8	11.2	29.4	177.9	4,824.3
D&S RTC		(0.3)	602.2	0.0	84.9	2.6	0.0	0.0	8.4	0.0	0.0	0.0	19.3	717.0
Corporate		77.3	0.0	0.0	202.3	23.0	0.0	26.6	0.7	154.5	145.9	114.1	286.0	1,030.5
Medicine		549.0	0.0	0.0	1,000.3	273.3	0.0	0.0	0.0	16.1	0.0	0.0	86.0	1,924.7
Surgery		83.6	0.0	0.0	1,546.8	6.7	221.4	0.0	0.0	(1.1)	0.0	0.0	125.4	1,982.8
D&S		4.6	0.0	0.0	632.2	94.1	0.0	0.0	0.0	0.0	7.3	0.0	227.0	965.2
W&C		325.2	0.0	0.0	336.2	38.1	0.0	0.0	0.0	15.1	0.0	0.0	0.2	714.9
GMS		152.0	0.0	0.0	288.7	0.0	0.7	2.2	10.8	356.9	0.6	0.0	185.2	997.2
Total		**1,193.0**	**605.7**	**222.5**	**4,970.4**	**438.8**	**224.4**	**55.5**	**3,156.4**	**874.3**	**165.0**	**143.6**	**1,107.0**	**13,156.6**

Month		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
		£000s												
Trust	Revenue Pay	135.8	23.5	0.0	253.4	36.3	0.3	0.0	0.0	0.0	36.7	0.0	0.0	486.1
	Revenue Non Pay	0.0	38.8	0.0	0.0	0.1	2.3	15.2	(0.3)	259.8	15.4	(3.5)	398.5	726.4
Total		**135.8**	**62.4**	**0.0**	**253.4**	**36.5**	**2.7**	**15.2**	**(0.3)**	**259.8**	**52.1**	**(3.5)**	**398.5**	**1,212.4**
Central		0.0	0.0	0.0	76.6	0.0	0.0	17.9	(0.3)	141.7	0.0	0.0	58.4	294.3
D&S RTC		0.0	62.4	0.0	11.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	73.5
Corporate		2.5	0.0	0.0	(6.6)	0.1	0.0	(4.7)	0.0	18.9	50.3	(3.5)	199.4	256.5
Medicine		13.0	0.0	0.0	129.1	5.7	0.0	0.0	0.0	16.1	0.0	0.0	25.6	189.5
Surgery		0.4	0.0	0.0	46.9	0.0	2.7	0.0	0.0	(5.2)	0.0	0.0	104.3	149.0
D&S		0.4	0.0	0.0	60.4	18.2	0.0	0.0	0.0	0.0	1.2	0.0	3.6	83.8
W&C		56.6	0.0	0.0	(11.3)	12.5	0.0	0.0	0.0	15.1	0.0	0.0	0.0	72.9
GMS		62.9	0.0	0.0	(52.9)	0.0	0.0	2.0	0.0	73.2	0.6	0.0	7.2	93.0
Total		**135.8**	**62.4**	**0.0**	**253.4**	**36.5**	**2.7**	**15.2**	**(0.3)**	**259.8**	**52.1**	**(3.5)**	**398.5**	**1,212.4**

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Recommendations

The Board 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 £8.48m.

Authors: **Tony Brown, Senior Finance Advisor and Johanna Bogle, Associate Director of Financial Management**

Presenting Director: **Karen Johnson, Director of Finance**

Date: **September 2020**

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LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

TRUST PUBLIC BOARD – 08 OCTOBER 2020
Microsoft Teams, Commencing at 12:30

Report Title

Digital Report

Sponsor and Author(s)

Author: Nicola Davies, Digital Engagement Lead
Sponsor: Mark Hutchinson, Exec. CDIO

Executive Summary

Purpose
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.

Key issues to note

- Phase 1 of order comms (IPS results into Sunrise EPR) went live on 19th August. This means pathology results (backdated to May 2020) can now be viewed by any clinician with access to Sunrise.
- Phase 2 of electronic order comms (requests and results) went live on Sunrise EPR on 26th August 2020. This has impacted all adult inpatient wards requesting radiology and pathology tests. A verbal update will be provided at the meeting.
- TrakCare optimisations continue and MR9 upgrade happened successfully on 19th August.
- A data quality update provides assurance on how we are working with specialities to better manage their data and reporting requirements. A recent audit demonstrates improvements in this area.

Conclusions
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.

Implications and Future Action Required
Implementation of our digital strategy will realise both quality and financial benefits across the organisation. Benefits realisation requires continued commitment and focus from finance and operational teams to ensure that we maximise the opportunities digital transformation presents and continue to invest in the future.

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

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							

FINANCE & DIGITAL COMMITTEE SEPTEMBER 2020

DIGITAL PROGRAMME UPDATE

1. Introduction

This report provides updates and assurance on the delivery of digital projects within GHFT, as well as business as usual functions within the digital team. This includes the implementation of Sunrise EPR, TrakCare optimisation, digital programme office, data quality and IT. The progression of the digital agenda is in line with our ambition to become a digital leader. This latest update was provided to Digital Care Delivery Group earlier this month.

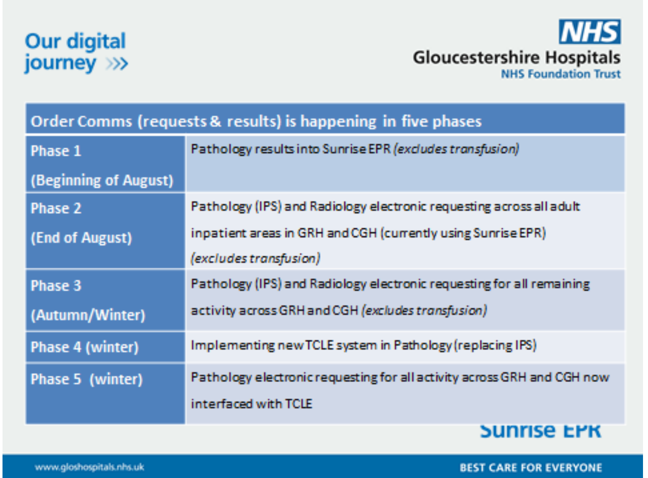
The reporting cycle for cyber assurance, IG and CITS monitoring has been adjusted in line with the meeting cycle of the Digital Care Delivery Group. Therefore these reports will be submitted a month in arrears, so August reports will come to October meeting of Finance and Digital Committee.

2. Sunrise EPR Programme Update

Sunrise EPR implementation is being delivered at pace, and this section provides an update on workstreams and interdependent digital projects, in particular the latest position on order communications (requests and results). Detailed information on each workstream, including RAG status is in section 2.5.

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.

The proposed timeline is below, although plans for phases three, four and five are now being reviewed and revised roadmap will be presented during the October committee cycle.



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

2.1. Order Comms Project Summary

Phase 1 order comms is complete.

Phase 2 order comms went live on 26th August with a two week go live plan supporting wards, clinicians, phlebotomy, radiology and pathology to embed the new processes, enabling it to move to BAU. It also provides a vital opportunity to improve and learn. A verbal update will be provided at the meeting.

InterSystems MR9 was delivered. This release had a number of system fixes that will enable TCLE.

TCLE testing plan has been delayed, partly by phase 2 order comms build but also delays in getting other system environments set up for TCLE interfacing. Re-planning is underway.

2.2. Activity for the next period (September 2020)

Additional end user devices will be rolled out after go live. There will be a further period of optimisation build taking into account user feedback and any issues logged during go live.

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.

2.3. Project risks

Current risks to the project timeline, as reported to Digital Care Delivery Group, include:

- Pathology, Radiology and clinical operational capacity for validation and testing in light of the COVID-19 NHS response.
- TCLE build needs to be reworked due to changes from Sunrise..
- InterSystems MR9 was delivered. This release had a number of system fixes that will enable TCLE. There is a genuine risk that a further upgrade might be required, as yet unknown.
- Phase 4 (TCLE) resources are being diverted on to phase 2 activities. Delaying TCLE may result in penalties from InterSystems being levied. We are working on a correction plan with the labs and InterSystems.

2.4. EPR Programme Detail

The programme detail is correct as of 1St September 2020 and reported to Digital Care Delivery Group. A verbal update will be provided.

2.5. Order Comms (requests and results) workstream updates

Workstream	Workstream update	RAG Status
IPS Results into SCM	• Results from IPS to SCM went live on 20th August	**Complete**
Benefits	• Time and motion studies completed ahead of go live • Benefits being gathered throughout	**Green**
Future State Design	• Phase 2 FSD is complete. • Phase 3 FSD delayed at present.	**Amber**
Build	• Phase 2 build is complete • Phase 2 build optimisation commenced at go live • Phase 3/4/5 build will follow phase 2 go live	**Amber**
Testing	• Complete	**Complete**
Reporting	• Label issues resolved in time for go live and improvements continuing throughout	**Green**
Training	• Training has not met expectations but as phase 2 areas already use Clinical Documentation in EPR, the targets have been lowered. Training figures as of 23rd August: A verbal update will be provided.	**Amber**

User Group	Total Number	Training Attended (Classroom or eLearning)	Previous Compliance Target	Difference
Nurses & HCA's	2863	35%	70%	-35%
Doctors	502	44%	75%	-31%
Consultants	379	39%	75%	-36%
AHPs	219	20%	75%	-55%
Phlebotomists	58	64%	75%	-11%
Physician Associate	16	81%	75%	6%
Pharmacy	80	48%	75%	-28%

Comms & Engagement	Go live communications complete and will continue throughout the go live period.	**Green**
Clinical Site Readiness	• Final roll out and testing of end user kit to enable go live completed. Improvements will continue to be made throughout the go live period	**Green**
Interfacing / Integration	• Build out of environments for systems interfaced to TCLE is underway. This has delayed phase 4 and phase 5 activities.	**Amber**
TrakCare MR9 Upgrade	• Deployed to live on 19th August.	**Complete**
TCLE	• Subject to re-planning exercise which will delay the go lives until 2021.	**Red**

2.6. Additional EPR workstreams

Red	Significant issues with the workstream – scope, time or budget is beyond tolerance level
Amber	Issue/s having negative impact on the workstream performance, workstream is close to tolerance level
Green	On track

Workstream	Workstream update	RAG status
EPR Optimisation	• All activities parked until phase 2 go live is completed.	**Amber**
Pharmacy Stock Control	• TPN (v10.20) upgrade completed (July-2020). • Database build is on track for the end of September 2020 with static and drug data. • UAT and Training is targeted for the end of October. • Deployment and go live is targeted for the end of December. • ePMA current state assessment is underway	**Green**

3. EPR Quality and Financial Benefits

Order comms benefits assumptions are now in place with benefits baselines collected and collated. A sign off process is underway, including feedback from the digital team, finance team and the operational owner of each benefit. The EPR Programme Delivery Group (PDG) will now agree a plan for further time and motion studies to take place two months after go live. Reports on initial findings will be produced in the new year.

Sunrise EPR has already delivered benefits above and beyond what the business case stated, and that is only taking nursing documentation and e-observations functionality into consideration.

Benefits realisation requires continued commitment and focus from finance and operational teams to review changes in service and benefit assumptions. Monthly meetings are now behind held with finance colleagues to support this.

4. Digital Programme Update

This section provides a brief overview of projects within the Digital Programme Management Office (PMO). The current status and numbers of those projects that report to Digital Care Delivery Group are as follows:

Number of Capital Funded Projects 8	Number of Other Key Projects 10	Number of Primary Care / CCG Projects 3	Projects Complete or in closure 11	On Hold 5	Number of Red Rated Projects 4	Number of Amber Rated Projects 9	Number of Green Rated Projects 7

4.1. Areas of Concern

The main areas of concern fall under projects with a red RAG status suggesting that they will not be delivered on time or indeed have not been delivered and the delivery date has passed.

Upgrade of ICNet

A lack of integration resource has prevented data transmission analysis, testing and process resolution for the surgical element of the project. Wider testing has been limited due to access to and availability of Infection Control staff during the Covid period. At present there is no date for go-live.

Windows 2003 Upgrade

Further pressure needs to be put on system owners to enable decommissioning to continue and a revised end date will be proposed once we have dates for the remaining servers.

SQL Migration

This project had an end date of July 2020 which was not achieved because of issues securing technical resource necessary to complete it. There is a robust plan, although resourcing remains the main concern for the project.

Viewpoint 6 Upgrade

A governance structure and approval by the Clinical Safety Group are still awaited. The reconfiguration of ultrasound modalities has not commenced following the estimate of costs being queried and this has prevented testing. A revised go-live date at the end of September 2020 has been proposed but has not yet been confirmed.

5. TrakCare Update

This section provides an update on TrakCare optimisation workstreams as well as the outcomes of a recent data quality audit and recommendations for improvements.

5.1. TrakCare Optimisation

There are nine workstreams in the TrakCare Optimisation Programme for 2020/21. The priority for the TrakCare Optimisation Programme from April through to August 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. On site meetings are now being organised when required and safe to do so.

MR9 upgrade testing was completed and the 19th August deployment delivered successfully.

5.2. TrakCare Workstream Updates

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 July and August, the deep dive for the Central Booking Office has started, and enhancements for Theatres are being deployed.

RTT/WL	Maintaining levels of data quality issues and continuing activities to prevent new issues arising. The number of new issues being generated has reduced, but the number of priority data quality issues had been increasing. The Trust Validation Team have returned to a weekly data	A

	quality validation process in July / August to stabilise the position, with additional hours committed to data quality work. The Optimisation and Data Quality teams are reviewing the data quality issues to target areas such as non RTT services appearing in RTT reports, examples include non-consultant led services and "planned" patients. Work has started with Audiology to review outstanding data quality issues prior to the expected return to national reporting that was suspended during Covid-19. An external review of the RTT waiting lists was undertaken by NHSE at the beginning of August 2020.	
Maternity	There is a risk on achieving CNST (Clinical Negligence Scheme for Trusts) submissions as not all data items can be collected on TrakCare. We have now received details of the data items to be made available from ISC. CNST Maternity reporting is paused, with no date for restart confirmed. This issue has formally been raised with ISC as non-compliance with a national data standard. The data items are expected to be available to the Trust in late September 2020, but no confirmed date for deployment is available from ISC.	A
Outpatients	Palliative Care services will start recording on TrakCare from August, with full roll out early September, with dates for EPR recording to be confirmed. Processes for Interventional Radiology are under review, with the plan to extend use of TrakCare e.g. waiting list management. The priority work has been deployment of virtual appointment types working with TrakCare Support, CBO, eRS, outpatients and clinical services. Respiratory and T&O are piloting the set-up of virtual appointments for video and telephone consultations, and a timetable has been set out for other services. The process for setting up new appointments and applying to schedule is complex and will take significant resource to complete. Training of additional staff is being arranged with ISC, and a funding application to NHSE has been made to support deployment of additional resources.	A
Upgrades / Maintenance	Go live delivered on the 19th August. New RTT back office functionality available in MR9 that will support corrections to RTT pathways. New security patch being deployed across all environments. Associated TCLE milestones continue to be met.	G
Enhancement	Whilst MR9 was on hold, enhancements that were made available during previous releases were being pursued for deployment. There are some delays whilst awaiting	G

	demonstration of functionality from ISC. Theatres items are being deployed (see below), and the process for testing links from the national eReferral System (eRS) and Child Protection Information System (CPIS) to TrakCare is being raised with NHS Digital.	
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. The WHO checklist was deployed for Orthopaedic Theatres 03/08/2020, with other items awaiting sign off from Theatres and Operational teams.	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, with lower levels of attendances reducing the impact of this issue, but attendance levels are now increasing. List of improvements / snag list created, but work delayed by operational staff availability due to Covid-19. Options for deploying the national emergency Care Data Set (ECDS) are being explored. The programme team have supported the setup and deployment of GPAU on TrakCare.	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, issues are being reviewed where possible. Central Booking Office (CBO) project started 14/07/2020 with priority areas including vetting, reporting and eRS processes. Other areas being considered include Audiology, Paediatrics and Trauma and Orthopaedics.	G
BAU Transition	Ongoing delays in transitioning project work to “business as usual” due to Covid-19 pressures. Paper on BAU transition to be presented to Digital Care Delivery Group in September 2020.	A

5.3. Risks

The optimisation programme has been affected by Covid-19, with some workstream activities delayed by limited access to operational staff. This has been mitigated by focussing staff resources on the recent MR8 and MR9 system updates and completing those to faster timescales than planned.

There is an ongoing risk to the reporting for maternity CNST requirements. This continues to be discussed with InterSystems but with no immediate resolution. This has been mitigated in the short term by the deferral of the national requirements until August 2020.

The delivery of a revised process for booking virtual appointments for Outpatients requires significant resource to put this in place for all services.

5.4. **Data Quality Update**

We currently monitor 22 RTT and waiting list related data quality indicators on a weekly basis, with 19 of those reported in the Total DQ records, and five of those prioritised for maintaining the quality of RTT reporting. All five priority indicators are now "managed indicators" which means they are managed routinely each month through data validation and correction by the Trust Validation and TrakCare Support teams. This does rely on resource being available to complete these corrections on a monthly basis.

Routine meetings are held between TrakCare Optimisation, BI and Validators. These meetings monitor progress in resolving data quality issues and highlight any specific areas that need further attention. New reports to further monitor data quality of waiting lists, and related processes, are in development.

5.5. RTT Audit

An audit of data quality associated with RTT reporting was undertaken in February 2020. The conclusions were:

- Our testing of the performance figures reported internally and externally showed in all cases these had been accurately compiled from the raw data sets. Our detailed testing found some exceptions in application of clock starts and stops. However, in the majority of cases these had already been identified and rectified by the Data Validation team, and none impacted on the performance data reported.

- We have noted three medium priority findings relating to improving the quality of data and preventing errors from occurring within the specialities. We have also included an observational finding which reviews the new Access Policy against our prior year recommendations and notes the need to ensure the new policy is communicated and reflected in the ongoing training.

- In conclusion, we have reported a substantial design and moderate operational effectiveness. This is a significant improvement since our previous review, and exceptional when compared to similar reviews at other Internal Audit clients.

We will continue to use the exceptions reports to identify gaps. This could mean we provide targeted training or include data quality in the staff appraisal process. Performance will be reported at executive team level so that action is taken to address the poorest performing areas.

We are now reporting at specialty level and additional information included in the monthly programme reports. This includes data quality issues broken down by service, showing the top 25 service by volume of issues. All of these services have worked with The Trak Optimisation team to improve specific processes in their areas, but further work is being undertaken with services to ensure data quality issues are not being generated.

Author: Nicola Davies, Digital Engagement Lead
Presenter: Mark Hutchinson, Executive Chief Digital & Information Officer

REPORT TO TRUST BOARD – October 2020

From: The Finance and Digital Committee Chair – Rob Graves, Non-Executive Director

This report describes the business conducted at the Finance and Digital Committee held 24 September 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	Detailed project by project update highlighting the status of the Order Comms go-live and associated future plans and the revised timetable for the replacement pathology system	Do temporary changes implemented at Cheltenham General impact TrakCare set up? Is the current approach to Windows 2003 upgrade still appropriate?	Planning and sequencing of implementation/revision steps is under way In certain instances software is highly specialised and upgrade may not be cost effective. Incorporation in to EPR will be considered as a viable alternative	
		Following previous input to the committee how is the team coping with demands and limited capacity?	While the situation remains difficult organisation development work is underway and project timelines are being re-assessed	Maintain under review
		How are system themed concerns that are raised in other committees captured e.g. Datix?	All requests are put through a prioritisation process	Prioritisation process to be shared with Committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital Risk Register	Addition of two new risks - Functionality to meet maternity operational and reporting requirements - Failure to meet Emergency Care Data Set requirements		Discussion is underway concerning the appropriate clinical strategy for maternity	
Financial Performance Report	In Month 5 the Trust recorded a break-even position requiring £6.5 million “true-up” funding. The year to date position is at break-even with cumulative “true-up” finding of £17.5 million.	What is the impact of the change in loans on the Public Dividend Capital (PDC) charge? Have the full GenMed charges been accrued? Will changes to Agency charges impact the Trust?	PDC is payable ay 3.5% and is accrued but will result in a cost pressure Yes all charges now accrued to date on the revised tax treatment basis No - efficiency savings still expected and no special national monitoring requirements in 20/21	
Capital Programme Report	Significant success has been achieved in responding to short notice NHS capital bid opportunities – total year capital now £37.2 Million vs £28.6m in March	Does the Trust have the capacity to manage the increased project workload?	Summary financial impact will be addressed at October Committee meeting	Operational impact needs to be kept under review
Cost Improvement Programme	Slippage at month of £1.4 million reviewed by division and programme – challenge significantly greater n the balance of the year. New techniques being explored.	Scale of the task well understood and new approaches encouraged.		Drivers of the Deficit analysis to be reviewed in depth

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Costing	Briefing on the status of the work to comply with the National Costing Submission	How strong is the link between the costing and CIP teams?	Teams work together and include reference to the benchmarking lead	
Financial Regime	Detailed briefing on the anticipated proposed financial regime for the balance of the year and the planning activities and associated timetable that are currently the key focus for the team.	How will the Board be updated on the position prior to national submission?		Appropriate review meeting to be set
	The briefing reinforced strong cross organisation working at ICS level			

Rob Graves
Chair of Finance and Digital Committee
01 October 2020

REPORT TO TRUST BOARD – OCTOBER 2020

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

This report describes the business conducted at the Estates and Facilities Committee held 24 September 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
Matters Arising	There remains an action outstanding to report back on the life cycle costs of the PFI contract.	Are these costs being effectively managed, to ensure that the Trust achieves value for money? There is a similar question on the parking contract.	GMS manage these contracts on behalf of the Trust.	A review of "Trust retained contracts" is to be submitted to the next Committee meeting.
Contract Management Group Exception Report	Assurance was provided to the Estates and Facilities Committee that Gloucester Managed Services (GMS) have met all their contractual key performance measures for the reporting period.	Is the performance against the cleaning KPIs being masked by averaging across audits and/or locations?	Cleaning KPIs are being closely monitored by the Infection Control Group. However, more contemporaneous KPI data is also required (there is too much of a time lag).	New KPIs will be presented to Committee once they have been formally agreed by both contract parties and the OHFA contract updated.
Estates Strategy Phase 1	This refers to the Strategic Site Development Programme, which remains on track. Plans are now being developed for decanting key activities in GRH.	How might Covid-19 impact the delivery of our capital project?	The Director of Strategy is developing responses to different C-19 scenarios.	
Capital Programme Delivery	A report was presented that showed the Trust is on track to deliver on its capital projects in	How can we be assured that the projects for the	All capital spending projects are reviewed and approved by the Infrastructure Development Group.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Update	this financial year. It was reported that the Trust has received additional capital funding: £4.4mln for urgent and emergency care, £2.67mln for critical infrastructure and £1.85 for critical care.	additional spending fit within an overall strategic plan to ensure that there are no inefficiencies between different projects, and no regret costs? Does the Trust, and the contractor market, have the capacity to manage all this additional work in the time required?	Opportunities to leverage across capital projects is being actively pursued. The Trust is also starting to develop Master Plans for each site that will provide a prioritised template for where future spending should be deployed. The Trust has capacity, and we may also be able to leverage the professional services of Kier, the main contractor for the Strategic Site Development.	
GMS Business Assurance Framework	The overall strategic risks that may prevent delivery of GMS's Business Strategy were presented, together with controls and assurances in place, and gaps identified.	Where does responsibility for statutory duties sit, where the duty is on the Trust, but action has been delegated to GMS?	The duties are addressed by the GMS business assurance framework. However, the Trust remains ultimately accountable for compliance.	Follow up discussions are required to ensure a clear understanding between all parties.
Trust Business Assurance Framework	The overall strategic risks that may prevent delivery of the Trust's Strategic Objective for "Effective Estate" were presented.	The objective includes "minimising environmental impact" and a key control is the Sustainability Strategy, but do we have a current one?	There is a strategy in place, that runs to the end of 2020. However, it was acknowledged that this is now largely out of date, given the Trust's recent developments and progress.	A new Sustainability Strategy is required. It will be added to the Committee workplan for review.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Hard FM	A report on the Trust's position against the Estates Returns Information Collection (ERIC) data for similar-sized acute Trusts was presented. It showed that the 2018-19 Trust performance compares well ("middle of the pack") on most measures for hard services, despite the Trust's backlog maintenance being relatively high.	The benchmarking looks at costs, rather than condition, so doing less maintenance improves the scores, but may negatively impact our benchmark position.	Further analysis will be provided with the 2019-20, once available, this is likely to be March 2021, and will also include analysis of soft services (cleaning, catering, etc.)	

Mike Napier
Chair of Estates and Facilities Committee
1 October 2020

TRUST PUBLIC BOARD – 08 OCTOBER 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 August 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 the subsequent month. Un-validated data, broadly due to timing of reporting is identified within the QPR. Future QPRs will contain the delivery against the Phase 3 activity indicators.

Quality Delivery Group

Executive Summary
The Quality Delivery Group (QDG) continues to monitor the performance of the quality metrics. We have improvement programmes in place with the QPR and improvement plans being reviewed at QDG on a regular basis. QDG have agreed the minimum standards for each improvement programme.

Safe
Never Event Thematic Analysis
There is a contributing factor review for the wrong site surgery never events and this report will be received by QDG in October 2020.

Falls Metrics and Improvement Plan progress - red RAG rated indicator Falls per 1000 bed days
This indicator has remained RAG rated red over a sustained period and so a review has been undertaken to review whether the metric RAG rating should be changed as this score cannot be benchmarked with any external Trusts. The review has also concluded that an additional metric of our falls risk assessment will be added in to the suite of metrics once the whole picture across the ward is being recorded and not just the new admissions. The Associate Chief Nurse leads the improvement programme with our Falls Specialist Nurse. We have had an sustained an improved picture with the number of our patients having moderate or severe harm with a fall and so the improvement programme change ideas appear to be have an impact.. The Preventing Harm Hub continues to provide immediate learning and feedback to wards which is vital for continuous improvement.

Pressure Ulcers Metrics and Improvement Plan - red RAG rated indicator unstageable pressure ulcers

Unstageable pressure ulcers are also reviewed at the preventing harm hub and themes in this period were found to be missed opportunities to risk assess patients, timely provision of equipment and robustness of pressure relieving measures. The Medicine and Surgical Division now have plans in place to improve actions to prevent pressure ulcers.

Effective

Dementia screening - red RAG rated indicator DAR

This indicator has been paused by NHSI. The local metrics for dementia are being reviewed as part of enhancing our improvement programme and the nationally reported metric is under review as well.

VTE risk assessment - red RAG rated indicator VTE assessment 92.3%

This indicator is not being reported nationally to NHSI - internal reporting continues. This indicator has been amber for a number of consecutive months the indicator shows stable performance of a system but this is not at the 95% NHS Standard Contract threshold (August performance is 92.3% and is rated RED). In the last report published by NHSI in March 2020 (Q3 2019/20) there are currently 61 providers that do not meet the 95% operational standard, 69% of those Trusts reported 90% and 95% of total admissions for VTE.

Caring

Friends and Family Test (FFT) and Real-time Surveys - red RAG rated indicator Inpatient, ED and Maternity

This month has seen the score drop to the lowest positive scores in 2020, as well as showing the highest number of responses in the same period. The question for FFT changed in June 2020, and July and August are the first full months where all responses will be for the new question, which may have impacted the scores. The Patient Experience team are proposing to split the current FFT data reporting in the QPR, so we have a score line for the previous question, and a new line of data reporting for responses against the new question, as they are no longer comparable data points. We will also need to review our current RAG thresholds, as there will be no national data for comparison for a number of months.

Performance

During August the Trust did not meet the national standards or Trust trajectories for; A&E 4 hour standard and 52 week waits. The Trust performance (type 1) for the 4 hour standard in August was 75.53% with system performance total 83.26%. The Trust did not meet the diagnostics standard for August at 25.49%, 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 & recovered the position for CT and MR diagnostics.

The Trust did not meet the standard for 2 week wait cancer at 90.8% in August, as predicted and for the 62day standard at 87.6% this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance 60% in August, un-validated at the time of the report, and improved from the July position. 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 as we continue to restore our services.

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 support 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. This is being supported in line with Phase 3 guidance.

Directors Operational Group 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, activity recovery aligned with Phase 3 requirements.

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 August 2020

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

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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 the summer. 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 August 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 August was 73.53%, against the STP trajectory of 85.90%. The system did not meet the delivery of 90% for the system in August, at 83.26%. Note that the August 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 August at 25.49%. 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 did not meet the standard for 2 week wait cancer at 90.8% in August, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 60% (un-validated) in August, 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 1,232 in August. 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	Aug-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	40
	Actual	57	53	42	50	77	96	145	159	127	161	105	105	61	57	88	78	166
Count of handover delays 60+ minutes	Trajectory	0	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	36
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%	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%	83.26%
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%	85.22%
	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%	73.53%
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%	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%	55.83%	59.59%
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	0
	Actual	93	91	90	78	77	78	62	45	39	28	14	33	156	366	694	1037	1232
% 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%	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%	25.49%
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%	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%	90.80%
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%	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%	95.90%
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%	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%	96.70%
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%	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%	100.00%
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%	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%	98.30%
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%	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%	87.20%
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%	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%	77.80%
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%	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%	90.00%
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%	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%	87.60%

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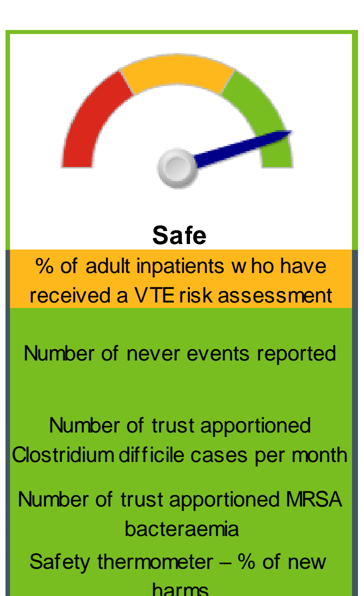
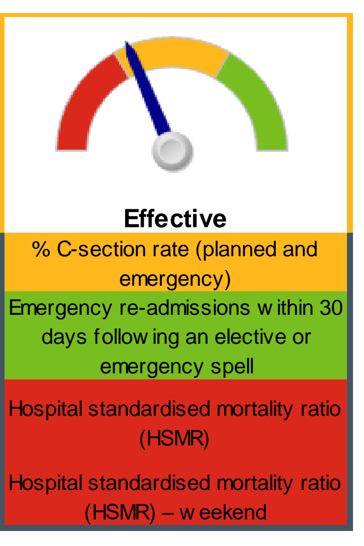
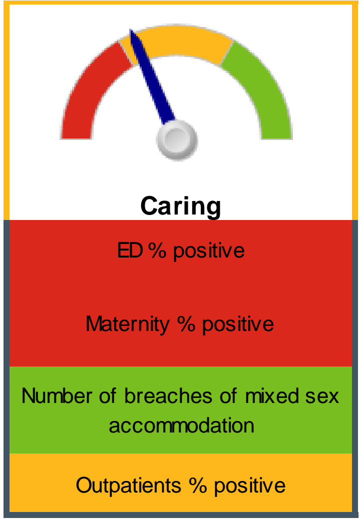
Summary Scorecard

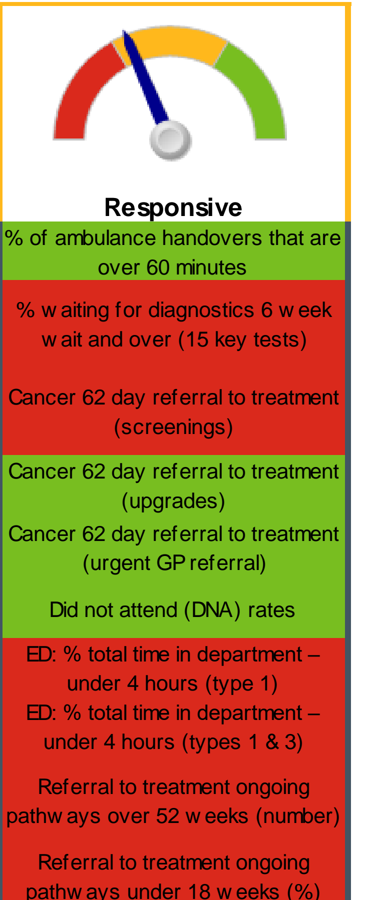
The following table shows the Trust's current monthly performance against the chosen lead indicators within the Trust Scorecard.

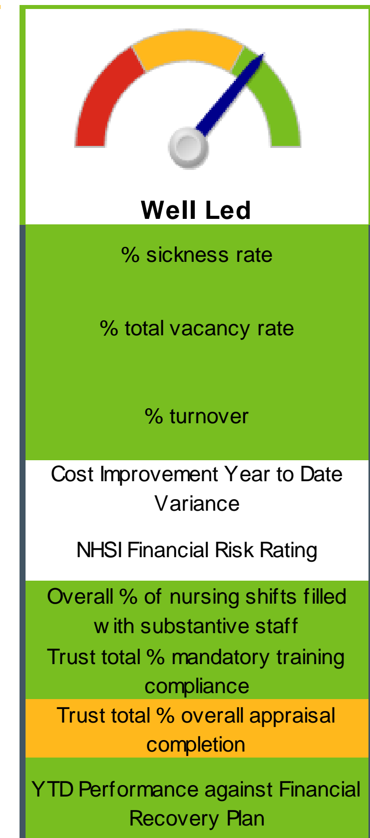
RAG Rating: Overall RAG rating for a domain is an average performance of lead indicators against national standards. Where data is not available the lead indicator is treated as red.











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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	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Monthly (Aug)	YTD
GP Referrals	10,302	10,429	11,836	13,356	11,169	10,191	9,595	7,888	3,076	3,946	3,185	8,119	7,784	-24.44%	-69.17%
OP Attendances	11,850	13,534	14,545	13,661	10,823	13,634	12,167	10,637	5,241	6,332	31,029	32,690	26,174	120.88%	70.35%
New OP Attendances											8,773	9,911	8,247		
FUP OP Attendances											17,060	22,779	17,927		
Day cases	6,348	6,276	7,142	6,578	6,228	7,067	5,304	4,216	1,473	1,786	2,721	3,467	3,109	-51.02%	-75.64%
All electives	7,378	7,238	8,275	7,690	7,155	8,039	6,294	4,966	1,780	2,183	3,252	4,242	3,965	-46.26%	-73.29%
ED Attendances	13,267	13,240	13,329	13,066	13,287	12,624	11,695	9,721	6,861	8,913	9,819	10,957	11,636	-12.29%	-34.98%
Non Electives	4,698	4,833	5,083	4,837	5,052	4,664	4,353	3,874	3,110	3,728	4,205	4,421	4,320	-8.05%	-20.37%

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Trust Scorecard – Safe (1)

Note that data in the Trust Scorecard section is subject to change.

	19/20	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-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	4	318	327	TBC	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission										68	7	1	1	0	76	77	TBC	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission										38	1	2	1	0	41	42	TBC	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission										33	4	1	1	1	38	40	TBC	
Number of trust apportioned MRSA bacteraemia	2	0	1	0	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	9	9	11	12	7	8	6	5	4	7	2	7	0	13	20	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	5	6	1	10	3	5	4	6	2	1	4	1	2	6	6	14	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	45	4	8	1	9	2	4	0	3	3	3	1	5	6	7	18	<=5	
Clostridium difficile – infection rate per 100,000 bed days	28.8	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	19.5	<30.2	
Number of MSSA bacteraemia cases	18	1	2	2	1	2	1	1	2	1	0	3	1	1	4	5	<=8	
MSSA – infection rate per 100,000 bed days	5.3	3.6	7.3	6.9	3.5	7	3.3	3.6	7	6.4		14.9	4.3	4	7.4	5.9	<=12.7	
Number of ecoli cases	46	4	3	2	5	9	3	3	2	1	3	2	4	3	6	13	No target	
Number of pseudomona cases	9	1	0	1	0	0	3	0	1	0	2	0	0	0	2	2	No target	
Number of klebsiella cases	18	3	4	1	1	1	1	2	1	1	2	0	1	1	3	5	No target	
Number of bed days lost due to infection control outbreaks	1,264	136	0	0	240	276	100	13	0		0	0	4	0		4	<10	>30

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Trust Scorecard – Safe (2)

	19/20	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	20/21 Q1	20/21	Standard	Threshold
Number of patient safety alerts outstanding	0	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	5.5	6.2	6.6	6.4	6.7	7.1	7	6.4	6	7.9	7.2	7	7.3	7	7.1	<=6	
Number of falls resulting in harm (moderate/severe)	4	1	5	7	1	4	5	5	0	2	4	4	3	4	10	17	<=3	
Number of patient safety incidents – severe harm (major/death)	6	12	4	7	3	3	6	5	2	4	1	5	2	7	10	19	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	3	1	2	1	1	5	2	1	2	3	2	6	1	7	14	No target	
Medication error resulting in low harm	12	11	10	21	23	7	10	8	11	9	15	7	8	14	31	53	No target	
Number of category 2 pressure ulcers acquired as in-patient	30	36	30	24	31	29	27	12	23	13	15	16	9	24	44	77	<=30	
Number of category 3 pressure ulcers acquired as in-patient	5	6	4	4	4	2	2	3	1	0	1	0	1	3	1	5	<=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	12	5	6	5	2	4	6	3	3	4	7	4	5	14	23	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	6	7	2	3	8	3	5	3	4	4	6	1	2	6	11	19	<=5	
RIDDOR																		
Number of RIDDOR	35	2	1	2	1	2	4	2	2	2	1	5	3	0	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	38			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	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	20/21 Q1	20/21	Standard	Threshold
Safety thermometer – % of new harms	97.1%	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	0	0	1	0	1	1	1	0	0	0	2	0	0	2	2	Zero	
Number of serious incidents reported	3	1	5	4	3	1	2	3	2	0	0	2	2	5	2	9	No target	
Serious incidents – 72 hour report completed within contract timescale	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%	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%	92.9%	91.6%	95.9%	91.8%	92.6%	90.1%	94.2%	92.7%		90.1%	94.0%	93.8%	90.7%	92.3%	92.3%	>95%	

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Trust Scorecard – Effective (1)

	19/20	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	20/21 Q1	20/21	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	0.8%	85.0%	63.0%	62.0%	50.0%	37.0%	37.0%	86.0%	74.0%	67.0%	63.0%	68.0%	71.0%			67.0%	>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	29.4%		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%	0.00%	3.00%	1.60%	No target	
% C-section rate (planned and emergency)	28.39%	25.61%	27.99%	25.97%	26.57%	31.30%	28.66%	30.23%	28.90%	27.73%	28.82%	25.94%	26.51%	27.80%	27.43%	27.11%	<=27%	>=30%
% emergency C-section rate	15.74%	14.02%	16.04%	13.70%	15.77%	13.48%	13.60%	16.36%	14.48%	12.73%	15.27%	12.08%	12.73%	16.20%	13.32%	13.81%	No target	
% of women booked by 12 weeks gestation	88.9%	85.3%	89.6%	91.8%	92.2%	91.9%	90.3%	89.5%	89.7%	89.6%	93.1%	93.3%	93.0%	92.4%	92.1%	92.5%	>90%	
% of women that have an induced labour	28.65%	26.83%	29.66%	29.04%	29.59%	30.00%	27.20%	28.42%	27.98%	27.50%	28.60%	29.70%	35.49%	31.20%	28.63%	30.59%	<=30%	>33%
% of women smoking at delivery	10.95%	10.16%	9.14%	10.22%	13.63%	11.52%	13.18%	8.64%	12.39%	9.55%	10.97%	11.29%	9.39%	13.80%	10.63%	10.26%	<=14.5%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.22%	0.20%	0.19%	0.20%	0.43%	0.43%	0.21%	0.00%	0.23%	1.14%	0.00%	0.20%	0.42%	0.00%	0.42%	0.00%	<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						1.1	NHS Digital	
Hospital standardised mortality ratio (HSMR)	108	98	97.6	99.7	99.8	103.9	99.9	107.2	108	111.3	110.7					110.7	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	112.7	100.5	101.6	102.7	102.1	110.3	104.3	110.9	112.7	117.4	117.5					117.5	Dr Foster	
Number of inpatient deaths	1,964	124	143	144	152	212	215	167	192	252	126	112	120	141	490	751	No target	
Number of deaths of patients with a learning disability	15	2	0	0	0	1	4	0	0	4	2	0	1	3	6	10	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	7.5%	7.2%	6.7%	7.1%	6.4%	6.6%	6.7%	8.3%	9.6%	8.5%	7.2%	7.9%		8.3%	8.1%	<8.25%	>8.75%
Research																		
Research accruals		103	76	121	101	73	110	98									No target	

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Trust Scorecard – Effective (2)

	19/20	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	20/21 Q1	20/21	Standard	Threshold
Stroke care: percentage of patients receiving brain imaging within 1 hour	49.5%	50.6%	48.6%	52.5%	39.4%	48.7%	45.2%	56.4%	46.2%	37.0%	53.0%	45.0%	63.5%	60.9%	45.0%	51.9%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.7%	98.8%	87.9%	84.5%	81.1%	87.3%	88.5%	87.7%	90.4%	88.5%	78.0%	84.0%	95.1%		83.5%	83.5%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours	54.80%	68.40%	62.00%	64.90%	41.40%	40.00%	38.40%	30.80%	49.30%	49.00%	21.00%	65.00%	74.50%	50.70%	45.00%	45.00%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival	70.70%	67.60%	71.40%	77.80%	71.20%	71.70%	69.20%	71.00%	65.20%	68.00%	76.00%	65.00%	78.60%	59.30%	69.70%	69.40%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.7%	46.6%	66.7%	39.6%	56.1%	58.3%	73.1%	58.6%	48.6%	75.0%	62.4%	72.7%	56.7%	71.9%	68.9%	68.5%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.90%	45.21%	66.70%	37.90%	56.06%	58.30%	73.10%	55.20%	48.60%	53.10%	60.60%	70.91%	56.70%	70.20%	67.00%	62.70%	>=65%	<55%

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Trust Scorecard – Caring (1)

	19/20	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	20/21 Q1	20/21	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	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%	86.0%	90.9%	88.8%	>=96%	<93%
ED % positive	82.1%	83.3%	82.3%	82.9%	87.9%	78.9%	79.9%	79.2%	79.6%	90.2%	85.8%	86.8%	81.8%	77.2%	87.5%	83.3%	>=84%	<81%
Maternity % positive	97.4%	100.0%	96.9%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	97.2%	100.0%	90.2%	100.0%	85.2%	94.4%	92.5%	>=97%	<94%
Outpatients % positive	93.0%	93.2%	92.7%	92.8%	93.8%	93.2%	93.1%	93.0%	94.3%	94.0%	93.6%	93.9%	93.7%	93.5%	93.9%	93.9%	>=94%	<91%
Total % positive	91.2%	91.3%	91.0%	91.1%	92.8%	91.3%	91.4%	91.1%	92.2%	92.9%	91.8%	92.4%	91.3%	90.0%	92.3%	91.4%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?	79.00%	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%	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%	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%	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%	97.17%	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%	96.40%	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%	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	11	9	0	0	2	2	1	8	6	13	21	23	1	40	64	<=10	>=20

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Trust Scorecard – Responsive (1)

	19/20	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	20/21 Q1	20/21	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait										53.9%	79.6%	77.9%	79.9%	79.4%	71.4%	74.1%	TBC	
Cancer – 28 day FDS breast symptom two week wait										91.4%	95.7%	98.6%	99.1%	80.6%	100.0%	97.6%	TBC	
Cancer – 28 day FDS screening referral										76.0%	50.0%	76.9%	100.0%	78.6%	72.7%	79.5%	TBC	
Cancer – urgent referrals seen in under 2 weeks from GP	92.5%	86.0%	96.5%	94.4%	94.6%	96.9%	95.1%	96.1%	95.1%	90.6%	99.1%	98.0%	96.5%	90.8%	96.7%	95.1%	>=93%	<90%
2 week wait breast symptomatic referrals	97.5%	98.4%	99.3%	98.2%	96.0%	97.4%	96.3%	97.8%	98.4%	87.9%	97.8%	95.7%	96.4%	95.9%	94.6%	95.3%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	93.4%	92.3%	91.0%	91.4%	91.4%	93.0%	95.5%	94.3%	95.5%	96.6%	96.0%	95.3%	98.1%	96.7%	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%	94.0%	97.0%	100.0%	98.3%	100.0%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	93.6%	89.8%	97.6%	100.0%	98.0%	90.2%	98.3%	97.4%	94.1%	98.2%	92.6%	81.3%	78.9%	87.2%	89.8%	90.9%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	94.9%	84.8%	80.8%	99.2%	94.8%	95.6%	96.7%	97.5%	100.0%	98.3%	96.7%	86.5%	83.0%	98.3%	93.4%	96.0%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	73.1%	75.4%	71.0%	76.7%	71.4%	74.2%	68.0%	76.5%	78.2%	78.0%	69.0%	78.0%	85.6%	87.6%	76.4%	81.3%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	95.4%	100.0%	100.0%	96.4%	95.1%	91.1%	97.8%	96.7%	94.7%	90.9%	54.5%	60.0%	66.7%	77.8%	82.1%	80.3%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	72.2%	75.0%	66.7%	61.5%	83.3%	87.5%	69.2%	63.6%	76.5%	100.0%	88.9%	73.7%	91.7%	90.0%	85.4%	89.5%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	170	13	9	15	12	6	5	4	3	4	8	8	21	2		4	Zero	
Number of patients waiting over 104 days without a TCI date	407	32	28	36	22	25	19	14	20	33	79	66		15		33	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	3.16%	0.71%	0.72%	0.54%	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	29.54%	25.49%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	825	714	756	756	763	835	853	803	825	1,035	1,230	1,367	1,465	1,569	3,632	3,632	<=600	
Discharge																		
Number of patients delayed at the end of each month	15	41	35	44	32	22	55	54	15	4	3	7	11	24	14	49	<=38	
Patient discharge summaries sent to GP within 24 hours	56.5%	55.1%	56.5%	58.0%	56.4%	56.3%	58.9%	59.4%	57.7%	55.4%	57.8%	60.2%	60.0%		58.0%	58.6%	>=88%	<75%

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Trust Scorecard – Responsive (2)

	19/20	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	20/21 Q1	20/21	Standard	Threshold
ED: % total time in department – under 4 hours (type 1)	81.58%	88.16%	84.03%	80.58%	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	86.16%	82.88%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	87.40%	92.01%	89.13%	86.36%	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	89.68%	87.55%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	93.70%	96.20%	92.68%	95.54%	90.92%	88.74%	91.50%	93.02%	94.10%	95.42%	96.43%	98.93%	99.85%	99.91%	96.91%	98.21%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	81.59%	84.25%	79.90%	73.72%	69.25%	65.20%	63.30%	64.91%	71.69%	84.28%	80.59%	84.01%	84.46%	73.53%	83.37%	80.09%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2	0	0	0	0	1	0	0	1	0	0	0	0	1	0	1	Zero	
ED: % of time to initial assessment – under 15 minutes	71.2%	75.7%	71.4%	68.4%	66.5%	64.3%	68.0%	65.8%	70.1%	80.4%	77.0%	72.7%	72.5%	63.7%	76.3%	72.4%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	31.3%	31.2%	29.9%	28.3%	26.6%	26.0%	31.9%	29.0%	40.9%	68.0%	57.5%	52.0%	44.5%	31.4%	58.2%	48.6%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	2.40%	1.93%	2.48%	3.48%	3.71%	2.81%	3.76%	2.76%	2.87%	2.09%	1.74%	2.57%	2.04%	4.17%	2.14%	2.58%	<=2.96%	
% of ambulance handovers that are over 60 minutes	0.07%	0.00%	0.02%	0.07%	0.07%	0.24%	0.23%	0.13%	0.05%	0.00%	0.00%	0.15%	0.03%	0.90%	0.05%	0.24%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.03%	90.48%	95.12%	91.18%	64.71%	80.00%	88.89%	74.07%	74.03%	-120.00%	100.00%	100.00%	94.00%	86.67%	21.00%	56.14%	>=95%	
Urgent cancelled operations	8	0	2	3	0	1	1	1	0	0	0	0	11	2	0	13	No target	
Number of patients stable for discharge	86	88	88	90	87	81	112	101	70	14	33	45	66	68	31	165	<=70	
% of bed days lost due to delays	3.10%	4.32%	4.58%	3.67%	3.19%	2.70%	4.69%	4.54%	3.10%	0.56%	0.58%	0.93%	2.00%	2.11%	0.70%	1.24%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	423	360	371	380	406	403	431	427	358	204	213	248	288	332	222	257	<=380	
Average length of stay (spell)	5.14	4.78	4.88	4.84	4.95	5.25	5.68	5.36	6.16	5.22	4.49	4.54	4.69	4.66	4.72	4.7	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	5.25	5.38	5.35	5.56	5.77	6.43	6.07	6.91	5.37	4.75	4.81	5.13	5.16	4.96	5.04	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.66	2.76	2.61	2.83	2.65	2.87	2.42	2.62	2.65	3.73	2.17	2.62	2.46	2.31	2.75		<=3.4	>4.5
% day cases of all electives	85.59%	86.04%	86.71%	86.31%	85.54%	87.04%	87.91%	84.27%	84.90%	82.75%	81.81%	83.67%	81.73%	78.41%	82.88%	78.41%	>80%	<70%
Intra-session theatre utilisation rate	87.20%	87.60%	87.70%	88.20%	88.00%	87.40%	86.40%	87.50%	85.60%	91.80%	87.60%	84.05%	87.30%	88.60%	85.20%	87.10%	>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	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	20/21 Q1	20/21	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	82.0%	81.0%	79.0%	80.0%	82.0%	82.0%	83.0%	85.0%	85.0%	85.0%	85.0%	78.0%	80.0%	82.0%	76.0%		>=90%	<70%
Trust total % mandatory training compliance	92%	92%	91%	91%	92%	92%	90%	90%	90%	90%	90%	90%	91%	91%	90%		>=90%	<70%
Finance																		
Total PayBill Spend		31.7	30.9	31.5	31.3	31.4	30.1	31.6	30.2	32.5	33.8	34.3	33.2	33.9				
YTD Performance against Financial Recovery Plan		.5	.6	.7	.6	.4	.3	.1	1.5	0	-.1	0	0	0				
Cost Improvement Year to Date Variance		2	2	1	1	-2	-2	-4	-8	0	0	0	0	0				
NHSI Financial Risk Rating		3	3	3	3	3	3	3	3	3	3	3	0	0				
Capital service		4	4	4	4	4	4	4	3	3	3	3	0	0				
Liquidity		4	4	4	4	4	4	4	4	4	4	4	0	0				
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3	3	3	3	3	3	0	0				
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	97.40%	95.40%	96.40%	98.40%	99.40%	98.30%	99.30%	98.30%				90.52%	100.77%	102.10%	90.52%	97.80%	>=75%	<70%
% registered nurse day	98.20%	96.50%	97.40%	99.40%	100.70%	98.70%	98.50%	98.10%				89.23%	100.82%	101.90%	89.23%	97.20%	>=90%	<80%
% unregistered care staff day	100.20%	99.40%	98.60%	101.40%	104.20%	98.60%	102.10%	100.20%				110.83%	120.86%	117.50%	110.83%	116.40%	>=90%	<80%
% registered nurse night	95.70%	93.30%	94.50%	96.40%	97.10%	97.50%	100.80%	98.60%				92.99%	100.69%	102.60%	92.99%	98.80%	>=90%	<80%
% unregistered care staff night	106.20%	105.30%	106.70%	108.60%	115.50%	105.40%	107.80%	109.70%				112.80%	131.01%	131.70%	112.80%	125.00%	>=90%	<80%
Care hours per patient day RN	4.7	4.7	4.7	4.7	4.8	4.9	4.6	4.7				6.2	5.8	5.6	2.1	5.9	>=5	
Care hours per patient day HCA	3	3	2.9	3	3	3	2.9	3				4.5	4.2	3.9	1.5	4.2	>=3	
Care hours per patient day total	7.7	7.6	7.6	7.7	7.8	7.9	7.6	7.7				10.8	10.1	9.5	3.6	10.1	>=8	
Vacancy and WTE																		
% total vacancy rate		8.60%	7.20%	7.00%	6.95%	7.00%	6.70%	6.15%	6.15%			5.97%	5.14%	7.10%			No target	
% vacancy rate for doctors		0.53%	2.70%	2.25%	2.80%	2.80%	3.62%	1.24%				4.90%	2.70%	3.27%			No target	
% vacancy rate for registered nurses		8.65%	8.07%	8.22%	8.30%	8.30%	9.92%	10.26%	10.26%			8.12%	8.44%	8.90%			No target	
Staff in post FTE		6226.64	6350.1	6358.09	6354.32	6355	6351.41	6387.05	6422.86	6421.87	6549.97	6573.86	6485.99	6463.25			No target	
Vacancy FTE		500	492.55	478.95	474.24	475	457.45	418.47	418.47			416.06	358	494.04			No target	
Starters FTE		60.55	147.7	72.72	51.61	69.42	55.75	63.74	44.17	32.81	30.05	57.65	49.45	62.46			No target	
Leavers FTE		46.75	84.63	40.81	47.02	49.37	52.49	36.99	58.37	43.37	46.93	38.57	96.43	106.66			No target	
Workforce Expenditure and Efficiency																		
% turnover		11.1%	11.9%	11.6%	11.7%	11.5%	11.5%	11.3%	11.1%	10.8%	10.9%	10.4%	10.2%	10.3%			<=12.6%	>15%
% turnover rate for nursing		10.77%	11.40%	11.09%	10.75%	10.93%	11.12%	10.92%	10.73%	10.59%	10.72%	10.14%	9.98%	10.34%			<=12.6%	>15%
% sickness rate		3.9%	3.9%	3.9%	3.9%	4.0%	3.9%	3.9%	3.5%	3.8%	3.8%	3.8%	3.7%	3.7%			<=4.05%	>4.5%

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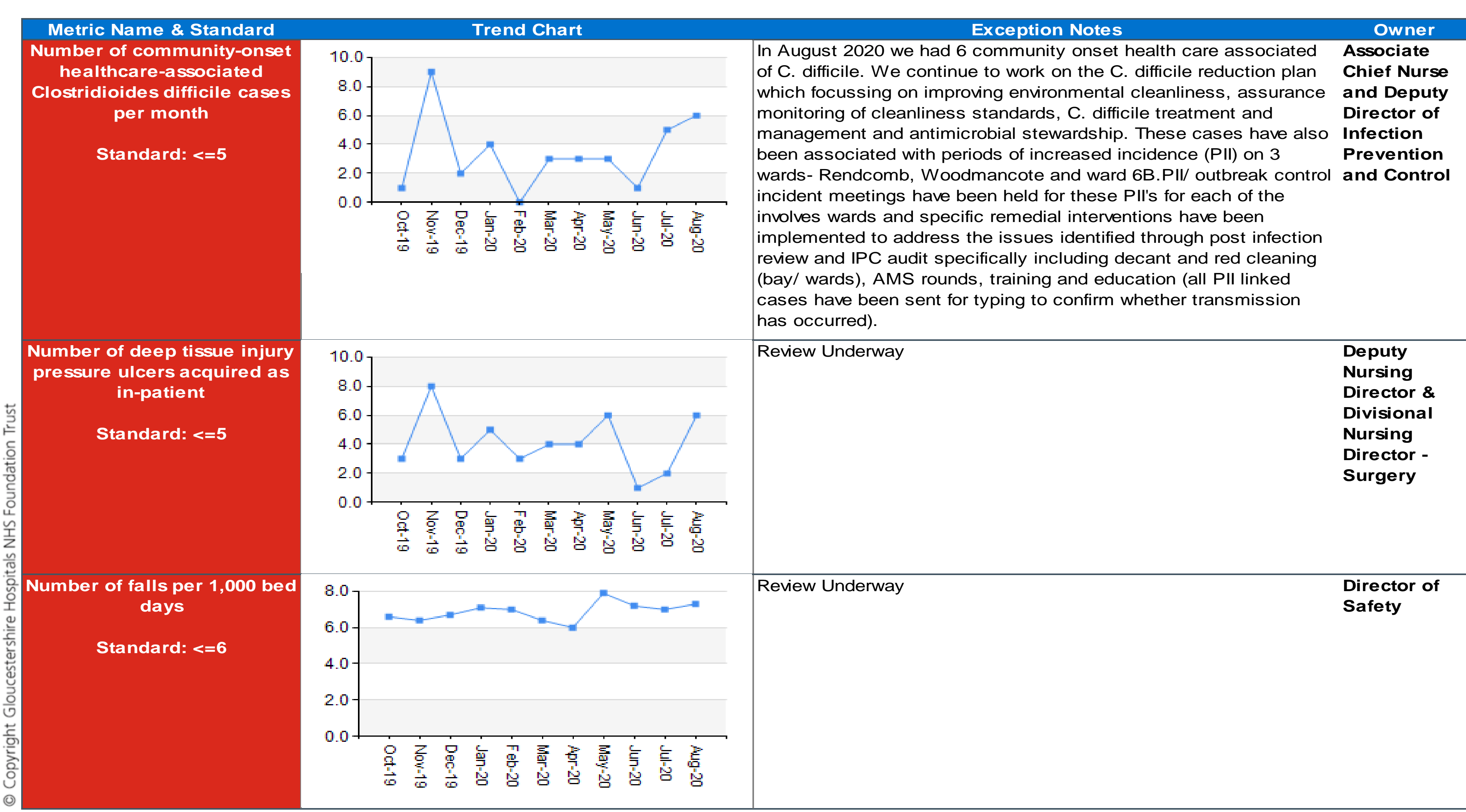
Exception Reports – Safe (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of community-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		In August 2020 we had 6 community onset health care associated 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. These cases have also been associated with periods of increased incidence (PII) on 3 wards- Rendcomb, Woodmancote and ward 6B.PII/ outbreak control incident meetings have been held for these PII's for each of the involves wards and specific remedial interventions have been implemented to address the issues identified through post infection review and IPC audit specifically including decant and red cleaning (bay/ wards), AMS rounds, training and education (all PII linked cases have been sent for typing to confirm whether transmission has occurred).	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		Review Underway	**Deputy Nursing Director & Divisional Nursing Director - Surgery**
Number of falls per 1,000 bed days **Standard: <=6**		Review Underway	**Director of Safety**

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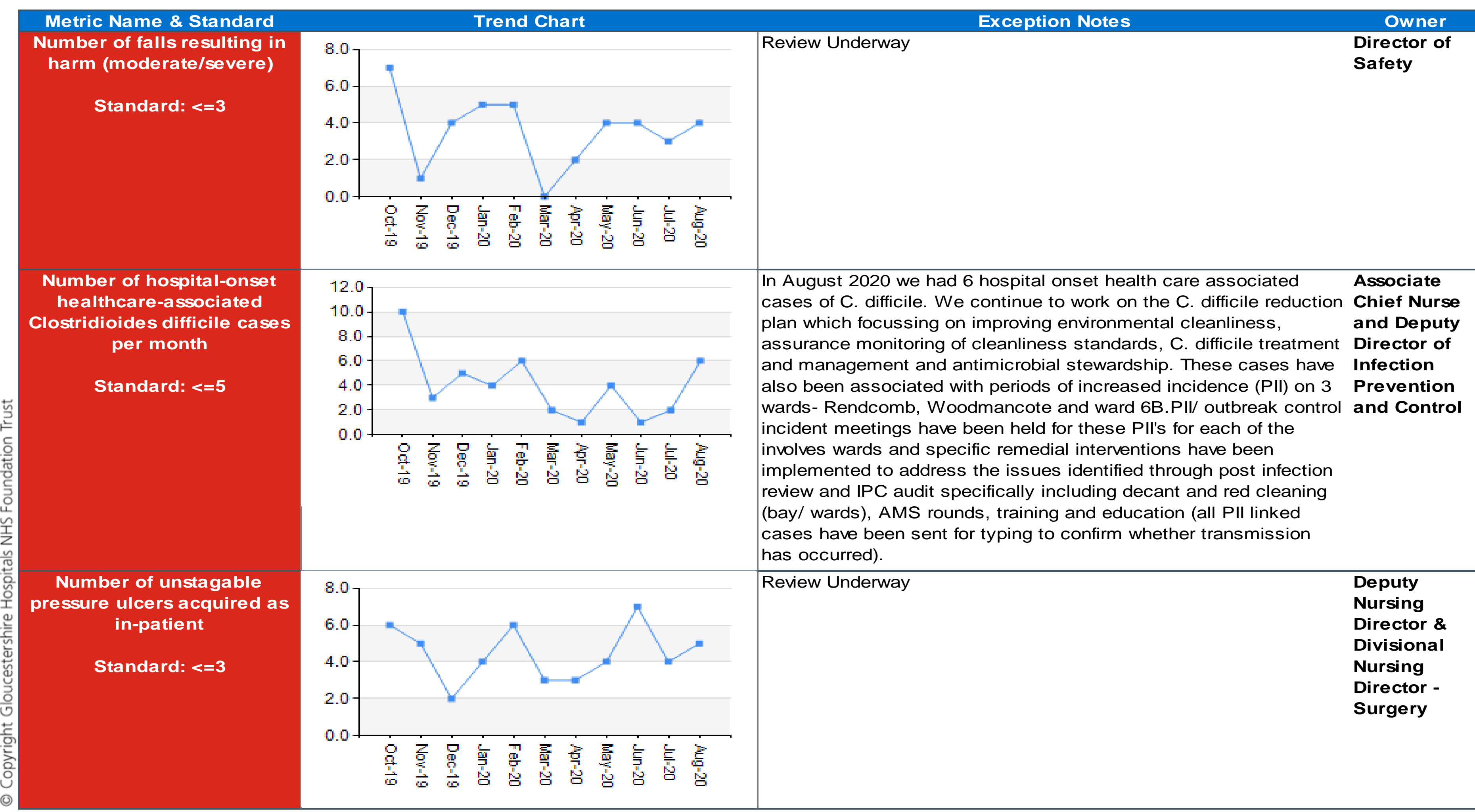
Exception Reports – Safe (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		Review Underway	**Director of Safety**
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		In August 2020 we had 6 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. These cases have also been associated with periods of increased incidence (PII) on 3 wards- Rendcomb, Woodmancote and ward 6B.PII/ outbreak control incident meetings have been held for these PII's for each of the involves wards and specific remedial interventions have been implemented to address the issues identified through post infection review and IPC audit specifically including decant and red cleaning (bay/ wards), AMS rounds, training and education (all PII linked cases have been sent for typing to confirm whether transmission has occurred).	**Associate Chief Nurse and Deputy Director of Infection Prevention and Control**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		Review Underway	**Deputy Nursing Director & Divisional Nursing Director - Surgery**

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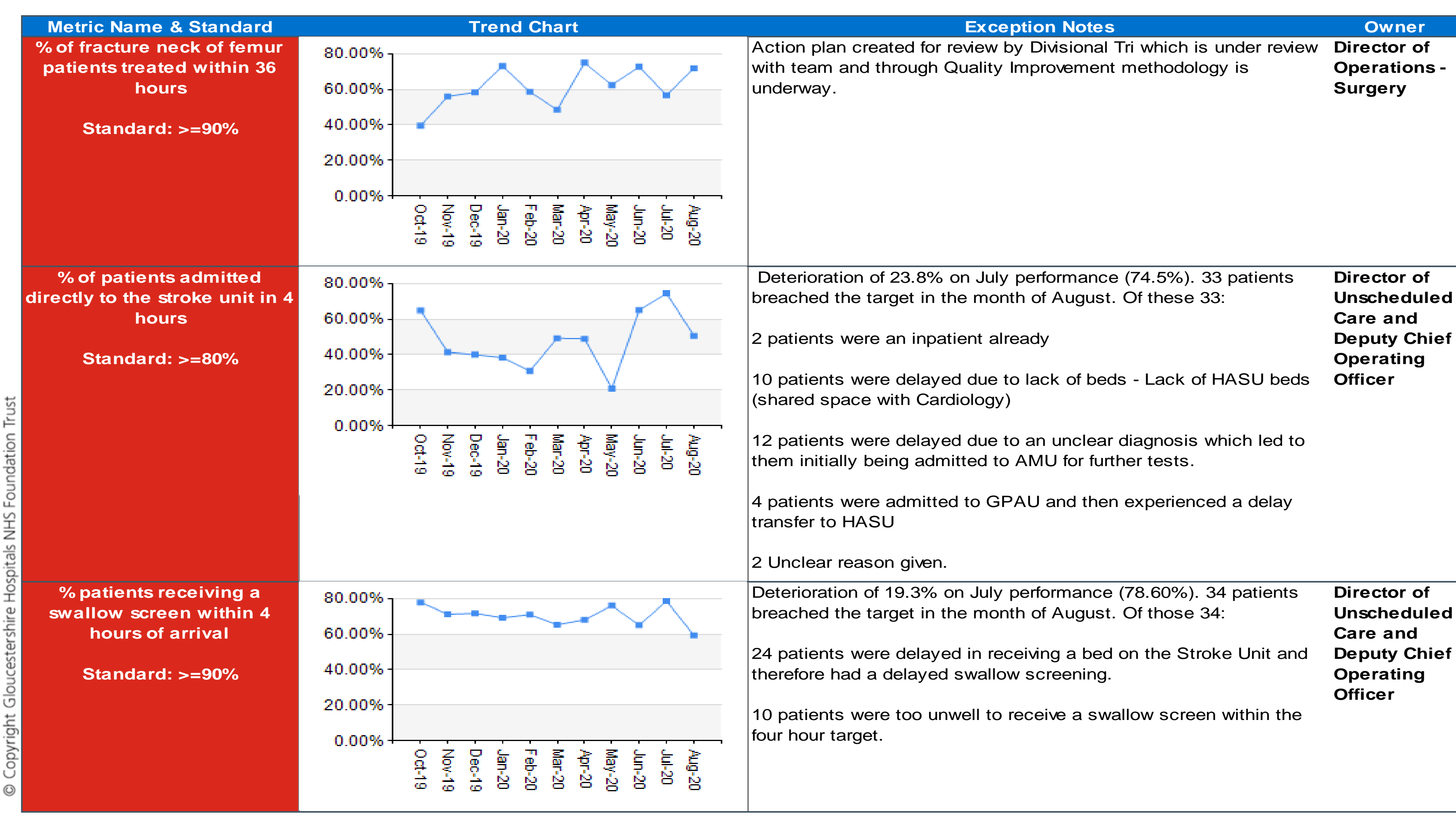
Exception Reports – Effective (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours Standard: >=90%	80.00% 60.00% 40.00% 20.00% 0.00% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	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%	80.00% 60.00% 40.00% 20.00% 0.00% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	Deterioration of 23.8% on July performance (74.5%). 33 patients breached the target in the month of August. Of these 33: 2 patients were an inpatient already 10 patients were delayed due to lack of beds - Lack of HASU beds (shared space with Cardiology) 12 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 4 patients were admitted to GPAU and then experienced a delay transfer to HASU 2 Unclear reason given.	Director of Unscheduled Care and Deputy Chief Operating Officer
% patients receiving a swallow screen within 4 hours of arrival Standard: >=90%	80.00% 60.00% 40.00% 20.00% 0.00% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	Deterioration of 19.3% on July performance (78.60%). 34 patients breached the target in the month of August. Of those 34: 24 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening. 10 patients were too unwell to receive a swallow screen within the four hour target.	Director of Unscheduled Care and Deputy Chief Operating Officer

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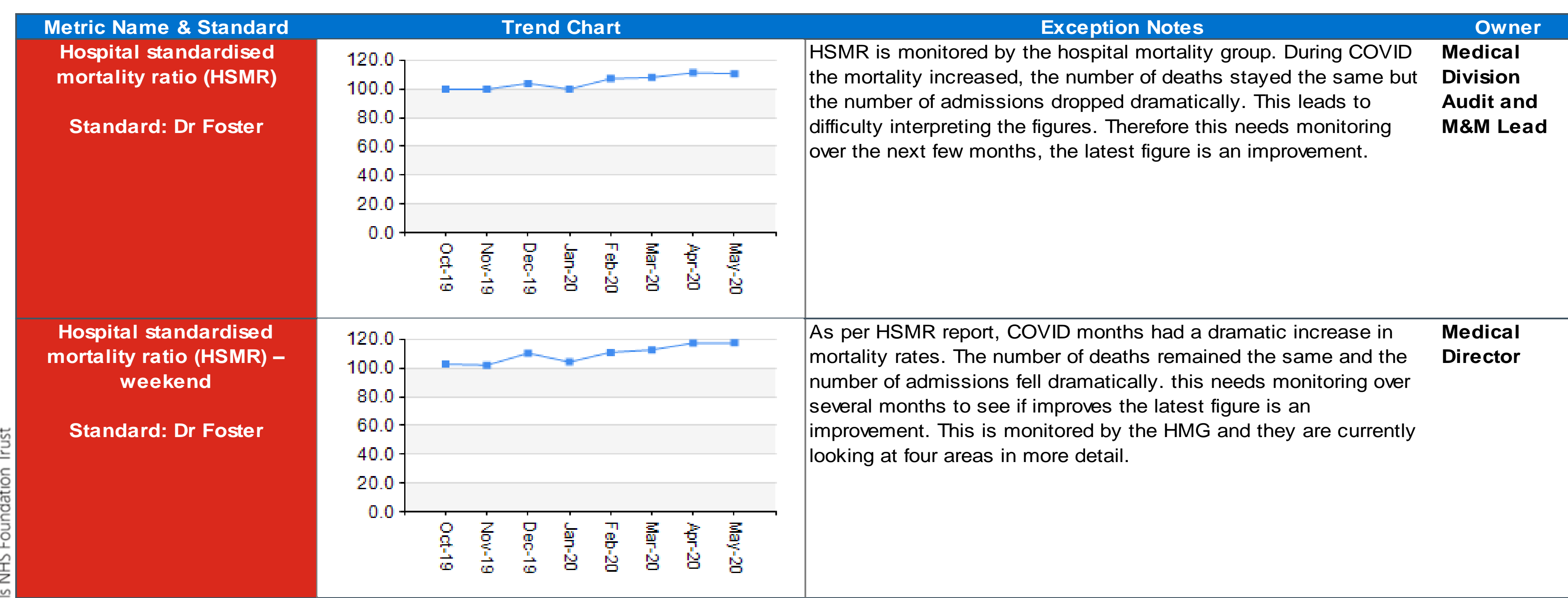
Exception Reports – Effective (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**	120.0 / 100.0 / 80.0 / 60.0 / 40.0 / 20.0 / 0.0 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20	HSMR is monitored by the hospital mortality group. During COVID the mortality increased, the number of deaths stayed the same but the number of admissions dropped dramatically. This leads to difficulty interpreting the figures. Therefore this needs monitoring over the next few months, the latest figure is an improvement.	**Medical Division Audit and M&M Lead**
Hospital standardised mortality ratio (HSMR) – weekend **Standard: Dr Foster**	120.0 / 100.0 / 80.0 / 60.0 / 40.0 / 20.0 / 0.0 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20	As per HSMR report, COVID months had a dramatic increase in mortality rates. The number of deaths remained the same and the number of admissions fell dramatically. this needs monitoring over several months to see if improves the latest figure is an improvement. This is monitored by the HMG and they are currently looking at four areas in more detail.	**Medical Director**

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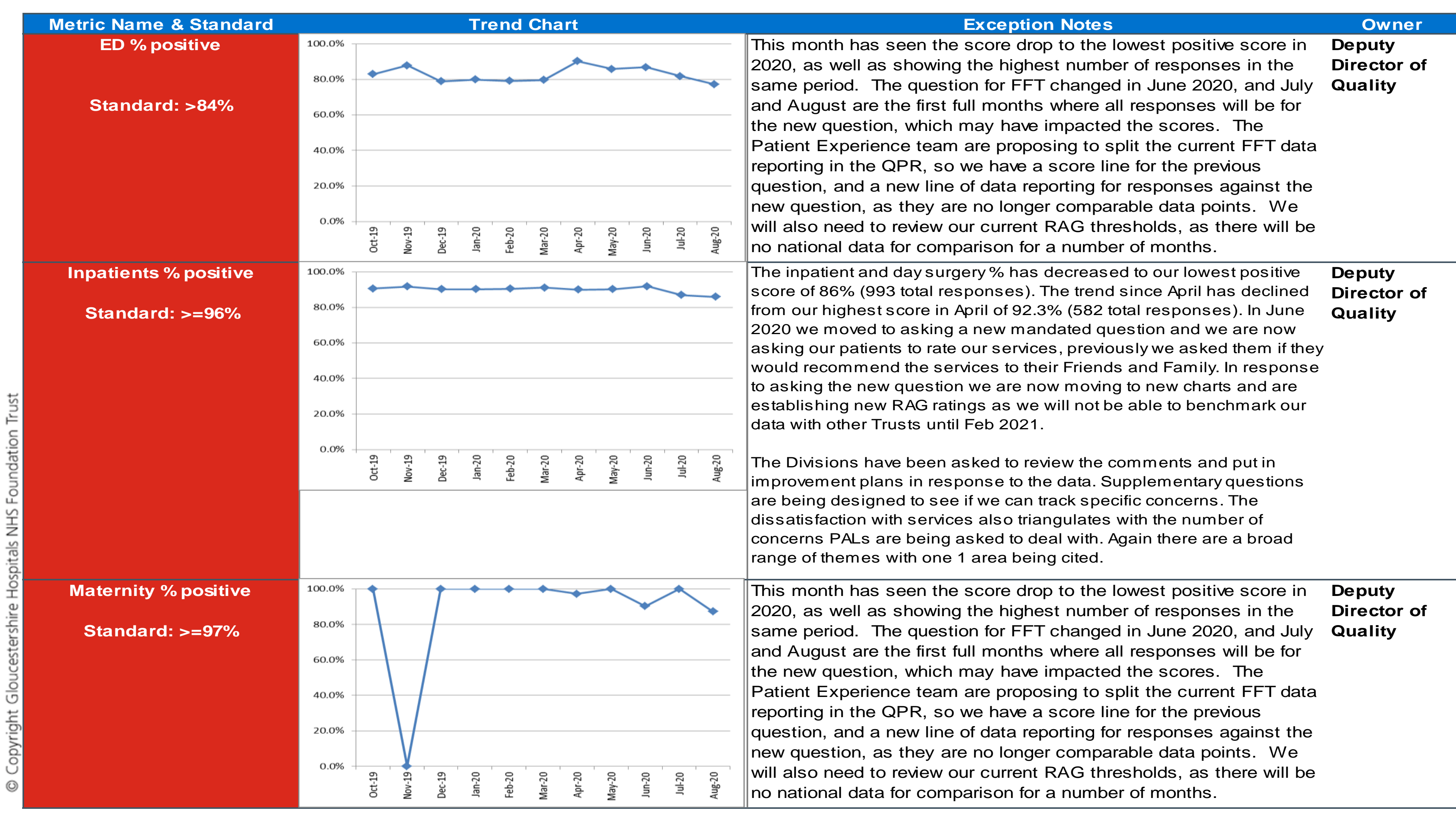
Exception Reports – Caring (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED % positive **Standard: >84%**	100.0% 80.0% 60.0% 40.0% 20.0% 0.0% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	This month has seen the score drop to the lowest positive score in 2020, as well as showing the highest number of responses in the same period. The question for FFT changed in June 2020, and July and August are the first full months where all responses will be for the new question, which may have impacted the scores. The Patient Experience team are proposing to split the current FFT data reporting in the QPR, so we have a score line for the previous question, and a new line of data reporting for responses against the new question, as they are no longer comparable data points. We will also need to review our current RAG thresholds, as there will be no national data for comparison for a number of months.	**Deputy Director of Quality**
Inpatients % positive **Standard: >=96%**	100.0% 80.0% 60.0% 40.0% 20.0% 0.0% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	The inpatient and day surgery % has decreased to our lowest positive score of 86% (993 total responses). The trend since April has declined from our highest score in April of 92.3% (582 total responses). In June 2020 we moved to asking a new mandated question and we are now asking our patients to rate our services, previously we asked them if they would recommend the services to their Friends and Family. In response to asking the new question we are now moving to new charts and are establishing new RAG ratings as we will not be able to benchmark our data with other Trusts until Feb 2021. The Divisions have been asked to review the comments and put in improvement plans in response to the data. Supplementary questions are being designed to see if we can track specific concerns. The dissatisfaction with services also triangulates with the number of concerns PALs are being asked to deal with. Again there are a broad range of themes with one 1 area being cited.	**Deputy Director of Quality**
Maternity % positive **Standard: >=97%**	100.0% 80.0% 60.0% 40.0% 20.0% 0.0% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	This month has seen the score drop to the lowest positive score in 2020, as well as showing the highest number of responses in the same period. The question for FFT changed in June 2020, and July and August are the first full months where all responses will be for the new question, which may have impacted the scores. The Patient Experience team are proposing to split the current FFT data reporting in the QPR, so we have a score line for the previous question, and a new line of data reporting for responses against the new question, as they are no longer comparable data points. We will also need to review our current RAG thresholds, as there will be no national data for comparison for a number of months.	**Deputy Director of Quality**

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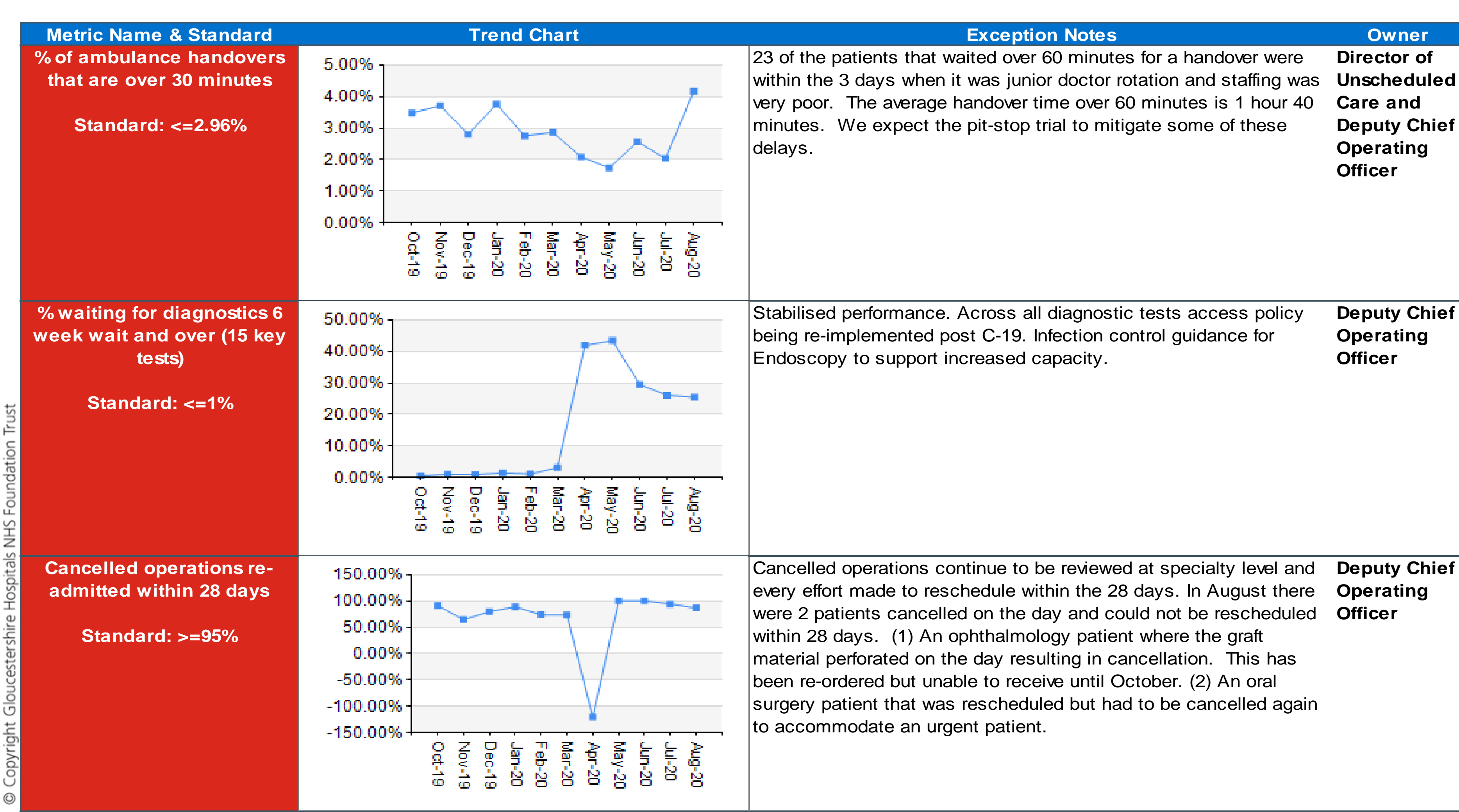
Exception Reports – Responsive (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes Standard: <=2.96%		23 of the patients that waited over 60 minutes for a handover were within the 3 days when it was junior doctor rotation and staffing was very poor. The average handover time over 60 minutes is 1 hour 40 minutes. We expect the pit-stop trial to mitigate some of these delays.	Director of Unscheduled Care and Deputy Chief Operating Officer
% waiting for diagnostics 6 week wait and over (15 key tests) Standard: <=1%		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
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 August there were 2 patients cancelled on the day and could not be rescheduled within 28 days. (1) An ophthalmology patient where the graft material perforated on the day resulting in cancellation. This has been re-ordered but unable to receive until October. (2) An oral surgery patient that was rescheduled but had to be cancelled again to accommodate an urgent patient.	Deputy Chief Operating Officer

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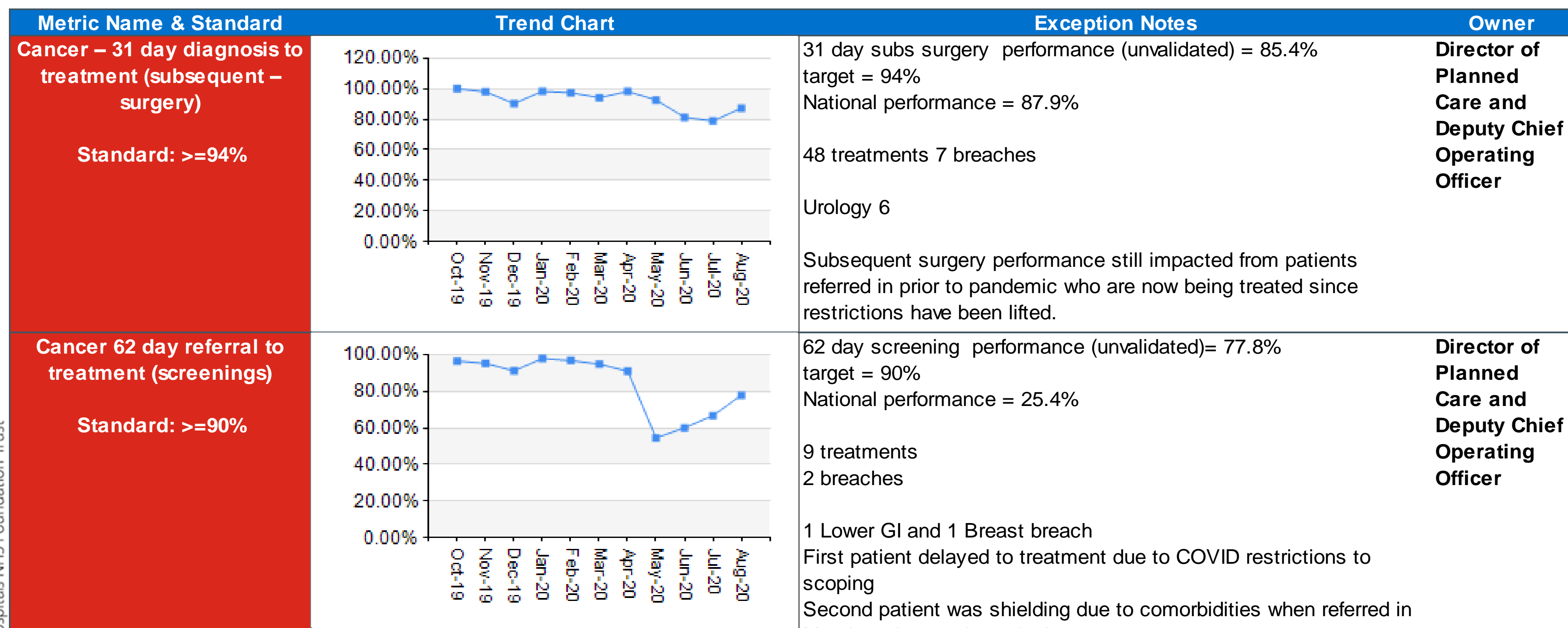
Exception Reports – Responsive (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**	120.00%, 100.00%, 80.00%, 60.00%, 40.00%, 20.00%, 0.00% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	31 day subs surgery performance (unvalidated) = 85.4% target = 94% National performance = 87.9% 48 treatments 7 breaches Urology 6 Subsequent surgery performance still impacted from patients referred in prior to pandemic who are now being treated since restrictions have been lifted.	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (screenings) **Standard: >=90%**	100.00%, 80.00%, 60.00%, 40.00%, 20.00%, 0.00% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	62 day screening performance (unvalidated)= 77.8% target = 90% National performance = 25.4% 9 treatments 2 breaches 1 Lower GI and 1 Breast breach First patient delayed to treatment due to COVID restrictions to scoping Second patient was shielding due to comorbidities when referred in	**Director of Planned Care and Deputy Chief Operating Officer**

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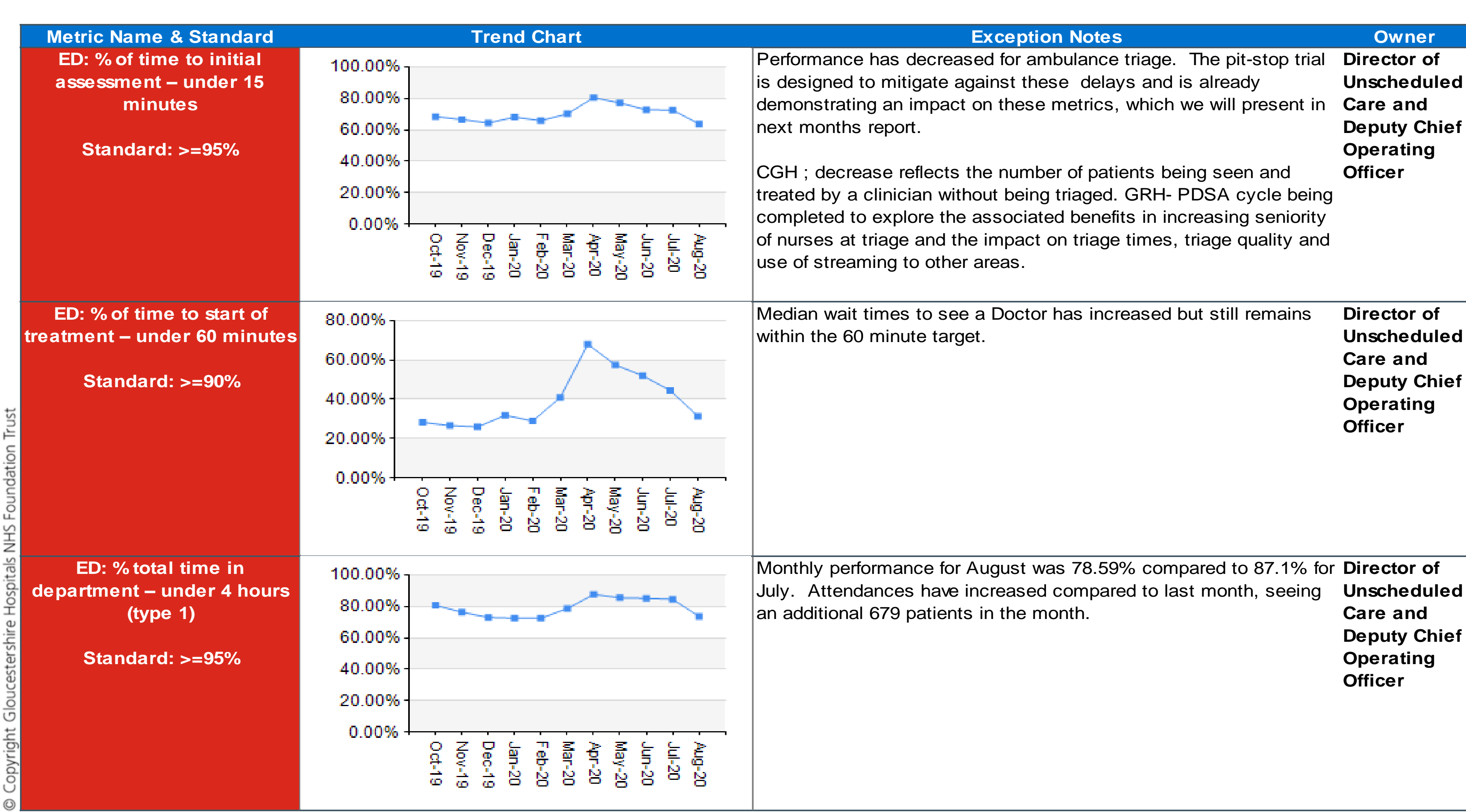
Exception Reports – Responsive (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Performance has decreased for ambulance triage. The pit-stop trial is designed to mitigate against these delays and is already demonstrating an impact on these metrics, which we will present in next months report. CGH ; decrease reflects the number of patients being seen and treated by a clinician without being triaged. GRH- PDSA cycle being completed to explore the associated benefits in increasing seniority of nurses at triage and the impact on triage times, triage quality and use of streaming to other areas.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Median wait times to see a Doctor has increased but still remains within the 60 minute target.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Monthly performance for August was 78.59% compared to 87.1% for July. Attendances have increased compared to last month, seeing an additional 679 patients in the month.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

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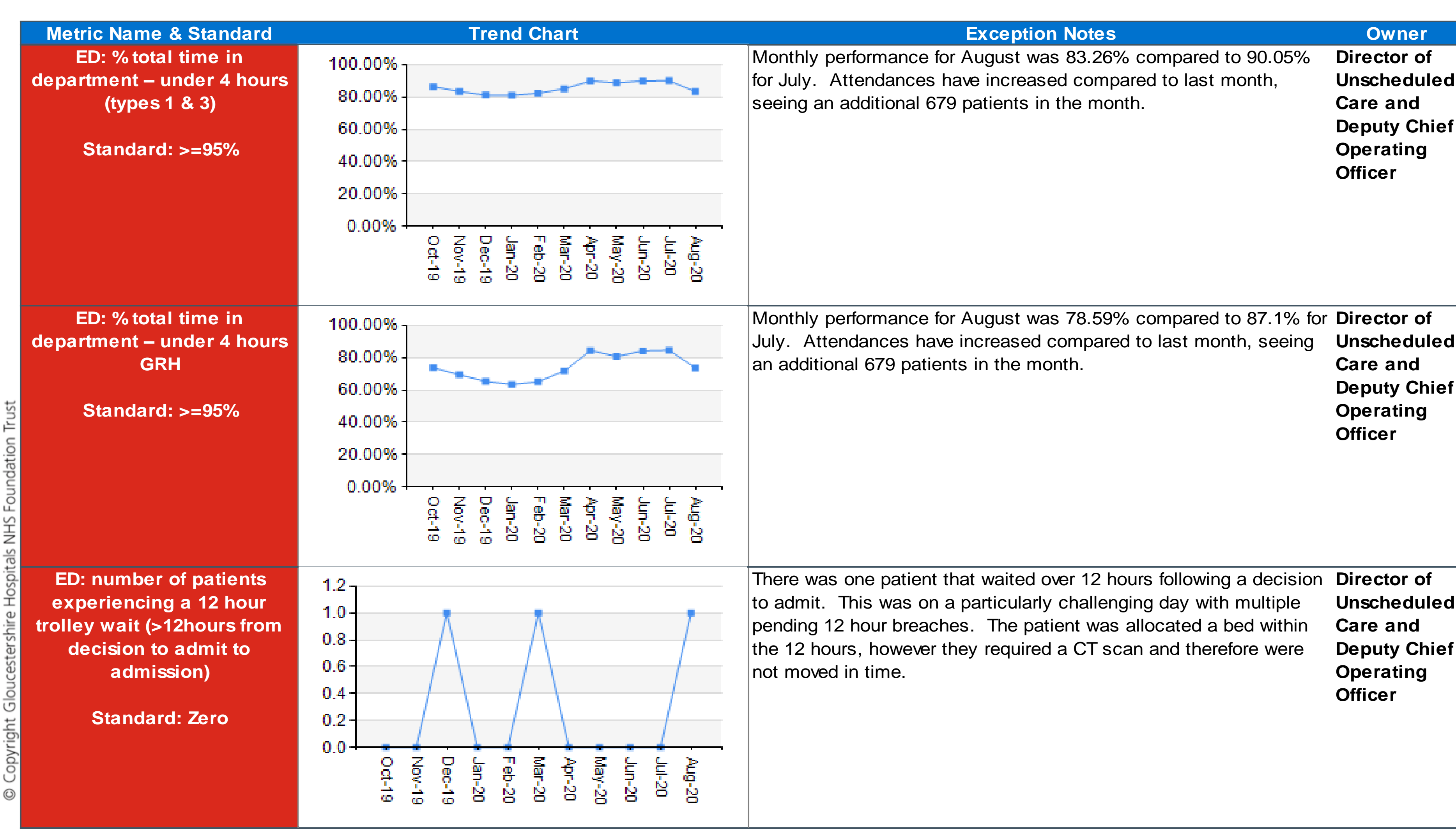
Exception Reports – Responsive (4)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) Standard: >=95%	100.00%, 80.00%, 60.00%, 40.00%, 20.00%, 0.00% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	Monthly performance for August was 83.26% compared to 90.05% for July. Attendances have increased compared to last month, seeing an additional 679 patients in the month.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH Standard: >=95%	100.00%, 80.00%, 60.00%, 40.00%, 20.00%, 0.00% Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	Monthly performance for August was 78.59% compared to 87.1% for July. Attendances have increased compared to last month, seeing an additional 679 patients in the month.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) Standard: Zero	1.2, 1.0, 0.8, 0.6, 0.4, 0.2, 0.0 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20	There was one patient that waited over 12 hours following a decision to admit. This was on a particularly challenging day with multiple pending 12 hour breaches. The patient was allocated a bed within the 12 hours, however they required a CT scan and therefore were not moved in time.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

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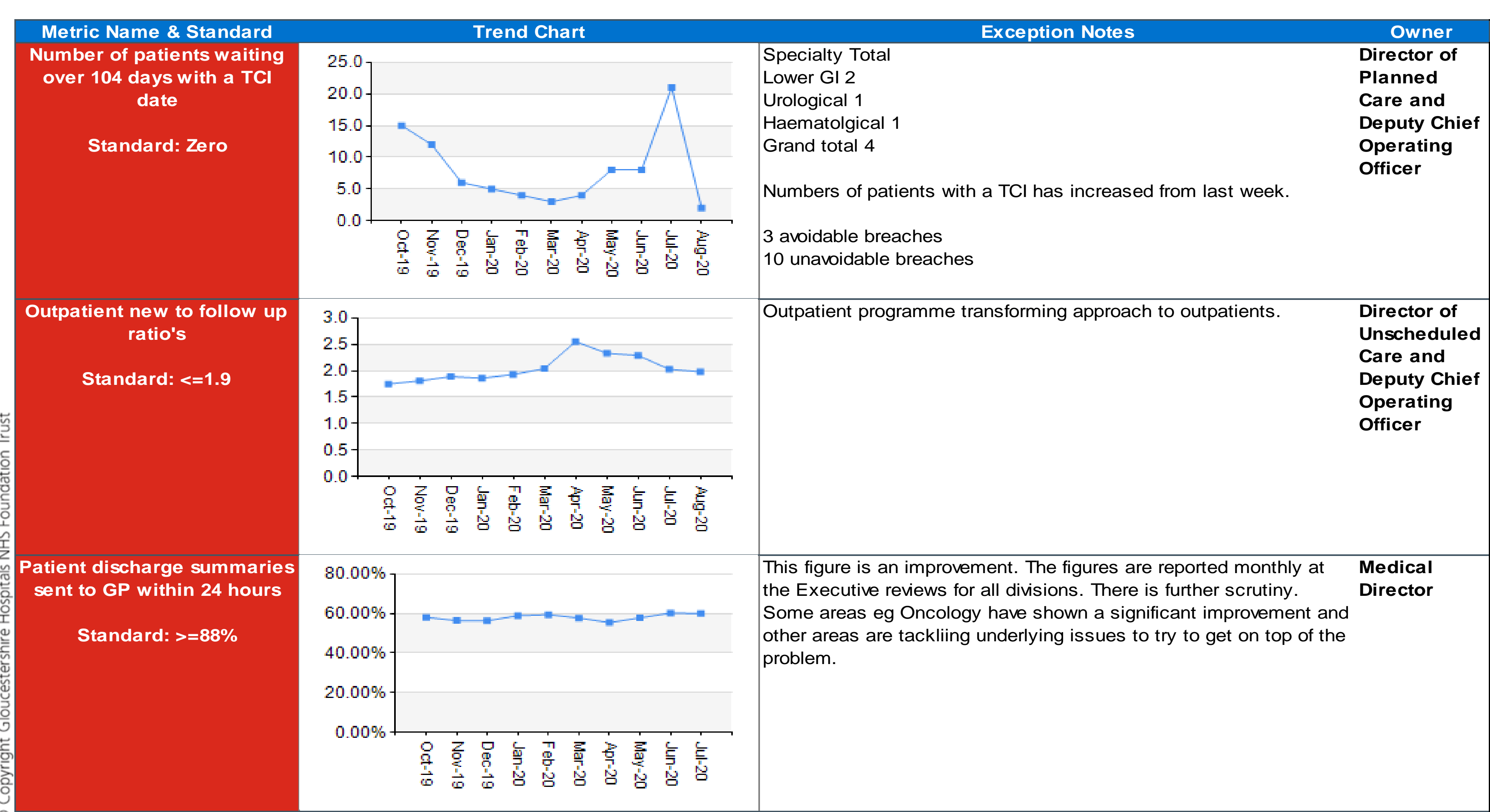
Exception Reports – Responsive (5)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Specialty Total Lower GI 2 Urological 1 Haematolgical 1 Grand total 4 Numbers of patients with a TCI has increased from last week. 3 avoidable breaches 10 unavoidable breaches	**Director of Planned Care and Deputy Chief Operating Officer**
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**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		This figure is an improvement. The figures are reported monthly at the Executive reviews for all divisions. There is further scrutiny. Some areas eg Oncology have shown a significant improvement and other areas are tackliing underlying issues to try to get on top of the problem.	**Medical Director**

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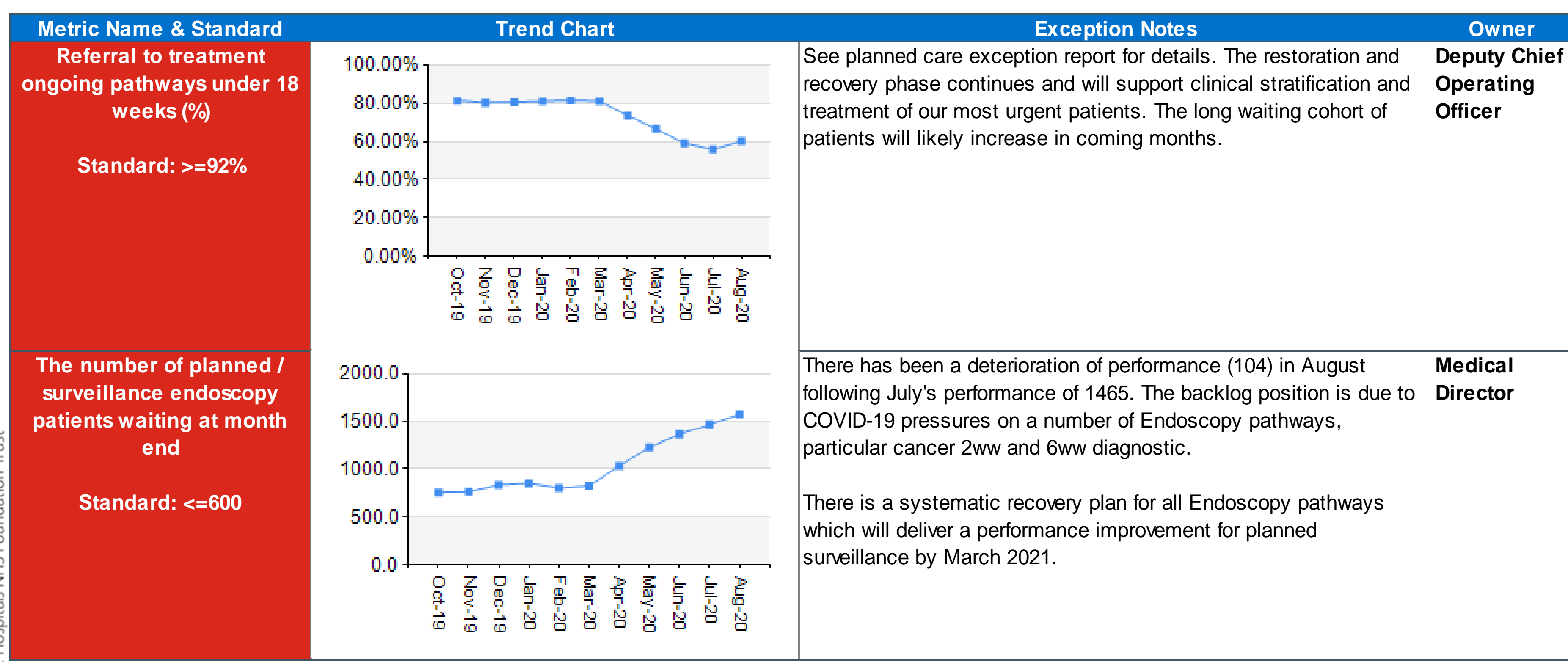
Exception Reports – Responsive (5)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
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**
The number of planned / surveillance endoscopy patients waiting at month end **Standard: <=600**		There has been a deterioration of performance (104) in August following July's performance of 1465. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particular cancer 2ww and 6ww diagnostic. There is a systematic recovery plan for all Endoscopy pathways which will deliver a performance improvement for planned surveillance by March 2021.	**Medical Director**

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Benchmarking (1)

Standard (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	July-20	70% 65% 60% 55% 50% 45% 40% 35% 30% 25% 20% 15% 10% 5% 0%; Berkshire Healthcare…, County Durham And…, University Hospitals…, Gloucestershire…, Oxford University…, Portsmouth Hospitals…, South Tees Hospitals…, University Hospitals Of…, England, United Lincolnshire…, Epsom And St Helier…, Norfolk And Norwich…, York Teaching Hospital…, Western Sussex…, Great Western Hospitals…, Worcestershire Acute…	42 / 162	2nd
Dementia	February-20	100% 80% 60% 40% 20% 0%; Bradford Teaching…, Norfolk And Norwich…, University Hospitals Of…, County Durham And…, Western Sussex…, Great Western Hospitals…, Oxford University…, York Teaching Hospital…, England, Gloucestershire…	82 / 82	4th

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Benchmarking (2)

*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)	August-20		98 / 115	4th
Cancer 62 Days GP Referrals	July-20		42 / 138	2nd

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Benchmarking (3)

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
RTT	July-20	100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% Cornwall Partnership…, Gloucestershire…, United Lincolnshire…, England, Portsmouth Hospitals…, Great Western Hospitals…, Oxford University…, Worcestershire Acute…, Western Sussex…, York Teaching Hospital…, Norfolk And Norwich…, Epsom And St Helier…, University Hospitals Of…, County Durham And…, South Tees Hospitals…	43 / 158	2nd
VTE (published quarterly)	December-19	100.00% 98.00% 96.00% 94.00% 92.00% 90.00% 88.00% Derbyshire Community…, Norfolk And Norwich…, Great Western Hospitals…, Oxford University…, United Lincolnshire…, University Hospitals…, Western Sussex…, York Teaching Hospital…, County Durham And…, University Hospitals Of…, Worcestershire Acute…, England, South Tees Hospitals…, Gloucestershire…, Epsom And St Helier…, Portsmouth Hospitals…	116 / 149	4th

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Benchmarking (4)

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
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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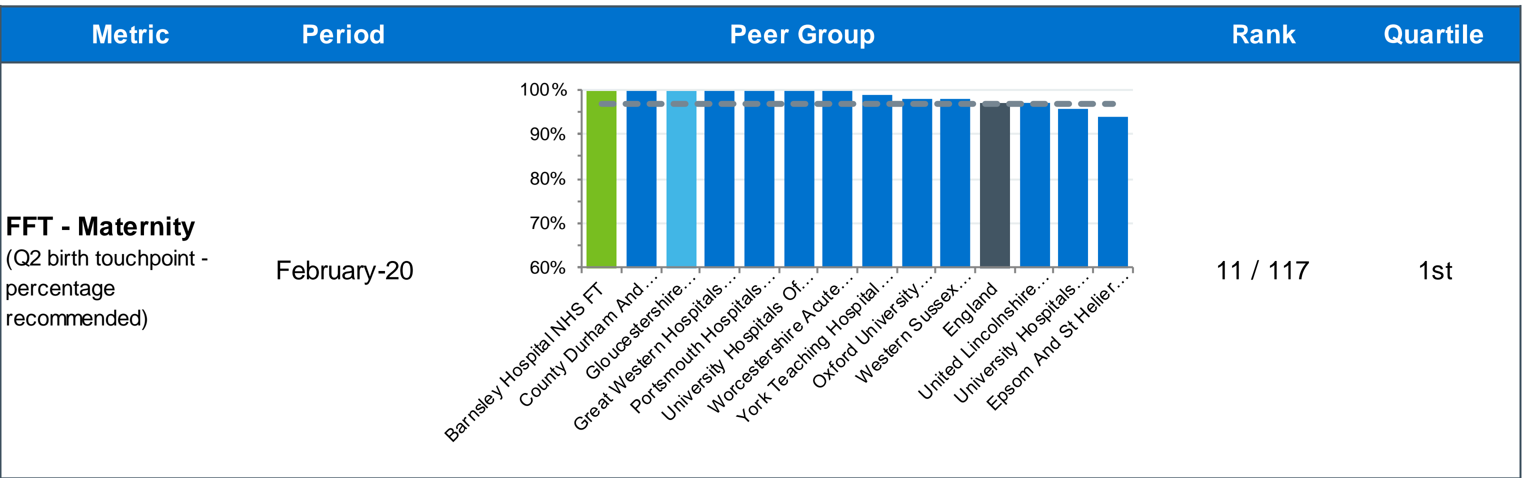
Benchmarking (5)

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 August 2020

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

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Financial	40
People & OD Risk Rating	41

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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 the summer. 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 August 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 August was 73.53%, against the STP trajectory of 85.90%. The system did not meet the delivery of 90% for the system in August, at 83.26%. Note that the August 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 August at 25.49%. 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 did not meet the standard for 2 week wait cancer at 90.8% in August, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 60% (un-validated) in August, 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 1,232 in August. 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	Aug-20	79.4%
Cancer	Cancer – 28 day FDS breast symptom two week wait	TBC	Aug-20	80.6%
Cancer	Cancer – 28 day FDS screening referral	TBC	Aug-20	78.6%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Aug-20	90.8%
Cancer	2 week wait breast symptomatic referrals	>=93%	Aug-20	95.9%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Aug-20	96.7%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Aug-20	100.0%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Aug-20	87.2%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Aug-20	98.3%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Aug-20	87.6%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Aug-20	77.8%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Aug-20	90.0%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Aug-20	2
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Aug-20	15
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Aug-20	25.49%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Aug-20	1,569
Discharge	Number of patients delayed at the end of each month	<=38	Aug-20	24
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Jul-20	60.0%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Aug-20	73.53%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Aug-20	83.26%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Aug-20	99.91%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Aug-20	73.53%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Aug-20	1
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Aug-20	63.7%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Aug-20	31.4%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Aug-20	4.17%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Aug-20	0.90%
Maternity	% of women booked by 12 weeks gestation	>90%	Aug-20	92.4%
Operational Efficiency	Number of patients stable for discharge	<=70	Aug-20	68
Operational Efficiency	% of bed days lost due to delays	<=3.5%	Aug-20	2.11%
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Aug-20	332
Operational Efficiency	Average length of stay (spell)	<=5.06	Aug-20	4.66
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Aug-20	5.16
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Aug-20	2.31
Operational Efficiency	% day cases of all electives	>80%	Aug-20	78.41%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Aug-20	88.6%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Aug-20	86.67%
Operational Efficiency	Urgent cancelled operations	No target	Aug-20	2
Outpatient	Outpatient new to follow up ratio's	<=1.9	Aug-20	1.98
Outpatient	Did not attend (DNA) rates	<=7.6%	Aug-20	6.20%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Jul-20	7.9%
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%	F	Aug-20	60.07%	L
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Aug-20	7155	H
RTT	Referral to treatment ongoing pathways 40+ Weeks (number)	No target		Aug-20	5398	H
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero	F	Aug-20	1233	H
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=50%	?	Aug-20	60.9%	H
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=80%	?	Jul-20	95.1%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=80%	?	Aug-20	50.7%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=90%	F	Aug-20	59.3%	
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%	?	Aug-20	71.9%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%	?	Aug-20	70.2%	

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Access:
SPC – Special Cause Variation

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, Aug 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

31 day new performance (unvalidated) = 97.1%
Target = 96%
National performance = 95.1%

Currently 97.3% for annual performance 20/21.

- 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 7 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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Access:
SPC – Special Cause Variation

Cancer – 31 day diagnosis to treatment (subsequent – surgery) - GHT Starting 01/04/18

Commentary

31 day subs surgery performance (unvalidated) = 85.4%
Target = 94%
National performance = 87.9%
48 treatments 7 breaches
Urology 6
Subsequent surgery performance still impacted from patients referred in prior to pandemic who are now being treated since restrictions have been lifted.

- 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 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

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Access:
SPC – Special Cause Variation

Cancer 62 day referral to treatment (urgent GP referral) - 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, Aug 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

62 day GP performance (unvalidated) = 88.1%
Target = 85%
National performance = 78.4%

The performance is still unvalidated however if the Trust meets the standard it will be two consecutive months of achieving the standard. This within the overall context that 10 out of 23 breaches were significantly impacted by Covid 19.

- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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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Access:
SPC – Special Cause Variation

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, Aug 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

62 day screening performance (unvalidated)= 77.8%
Target = 90%
National performance = 25.4%
9 treatments & 2 breaches
1 Lower GI and 1 Breast breach
First patient delayed to treatment due to COVID restrictions to scoping
Second patient was shielding due to comorbidities when referred in March and treated now in August

- 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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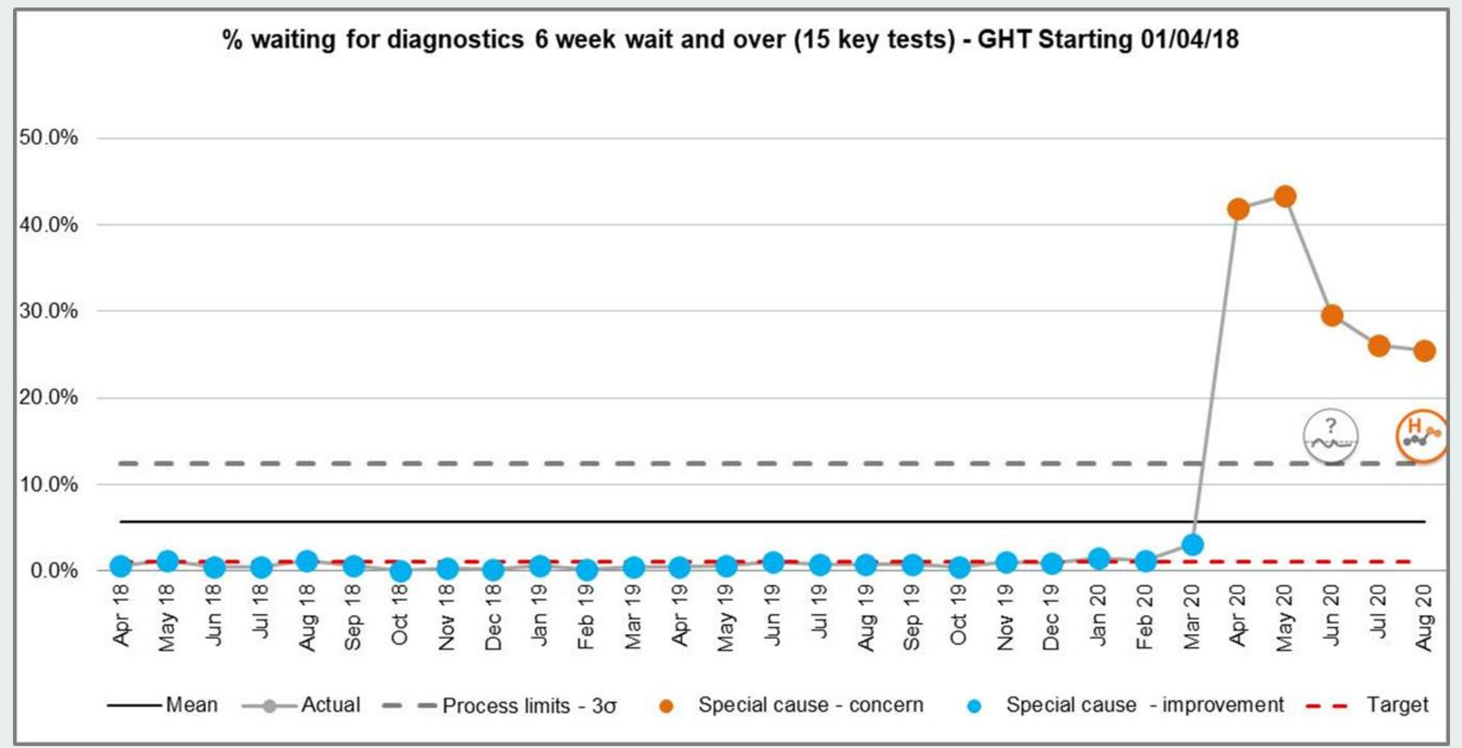
Access:
SPC – Special Cause Variation



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 5 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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Access:
SPC – Special Cause Variation

The number of planned / surveillance endoscopy patients waiting at month end - 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 6 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

Commentary

There has been a deterioration of performance (104) in August following July's performance of 1465. The backlog position is due to COVID-19 pressures on a number of Endoscopy pathways, particular cancer 2ww and 6ww diagnostic.

There is a systematic recovery plan for all Endoscopy pathways which will deliver a performance improvement for planned surveillance by March 2021.

- Medical Director

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Access:
SPC – Special Cause Variation

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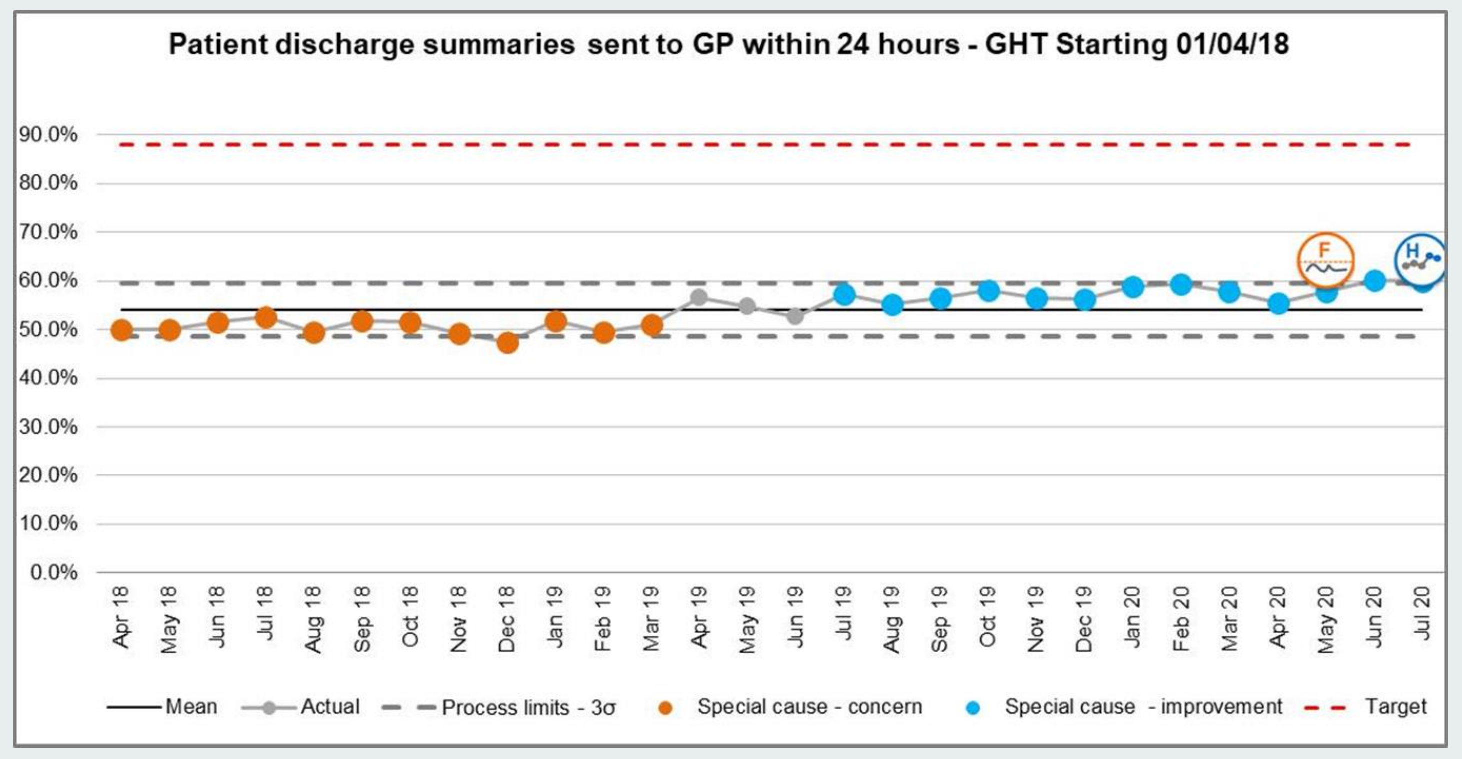

Commentary

This figure is an improvement. The figures are reported monthly at the Executive reviews for all divisions. There is further scrutiny. Some areas eg Oncology have shown a significant improvement and other areas are tackling underlying issues to try to get on top of the problem.

- 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 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 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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Access:
SPC – Special Cause Variation

ED: % total time in department – under 4 hours (type 1) - 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, Aug 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 5 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.
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

Monthly performance for August was 78.59% compared to 87.1% for July. Attendances have increased compared to last month, seeing an additional 679 patients in the month.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

ED: % total time in department – under 4 hours (types 1 & 3) - 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, Aug 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 4 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.
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

Monthly performance for August was 78.59% compared to 87.1% for July. Attendances have increased compared to last month, seeing an additional 733 patients in the month.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

ED: % total time in department – under 4 hours CGH - 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, Aug 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 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.
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

Commentary

99.91% of all patients that attended CGH were treated within 4 hours.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) - GHT Starting 01/04/18

1

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 Aug 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.
Rule 4	When more than 15 consecutive points lie within the mean +/- 1σ this process is considered to be out of control.

Commentary

There was one patient that waited over 12 hours following a decision to admit. This was on a particularly challenging day with multiple pending 12 hour breaches. The patient was allocated a bed within the 12 hours, however they required a CT scan and therefore were not moved in time.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

ED: % of time to initial assessment – under 15 minutes - 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, Aug 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 8 data points which are above the line. There are 7 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

Performance has decreased for ambulance triage. The pit-stop trial is designed to mitigate against these delays and is already demonstrating an impact on these metrics, which we will present in next months report.

CGH; decrease reflects the number of patients being seen and treated by a clinician without being triaged. GRH- PDSA cycle being completed to explore the associated benefits in increasing seniority of nurses at triage and the impact on triage times, triage quality and use of streaming to other areas.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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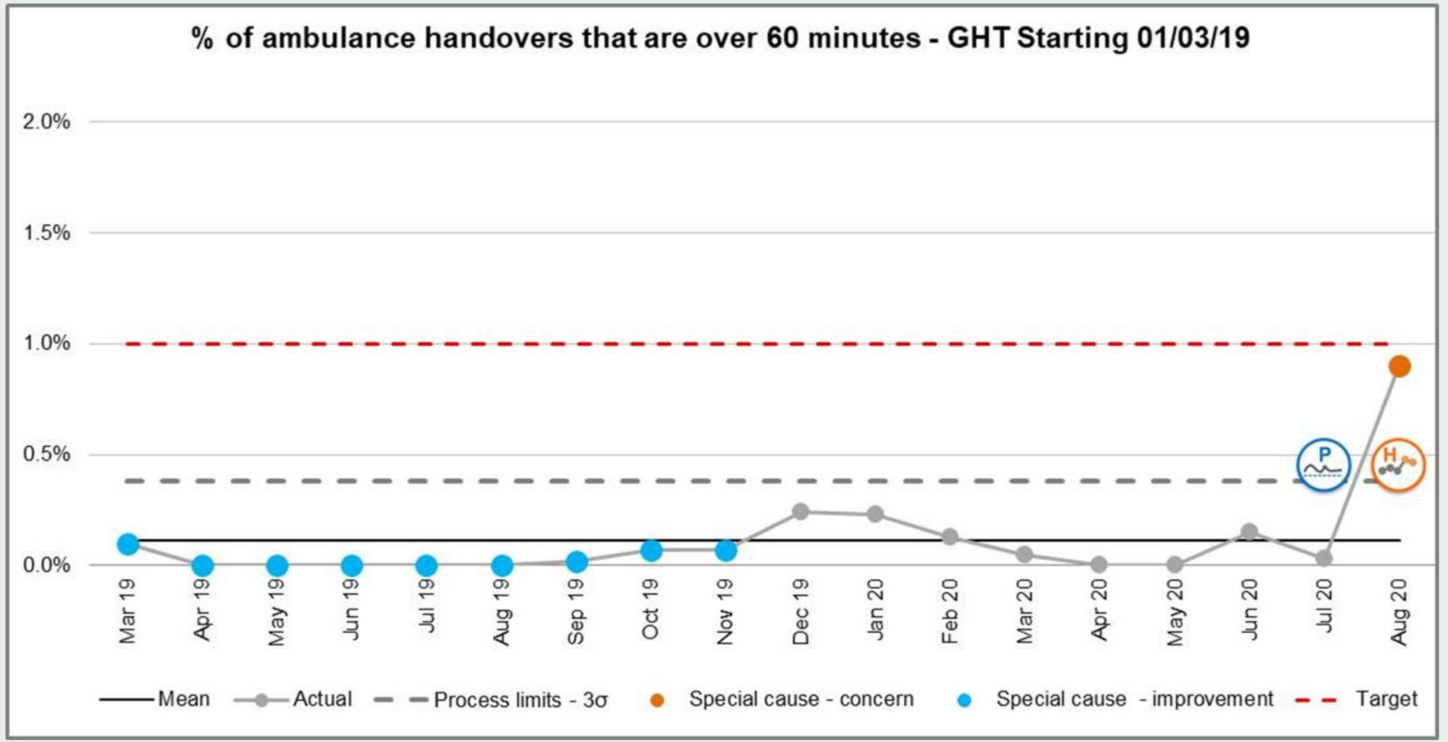
Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

23 of the patients that waited over 60 minutes for a handover were within the 3 days when it was junior doctor rotation and staffing was very poor. The average handover time over 60 minutes is 1 hour 40 minutes. We expect the pit-stop trial to mitigate some of these delays.

- 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 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:
SPC – Special Cause Variation

% day cases of all electives - GHT Starting 01/03/19

100.0%
80.0%
60.0%
40.0%
20.0%
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 Aug 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

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.

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Access:
SPC – Special Cause Variation

Referral to treatment ongoing pathways under 18 weeks (%) - GHT
Starting 01/03/19

100.0%
80.0%
60.0%
40.0%
20.0%
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, Aug 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 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

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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Access:
SPC – Special Cause Variation

Referral to treatment ongoing pathways 35+ Weeks (number) - GHT
Starting 01/03/19

7,000
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 | Aug 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 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 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 and 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

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 40+ Weeks (number) - GHT
Starting 01/03/19

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 Aug 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

See planned care exception report. Restoration and recovery underway.

- 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. 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.
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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Access:
SPC – Special Cause Variation

Referral to treatment ongoing pathways over 52 weeks (number) - GHT Starting 01/04/18

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, Aug 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 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 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 and 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

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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Access:
SPC – Special Cause Variation

Stroke care: percentage of patients receiving brain imaging within 1 hour - GHT Starting 01/04/18

Commentary

Review Underway

- Director of Unscheduled Care and Deputy Chief Operating Officer

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 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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Quality 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 Quality 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		
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%		Jul-20	71.0%	
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%	Consistently fail target	Aug-20	86.0%	Special Cause Concerning variation
Friends & Family Test	ED % positive	>=84%	Hit and miss	Aug-20	77.2%	Common Cause
Friends & Family Test	Maternity % positive	>=97%	Hit and miss	Aug-20	85.2%	Common Cause
Friends & Family Test	Outpatients % positive	>=94%	Hit and miss	Aug-20	93.5%	Common Cause
Friends & Family Test	Total % positive	>=93%	Hit and miss	Aug-20	90.0%	Common Cause
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero		Aug-20	0	
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Hit and miss	Aug-20	0	Special Cause Improving variation
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2019/20: 114	Hit and miss	Aug-20	0	Special Cause Improving variation
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Hit and miss	Aug-20	6	Common Cause
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Hit and miss	Aug-20	6	Common Cause
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Hit and miss	Aug-20	0	Common Cause
Infection Control	Number of MSSA bacteraemia cases	<=8	Hit and miss	Aug-20	1	Special Cause Improving variation
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7		Aug-20	4	
Infection Control	Number of ecoli cases	No target		Aug-20	3	Common Cause
Infection Control	Number of pseudomona cases	No target		Aug-20	0	Common Cause
Infection Control	Number of klebsiella cases	No target		Aug-20	1	Special Cause Improving variation
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Hit and miss	Aug-20	0	Common Cause

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	TBC		Aug-20	4	
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	TBC		Aug-20	0	
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	TBC		Aug-20	0	
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	TBC		Aug-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%	Hit and miss	Mar-20	92%	Common Cause
Inpatient Questions	Do you feel that you are treated with respect and dignity?	>=90%	Consistently hit target	Mar-20	100%	Common Cause
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%	Hit and miss	Aug-20	27.80%	Common Cause
Maternity	% emergency C-section rate	No target		Aug-20	16.2%	Common Cause
Maternity	% of women smoking at delivery	<=14.5%	Hit and miss	Aug-20	13.80%	Common Cause
Maternity	% of women that have an induced labour	<=30%	Hit and miss	Aug-20	31.2%	Common Cause
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Hit and miss	Aug-20	0.00%	Common Cause
Maternity	% of women on a Continuity of Carer pathway	No target		Aug-20	0.0%	
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital		Apr-20	1.1	Common Cause
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster		May-20	110.7	Special Cause Improving variation
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster		May-20	117.5	Special Cause Improving variation
Mortality	Number of inpatient deaths	No target		Aug-20	141	Common Cause

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Quality Dashboard

NHS
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	Aug-20	3
MSA	Number of breaches of mixed sex accommodation	<=10	Aug-20	1
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Aug-20	0
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Aug-20	7.3
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Aug-20	4
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Aug-20	7
Patient Safety Incidents	Medication error resulting in severe harm	No target	Aug-20	0
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Aug-20	1
Patient Safety Incidents	Medication error resulting in low harm	No target	Aug-20	14
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Aug-20	24
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Aug-20	3
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Aug-20	0
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Aug-20	5
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Aug-20	6
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	Aug-20	0
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%
Serious Incidents	Number of never events reported	Zero	Aug-20	0
Serious Incidents	Number of serious incidents reported	No target	Aug-20	5
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Aug-20	100.0%
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Aug-20	100%
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Aug-20	90.7%

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Quality:
SPC – Special Cause Variation

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, Aug 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 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

Commentary

The inpatient and day surgery % has decreased to our lowest positive score of 86% (993 total responses). The trend since April has declined from our highest score in April of 92.3% (582 total responses). In June 2020 we moved to asking a new mandated question and we are now asking our patients to rate our services, previously we asked them if they would recommend the services to their Friends and Family. In response to asking the new question we are now moving to new charts and are establishing new RAG ratings as we will not be able to benchmark our data with other Trusts until Feb 2021.

The Divisions have been asked to review the comments and put in improvement plans in response to the data. Supplementary questions are being designed to see if we can track specific concerns. The dissatisfaction with services also triangulates with the number of concerns PALs are being asked to deal with. Again there are a broad range of themes with one 1 area being cited.

- Deputy Director of Quality

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Quality:
SPC – Special Cause Variation

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.

Commentary

Zero bacteraemia cases were recorded In August 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

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Quality:
SPC – Special Cause Variation

Number of trust apportioned Clostridium difficile cases per month - GHT Starting 01/04/19

14
12
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, Aug 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.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Commentary

In August 2020 we had 6 community onset health care associated and 6 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. These cases have also been associated with periods of increased incidence (PII) on 3 wards- Rendcomb, Woodmancote and ward 6B.PII/ outbreak control incident meetings have been held for these PII's for each of the involves wards and specific remedial interventions have been implemented to address the issues identified through post infection review and IPC audit specifically including decant and red cleaning (bay/ wards), AMS rounds, training and education (all PII linked cases have been sent for typing to confirm whether transmission has occurred)

- Associate Chief Nurse and Deputy Director of Infection Prevention and Control

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Quality:
SPC – Special Cause Variation

Number of MSSA bacteraemia cases - GHT Starting 01/04/18

(Chart: y-axis 0–14; x-axis Apr 18 – Aug 20; legend: 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 August 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:
SPC – Special Cause Variation

Number of klebsiella cases - GHT Starting 01/04/18

Commentary

One bacteraemia case was recorded In August 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

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

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Quality:
SPC – Special Cause Variation

Hospital standardised mortality ratio (HSMR) - 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

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

HSMR is monitored by the hospital mortality group. During COVID the mortality increased, the number of deaths stayed the same but the number of admissions dropped dramatically. This leads to difficulty interpreting the figures. Therefore this needs monitoring over the next few months, the latest figure is an improvement.

- Medical Division Audit and M&M Lead

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.
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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Quality:
SPC – Special Cause Variation

Hospital standardised mortality ratio (HSMR) – weekend - GHT Starting 01/04/18

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

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 5 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

As per HSMR report, COVID months had a dramatic increase in mortality rates. The number of deaths remained the same and the number of admissions fell dramatically. this needs monitoring over several months to see if improves the latest figure is an improvement. This is monitored by the HMG and they are currently looking at four areas in more detail.

- Medical Division Audit and M&M Lead

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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
Aug 20
Mean
Actual
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Commentary

All timescales met, system continues to function consistently and to standard.#

- 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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Quality:
SPC – Special Cause Variation

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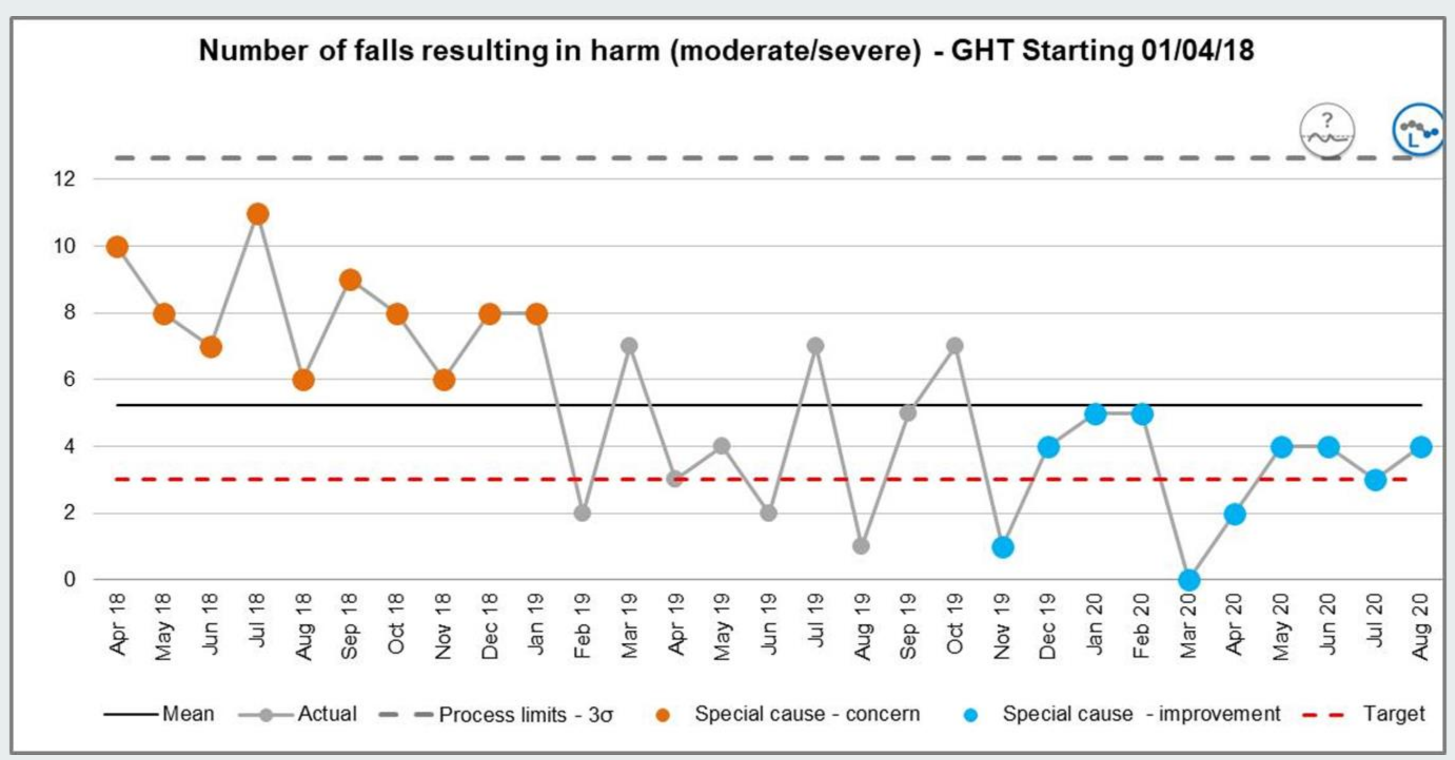

Commentary

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

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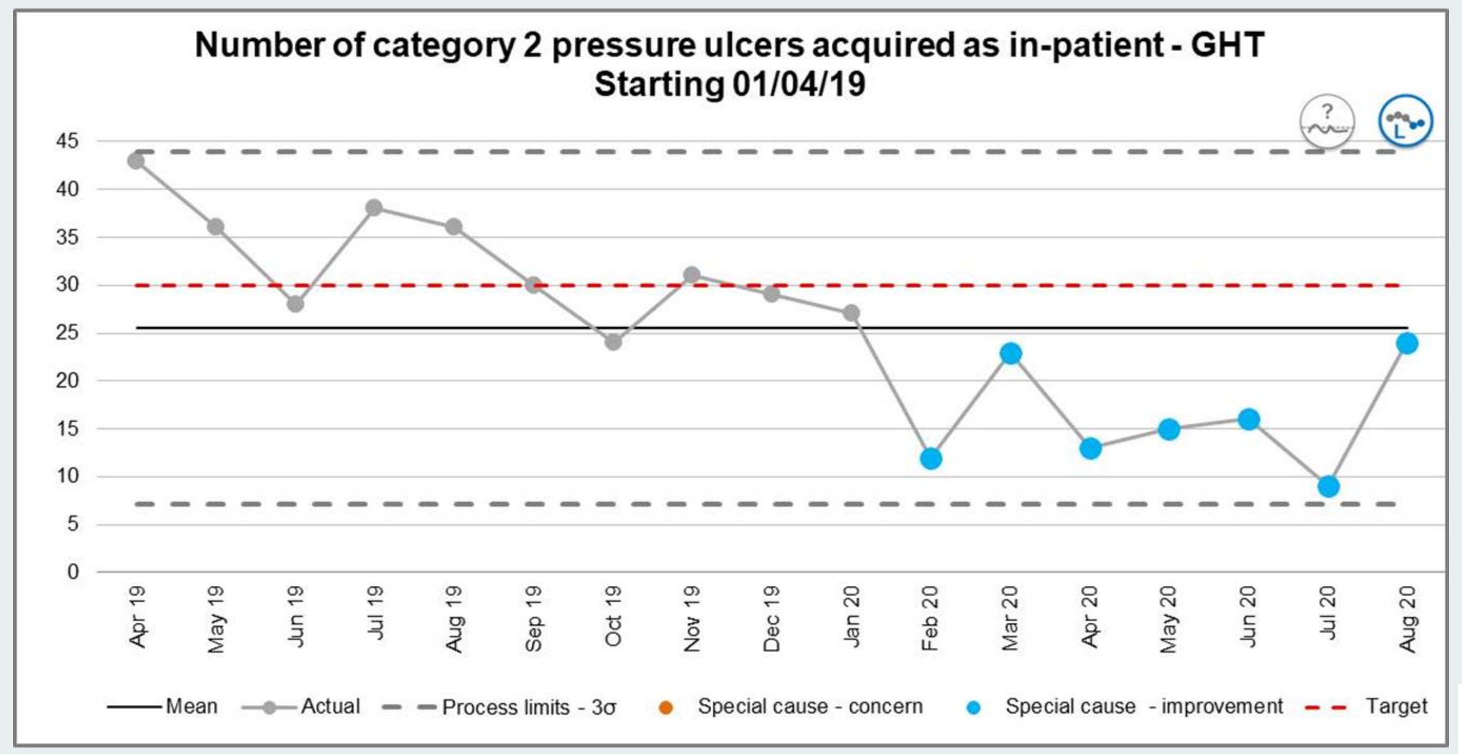

Commentary

Performance is as expected with continued sustained improvement.

- Deputy Nursing Director & Divisional Nursing Director - Surgery

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 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

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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 Aug 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 and UPL 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, Aug 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 timescales met, system continues to function consistently and to standard.

- Director of Safety

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Financial Dashboard

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.

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 & Variation
Finance	Total PayBill Spend	Aug-20	33.9
Finance	YTD Performance against Financial Recovery Plan	Aug-20	0
Finance	Cost Improvement Year to Date Variance	Aug-20	N/A
Finance	NHSI Financial Risk Rating	Aug-20	N/A
Finance	Capital service	Aug-20	N/A
Finance	Liquidity	Aug-20	N/A
Finance	Agency – Performance Against NHSI Set Agency Ceiling	Aug-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%	Consistently fail target	Aug-20	82.0%	Common cause
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	Hit and miss	Aug-20	91%	Common cause
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	Consistently hit target	Aug-20	102.1%	Special cause improving
Safe Nurse Staffing	% registered nurse day	>=90%	Consistently hit target	Aug-20	101.9%	Common cause
Safe Nurse Staffing	% unregistered care staff day	>=90%	Consistently hit target	Aug-20	117.5%	Special cause improving
Safe Nurse Staffing	% registered nurse night	>=90%	Consistently hit target	Aug-20	102.6%	Special cause improving
Safe Nurse Staffing	% unregistered care staff night	>=90%	Consistently hit target	Aug-20	131.7%	Special cause improving
Safe Nurse Staffing	Care hours per patient day RN	>=5		Aug-20	5.6	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	Hit and miss	Aug-20	3.9	Special cause improving
Safe nurse staffing	Care hours per patient day total	>=8		Aug-20	9.5	
Vacancy and WTE	Staff in post FTE	No target		Aug-20	6463.25	
Vacancy and WTE	Vacancy FTE	No target		Aug-20	494.04	Special cause improving
Vacancy and WTE	Starters FTE	No target		Aug-20	62.46	Common cause
Vacancy and WTE	Leavers FTE	No target		Aug-20	106.66	Special cause concerning
Vacancy and WTE	% total vacancy rate	<=11.5%	Consistently hit target	Aug-20	7.10%	Special cause improving
Vacancy and WTE	% vacancy rate for doctors	<=5%	Hit and miss	Aug-20	3.27%	Common cause
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	Consistently fail target	Aug-20	8.90%	Common cause
Workforce Expenditure	% turnover	<=12.6%	Consistently hit target	Aug-20	10.3%	Special cause improving
Workforce Expenditure	% turnover rate for nursing	<=12.6%	Consistently hit target	Aug-20	10.3%	Special cause improving
Workforce Expenditure	% sickness rate	<=4.05%	Consistently hit target	Aug-20	3.7%	Common cause

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People & OD:
SPC – Special Cause Variation

% turnover - GHT Starting 01/04/18

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Y-axis: 0.0%, 5.0%, 10.0%, 15.0%, 20.0%

X-axis: 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, Aug 20

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 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.
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

Turnover continues to maintain within target levels. Divisional hotspots are highlighted at executive review, with remedial actions considered.

- **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

14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

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, Aug 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Turnover continues to maintain within target levels. Divisional hotspots are highlighted at executive review, with remedial actions considered.

- **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 is 1 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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Leavers FTE - GHT Starting 01/04/19

120.0
100.0
80.0
60.0
40.0
20.0
0.0

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, Aug 20

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Staff turnover falls within acceptable range, hotspots are identified and discussed through the executive review process

- **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 is 1 data point which is above 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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REPORT TO TRUST BOARD – September 2020

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

This report describes the business conducted at the Quality and Performance Committee held on 23rd September 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	Detail of incident activity in reporting period and action plans which have been closed through governance process.	One serious incident noted to have no immediate actions advised, was this correct?	Serious incident review panel not quorate, sign off agreed outside of meeting	Review of governance and detail in this case to strengthen process and minuting of meetings, report back to committee
		How are we assured that unconscious bias does not play a role in care and treatment?	Review of individual case will incorporate this.	Depending on review results, may need further assurance to committee.
		There was a time gap in one incident occurring and the report of the panel, was that a concern?	Existing process includes divisional governance aspects, but will check the detail on this case.	To report back into committee
		Is the rise in complaints due to volume or trends the committee should be aware of?	Complaints are returning, to pre covid levels, with a dip in friends and family test (FFT) results. This is being monitored.	
		One incident does not give detail of why a delay in care or whether		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		follow up was self initiated	This aspect will be covered in the formal review.	
Corporate Risk Register	No changes to risk register in month, new risk management group arrangements noted and requirement for designated patient safety specialists in line with national strategy. Update on national strategy one year on.	An emerging divisional risk was highlighted at Audit and Assurance Committee the previous day, is there any concern which this committee needs to be aware of at this stage?	Good assurance of development of risk management arrangements and alignment with national patient safety strategy. Medical Director has set off a piece of work which will play through processes and be reported in.	
Maternity Assurance Action Plan	Progress against the actions is as expected and on track.	Is there anything from this review and learning which can help on a day to day basis in the service and across the Trust? Are the timescales within the plan achievable as extensive and small group of lead individuals?	Multi-layered organisational plan seen to be in place with outputs coming back to Committee. Anticipated to be good wider learning and extra support has been put in place short term to achieve. Maternity and neonatal safety champions meeting received	
Covid update	Current position noted and	Are we expecting any	Confirmed and	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	ongoing need for risk assessments over the coming months	new guidance from NHSE/I?	organisational response will mirror phase 1. Importance of ongoing staff support noted. Assurance received on leadership focus.	
Red rated quality Indicators review	Review of indicators rated 'red' for sustained/ prolonged period of time and assurance briefing that improvements programmes are in place. Data quality of definition, system for recording, reliability of data reviewed.	Noted that anecdotally falls had reduced with ePR introduction, has this continued? Are there weaknesses in the data set collected at Divisional level? When will committee see the outputs of the change to data?	Assurance received of focus on areas of improvement and desire to review the rating system to make more meaningful Numbers of falls similar but the level of harm has reduced. Felt that the data collection is stronger with monthly performance reviews at ward level and through executive reviews To return to committee in April 2021	
Quality Strategy, review of performance	Update on implementation of the quality strategy delivery plan	With the possibility of second surge of covid, are there aspects of the strategy which can continue at same pace	Assurance of project status and rationale. The way the strategy is framed, links in clearly with other work programmes which are enablers to better team	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		and/ or be delayed? Importance of the narrative and connection with staff important	working, so minimal deferral anticipated.	
Phase III update	Current position noted and ongoing meetings with NHSE/I		Importance of the right level of communications with patients to maintain confidence in the health services.	
Quality and Performance Report	Quality Delivery Group (QDG) Never Event thematic analysis due to report in October. Lower FFT results noted across inpatients, ED and maternity Cancer Delivery Group Strong performance and achievement noted in 2 ww, 28 day, 62 day metrics with increased activity from this time last year	With gap in current real time feedback, is there thinking of using different, innovative ways to get this feedback? What can be learnt from different industry sectors? The safeguarding update does not include the risk of information sharing, which was shared at Audit and Assurance Committee as an emerging divisional risk, is this a timing issue? At what point is the work undertaken to achieve standards deemed sustainable?	Trend analysis being undertaken re FFT. Consideration of employing a person to strengthen real time feedback system, as well as other potential solutions. Assurance was given that this was discussed at QDG but not pulled through into the report. Assurance of improved clinical pathways eg in urology rather than asking staff to work harder, quicker, longer.	Follow up at committee

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Operational and Assurance Group Current position shared and detail within specific areas, high level trajectories shared Urgent Care Delivery Group Current position outlined, deterioration in performance, activity has increased. Safety metrics for overflow areas in ED described in	Has the availability of capacity through reduction in elective activity created a space for cancer and if so, what is the risk when elective activity increases? Regarding patient communications, is there enough internal capacity to manage patient contact?	Colleague fatigue an issue for all post covid and key focus of work. Assurance given that priority is always given to patients requiring cancer treatment. Evidence of stratification of waiting lists by clinical urgency Communications are going to patients in a phased way, current standard is for central booking office to answer telephones within 3 rings. Detailed description of work in progress to improve flow and ensure safety of patients.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	detail.		Further review at next committee as time constraints precluded discussion	
Care Quality Commission (CQC)	Letters shared of CQC monitoring calls with Paediatric and Adult outpatient departments.		No issues raised by the CQC	

To note, the Trust is now a member of the Gloucestershire Quality Surveillance Group and the committee will receive regular assurance updates as necessary.

Alison Moon
Chair of Quality and Performance Committee
24th September 2020

REPORT TO MAIN BOARD – OCTOBER 2020

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

This report describes the business conducted at the Audit and Assurance Committee on 22 September 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
Internal Audit Update	Good progress reported on 2020/21 internal audit programme Reports received: 1. IT Asset Register A limited opinion was given. Areas requiring attention included IT asset database and licensing. 2. GMS contract Management Moderate assurance provided.	Discussion about level of confidence that improvements could be achieved and embedded within reported timescales. Consideration to be given to possibility of medical equipment asset register being developed in conjunction with IT asset register. Discussion as to make up of cleaning KPIs and intention to drill down below aggregated data levels.	Appointment of asset manager with specific responsibilities for these activities.	Further consideration to be given by Finance and Digital Cttee.
Risk Management Group Assurance Report	Progress report on work of Risk Management Group.	Discussion as to whether consistent divisional attendance and engagement has been achieved. Request for improved	Some reduction in attendance during height of Covid but good deputising arrangements are in place.	

		reporting on Duty of Candour. Discussion about implication of lack of single electronic record for maternity services.		
Clinical Audit	Comprehensive report received as to clinical audit activity in the Trust. Good source of assurance.			

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

TRUST PUBLIC BOARD – 08 OCTOBER 2020
Microsoft Teams, Commencing 12:30

Report Title							
ANNUAL REPORT AND ACCOUNTS 2019/20							
Sponsor and Author(s)							
Author: Sim Foreman, Trust Secretary Sponsor: Sim Foreman, Trust Secretary							
Executive Summary							
The Trust Board delegated authority at its June 2020 meeting for the Audit and Assurance Committee to approve the annual report and accounts 2019/20 at a meeting on 18 June 2020. The documents were laid before Parliament, pursuant on 2 September 2020 and have been published on the Trust website: https://www.gloshospitals.nhs.uk/about-us/reports-and-publications/annual-report-2019-2020/							
Recommendations							
The Board is asked to NOTE the publication of the Trust's Annual Report and Accounts for 2019/2020.							
Impact Upon Strategic Objectives							
None							
Impact Upon Corporate Risks							
None							
Regulatory and/or Legal Implications							
Annual report and accounts 2019/20 were presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.							
Equality & Patient Impact							
None							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	X

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
25 June 2020							Council of Governors (Confidential) – August 2020
Outcome of discussion when presented to previous Committees/TLT							
The Audit and Assurance Committee approved the annual report and accounts 2019/20 on 25 June and the Council of Governors noted the document at their confidential meeting on 19 August 2020.							