PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

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

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies	Chair		12:30	
1.	Patient story	Steve Hams			
2.	Declarations of interest	Chair		13:00	
3.	Minutes of the previous meeting	Chair	Approval		YES
4.	Matters arising	Chair	Approval		YES
5.	Update from the Chair	Chair	Approval		YES
6.	Chief Executive Officer's report	Deborah Lee	Information	13:05	YES
7.	Trust risk register	Emma Wood	Approval	13:15	YES
	AUDIT AND ASSURANCE				
8.	Board Assurance Framework	Sim Foreman	Assurance	13:25	YES
9.	Emergency Preparedness, Resilience and Response (EPRR) Assurance Report 2020-21 **Note this paper contains embedded documents as evidence of assurance; details have been made available through Committee review process and requests for specific detail should be directed to the Corporate Governance team.*	Rachael de Caux	Assurance	13:30	YES
10.	Assurance report of the Chair of the Audit and Assurance Committee	Claire Feehily	Assurance	13:40	YES
	ESTATES AND FACILITIES				
11.	Assurance report of the Chair of the Estates and Facilities Committee	Mike Napier	Assurance	13:45	YES
	BREAK			13:50	
	FINANCE AND DIGITAL				
12.	Finance report	Karen Johnson	Assurance	14:00	YES

13.	Digital report	Mark Hutchinson	Assurance	14:05	YES
14.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	14:15	YES
	QUALITY AND PERFORMANCE				
15.	Quality and Performance report	Steve Hams / Rachael de Caux / Mark Pietroni	Assurance	14:20	YES
16.	Annual Complaints Report	Steve Hams	Approval	14:30	YES
17.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	14:35	YES
	STANDING ITEMS				
18.	Governor questions and comments	Chair		14:40	
19.	New risks identified	Chair			
20.	Any other business	Chair			
CLOSE				14:45	

Date of the next meeting: Thursday 14 January 2021 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 Rob Graves Marie-Annick Gournet Balvinder Heran Alison Moon Mike Napier Elaine Warwicker	Deborah Lee, Chief Executive Officer Emma Wood, Director of People and Deputy Chief Executive Rachael de Caux, Chief Operating Officer Steve Hams, Director of Quality and Chief Nurse Mark Hutchinson, Chief Digital and Information Officer Karen Johnson, Director of Finance Simon Lanceley, Director of Strategy & Transformation Mark Pietroni, Director of Safety and Medical Director

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

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

PRESENT:		
Peter Lachecki	PL	Chair
Deborah Lee	DL	Chief Executive Officer
Rachael de Caux	RdC	Chief Operating Officer
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
IN ATTENDANCE:		
James Brown	JB	Director of Engagement
Alex d'Agapayeff	AdA	Deputy Medical Director
Sim Foreman	SF	Trust Secretary
Dee Gibson-Wain	DGW	Associate Director Education and Development
Marie-Annick Gournet	MAG	Associate Non-Executive Director
Craig MacFarlane	CM	Head of Communications
Simon Pirie	SP	Guardian for Safe Working
Katy Williams	KW	Occupational Therapist
APOLOGIES		
Mark Pietroni	MP	Director of Safety and Medical Director
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were six governors, four staff and three members of the public present.		

ACTION

187/20 STAFF STORY

DGW and KW attended for this item.

EW introduced DGW who outlined the range of career development opportunities within the Trust highlighting the Chief Nurse Fellowship programme which allows protected time for development whilst the individual remains in their current role. DGW then introduced KW who shared her story of career development at the Trust.

KW outlined her career with the Trust which began in April 2015 when she decided not to take up a midwifery degree and joined as a Ward Clerk on the Acute Medical Unit. KW saw this role as fundamental and at the heart of the ward environment, and continued in her role whilst she studied to become an Occupational Therapist (OT) with two of her

three degree placements at the Trust. KW identified a need to enhance her clinical skills to support her studies and trained as a Healthcare Assistant (HCA). KW qualified as an OT in September 2019 and began working on Gallery ward, subsequently moving onto a surgical ward in March 2020 where she recognised the power of multi-disciplinary team (MDT) working. KW had worked in the POD teams responding to coronavirus as a HCA and an acute care OT.

KW advised she was developing an idea to establish a network of newly qualified professionals linked to "GLOSTARS" and this would support her application for the next Chief Nurse Fellow programme

KW concluded that she had arrived at the Trust as a shy teenager who was passionate about the NHS and had embraced the opportunities available, supported by tremendous colleagues and friends, to qualify as an OT, via the ward clerk and HCA roles on the way.

The Chair thanked KW for her story and asked what more could the Trust do to help develop individuals. KW felt that raising awareness of Allied Health Professionals (AHPs), and GLOSTARS in particular, would help. KW added there were lots of opportunities available but people often needed a boost of confidence to pursue them. DL thanked KW for being a strong ambassador for the Trust on social media and that she could really help inspire, encourage and reach out to those staff who wanted to step forward.

EWa asked what the Trust needed to do to retain people like KW, both now and in ten years' time. KW replied that helping staff to maintain the passion for the patient and staff experience was key.

In response to a question from RG, KW advised the best thing the Trust had done for her was training as a HCA and that working in this role during COVID-19 would stay with her forever.

KW was also asked what she would like to like to change and what message should she or the Trust share with young people to bring them into the workforce. Her reply was to raise awareness of career progression opportunities for AHPs into ward management and other roles and her message would be "believe in yourself".

RESOLVED: The Board NOTED the staff story and the Chair thanked DGW and KW for their presentation.

188/20 DECLARATIONS OF INTEREST

There were none.

189/20 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meetings held on Thursday 08 October 2020 as a true and accurate record for signature by the Chair.

190/20 MATTERS ARISING

All matters were closed although the Chair clarified that Board Strategy and Development follow-up session on compassionate leadership was proposed for April 2021 not September 2021 as reported in the paper.

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

191/20 CHIEF EXECUTIVE OFFICER'S REPORT

DL presented the report and updated on the latest COVID-19 position. Community transmission was increasing slightly but noted that the effects of lockdown had yet to be seen, although hospital admissions were increasing with 115 COVID-19 patients at the time of reporting (three in critical care). Patients were less unwell than the first wave when 20% were in critical care and the average length of stay had fallen from 11 days to five days. This in part could be attributed to the access to drugs which became available in the summer and resulted in reduced mortality rates. Currently mortality was 8% compared with 31% in phase one.

DL also flagged the news related to vaccine development and whilst it was still unknown what mass vaccination would look like, the Trust had been asked to be the lead organisation for the county with SH as lead. There was increasing clarity on the priority groups for vaccination which would be on the basis of age, as well as NHS and social care frontline status. DL expected GP colleagues to become involved which may change the role of the Trust to oversight of co-ordination as the majority was likely to now be delivered in primary care settings.

As reported last month, the Virtual COVID-19 ward had gone live this week, allowing patients to be managed at home through monitoring oxygen levels in their blood and bringing them into hospital quickly if they deteriorated.

The Board heard the differences in this phase of the pandemic related to the increased workload alongside the complexity of maintaining services and the next couple of weeks would be challenging to the extent that some services may need to be paused i.e. respiratory outpatient clinics to allow those clinicians to care for patients on wards. However, the key message would remain that the hospitals were open for business, were safe places and patients should keep appointments. The temporary service changes were in place to keep Cheltenham General Hospital (CGH) as safe as possible.

Away from COVID-19, DL reported that the sustainability agenda and strategic programmes within Fit For the Future (FFtF) had kept going as the Trust and system looked three to five years ahead. The Trust was celebrating Occupational Therapy week and Ward Clerk week would take place from 26 November 2020.

DL shared her reflections from participating in the Black History Month Book Club and closed by updating on the session the previous day through the Board Leadership Academy on reciprocal mentoring, its

importance and what it could help the Trust achieve. The Chair reinforced this point and that this was another good example of how the Trust was working to develop a compassionate culture.

The Chair asked about mutual aid arrangements related to COVID-19, both in terms of receiving patients and providing staff. DL explained the formal arrangements were through the Cancer Alliance and Severn Critical Care network. Weekly reviews of cancer patients took place and those patients from other areas who could be treated at the Trust are brought in. If the critical care network capacity were to reach 80% then the Nightingale hospital in Bristol would be activated and there would be a need to look carefully at staffing, which would have to come from the existing staff base across the network area. The Trust had also been asked to signal what testing capacity it could make available to others, which it had, but this had not been drawn down.

CF shared that Non-Executives Directors (NEDs) had been receiving positive comments from their communities about the two week cancer pathway and thanked colleagues for their work on this. CF asked, given the changed COVID-19 patient profile, if there was confidence that adult social care had the purchasing power (and budget) required for beds. DL explained Gloucestershire County Council, as budget holders, were involved in all Integrated Care System (ICS) discussions. DL added, like most winters, there were usually 100 patients who were medically stable for discharge but assured partners continued to facilitate this although demand was considerable higher than is usual periods and this was problematic.

MAG sought feedback on the patient response to the oximetry aspects of the virtual COVID-19 ward. DL advised this was broadly positive and patients (and families) were reassured by the monitoring and management at home. A small number of patients found this provoked anxiety and had stepped away from the scheme.

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

192/20 TRUST RISK REGISTER

EW presented the report and confirmed five (four safety and one quality) new risks had been added to the Trust Risk Register (TRR).

EWa asked how the 50 plus controls related to the COVID-19 risk on the cover sheet were tracked and how the Board could be assured they were working. EW advised that the Corporate Risk Manager reviewed these weekly with stakeholders and updated Executives. RdC added that risks were also reviewed by Executives and divisional representatives at the weekly COVID-19 task and finish group and reported to the Risk Management Group. It was noted the dynamic pace of changes meant it was not possible to wait a month.

AM advised that the Quality and Performance Committee (QPC) had discussed fractured neck of femur at length. AM recognised the Trust had previously had historic issues regarding fractured neck of femur but had seen great improvements. AM asked if the current issues related to improvements not being embedded and whether there was opportunity

to reflect this within the risk. DL acknowledged there had been poor mortality rates and the Trust had improved to have one of the best rates nationally, partly due to recognising and embedding nutrition as a key element. DL advised the current loss of performance was attributed to the timeliness of getting patients into theatre (as better outcomes were evident within 36 hours) although the Trust had seen a 50% improvement over the past month.

RG asked if it would be possible to see numbers to show trends on the TRR. DL felt that the Board would receive assurance on these dynamically through the Board Assurance Framework and the management of risks was as Executive function but would welcome a discussion on how the Board could have greater assurance through Committees. EW agreed to discuss further what RG would like to see as she did not think bringing more detail to Board was necessarily the right approach. **EW**

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

193/20 PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

EW presented the report and highlighted a mainly GREEN dashboard. Retention, turnover and absence levels had been recognised nationally and NHS People has asked that the Trust share what was being done as best practice. The Trust was noted to be in the top quartile of peers and university hospitals, with a vacancy factor ambition of 6.7% in year one of the five year plan. 60 nurses had joined the Trust. The Trust only had 31 Whole Time Equivalent (WTE) medical gaps. Radiographer turnover rates were reducing to a rate of 10% (from 24%) with five new starters in the next quarter. A new course at the University of Gloucestershire would also help reduce this further. EW also flagged HCA turnover had reduced to 15%. The Board acknowledged this very positive picture and thanked EW and her team; they noted that there were still some areas of focus such as the Medical Division and more could be done to make improvements, as reflected in BH's chair's assurance report.

MN noted the focus on Equality, Diversity and Inclusion as well as bullying and harassment which was reflected strongly in the narrative of the cover sheet and asked if it would be possible to reflect and track progress within the dashboard. EW confirmed this could be developed and incorporated but also assured that the People and Organisational Committee (PODC) would continue to undertake deep dives on these topics in the meantime.

In response to a question from MAG, it was confirmed the in-depth review within Medicine would take place the following week and an update would be provided to the PODC in December 2020.

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

194/20 GUARDIAN REPORT ON SAFE WORKING HOURS FOR DOCTORS AND DENTISTS IN TRAINING

SP attended for this item.

SP presented the report and explained the 146 exception reports between July and September 2020 were back in line with pre-COVID-19 levels although no fines had been levied. The Board heard that all reports had been checked against Datix and clinical incidents. SP advised all the reports where immediate safety concerns were flagged had been investigated and this had shown the box had been ticked in error. A Junior Doctor forum was taking place the following week and SP reported these had been helpful during Phase 1 of the pandemic.

There were no questions on the report.

RESOLVED: The Board NOTED that the exception reporting process was robust and that the Junior Doctor Forum was functioning well and discharging its duties accordingly.

195/20 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND OD COMMITTEE

The Chair reordered the agenda to take this item ahead of the Engagement and Involvement Strategy.

BH reported a good PODC meeting was held in October 2020 that covered a wide range of issues which included an update on the ICS and the setting up of the new primary care network risk (creating more competition in the network) and the governance of COVID-19 being impacted by this.

The Board also heard the Committee had been concerned over the past year that Health and Safety had insufficient resources but there had been assurance that all bar one vacancy had since been filled.

BH supported EW's earlier report on the performance report and advised the Committee would continue to focus on performance and undertake deep dives as required.

The Freedom to Speak Up audit report showed that visibility of the Board was evidenced. It also recognised the activities related had shown good evidence.

The first employee relations report had been presented to the Committee and highlighted issues that the Trust was already concerned about including the impact on colleagues and patient experience and bullying and harassment.

The Engagement and Involvement Strategy was reviewed and the Committee were pleased to hear the engagement and involvement group would help drive the implementation and embedding of the work.

The Equality Report was considered and work would take place to look at improvements and areas for deep dives whilst ensuring the golden

thread of inclusion ran through all aspects, with equality, diversity and inclusion was maintained.

The Chair asked the Board to also note that that there was a sub-group of the People and OD Group looking at widening participation and the experience of BAME colleagues to address inequalities. This group unusually had three NEDs (including himself) as members.

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

196/20 ENGAGEMENT AND INVOLVEMENT STRATEGY

SL introduced JB and advised the Strategy was being presented for review and approval. JB explained the enabling pillars to deliver the strategy as well as the approach to working with stakeholders to deliver the aims, with a goal of more co-production and co-design as a guiding principle (recognising that it was not always possible to reflect all views in decision making but they could be heard)

CF welcomed the strategy and felt it would great to have some bottom up successes on the back this.

MN echoed the positive comments on the strategy, and said it had been long time coming. MN highlighted the 90 milestones, goals and measures referenced in the document and suggested it could simplified by including these in an appendix and leaving the strategy focus on the top two or three priorities. MN flagged a concern that the language of shared decision making and co-production could inappropriately raise expectations of extended partner organisations and single issue lobby groups. SL and JB responded that there would be a summary version of the document and that there would be occasions where agreement could not be reached, and where this happened it would be important to help people understand how decisions were made.

The Chair referred to comments he had shared at PODC about the inclusion of milestones on one to two year and three to four year milestones being potentially less valuable than having a year one action plan as a support to the strategy and its long term objectives. The Chair however commended the work on the direction and strategic intent and his feedback was to ensure the Trust made the most of the document.

EWa endorsed previous comments supporting the strategy and noted the challenge would be in the implementation. EWa asked that when doing this that appropriate links to equality and diversity and compassionate leadership were made as they were all interconnected.

DL and MAG suggested use of graphics, visuals and real examples to communicate the strategy, particularly the shared decision making process to be clear when stakeholders are influencing and when they are part of the decision making. JB agreed to do this. **JB**

RESOLVED: The Board APPROVED the Engagement and Involvement Strategy, subject to the comments and amendments, so that it could be published and work can begin to be delivered against the milestones

and SUPPORTED the timing and approach for launching this strategy.

197/20 FINANCE REPORT

KJ reported that Month 6 (M6) had been the last month with COVID-19 funding and M7 to M12 were covered by a new funding regime based on block contract arrangements with no true-up funding received.

The M6 position included a resubmission, at the request of regional finance colleagues, of the £4.2m VAT charge claim previously rejected by the national team.

The Trust reported a £5.1m deficit and top up had been requested as activity had increased in line with the plan (a 10% increase on the previous month equated to £2m). An additional £1.6m of COVID-19 costs were incurred, including £200k backdated PPE costs. KJ advised that whilst COVID-19 costs were coming down, the increased levels of activity and cases reported earlier would have an effect.

M6 accounted for a pay award totalling £800k covering M1 to M6 and also the VAT issue potential liability.

The Board heard that the forecast position was for a £15.5m deficit in line with national expectations; which included some technical adjustments such as annual leave accruals.

The Board were advised the M6 submission was being subjected to more national scrutiny for all Trusts and as a result the payment would be delayed by a month.

Regarding capital, KJ reported there had been a £21.3m programme at the start of the year which, due to national release to support critical infrastructure, had increased to £41m as the Trust had been successful in having all submitted bids approved. The Board noted the success of all involved in the bids and that scrutiny had taken place at the Finance and Digital Committee (FDC). KJ advised all capital would be spent by financial year end.

AM cross referenced to the FDC's chair's report and that the Trust was behind on the Cost Improvement Programme (CIP) target and asked how the coming months would flow through for this and if bigger schemes were needed. KJ replied that the Board, system and regional discussions allowed recurrent CIP at the start of the year but there was no additional requirement to find additional schemes or savings provided the Trust stayed within it financial envelope. KJ assured that the Trust had schemes to be more efficient and reduce waste and although the true impact for the next year was unknown, planning had commenced.

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

198/20 DIGITAL REPORT

MH reminded the Board that *Order Comms* went live in August 2020

and 100k tests had successfully been requested through the system. The team were now focussing on six issues and areas; maternity, theatres, Outpatients, configuring the Electronic Patient Record (EPR) to work for both Emergency Departments, progressing paperless outpatient appointments with specialities and seeking to go live with electronic prescribing in a year.

MH updated on the wider programme and was pleased to report the Trust had eradicated the use of fax machines as one of a number of closed projects. Work was underway to replace the wireless network across the hospitals with 671 access points already replaced in GRH and work also commenced in CGH.

The Board heard the Trust had achieved compliance with the national Information Governance target for 95% to have undergone training and noted this huge achievement, especially at this time.

The Chair and DL congratulated MH and his team on two national awards for the EPR Go Live and COVID dashboard. MH said this had proved to be a huge boost to the team.

AM asked how the Board would see the qualitative benefits of EPR (as referenced in Section 2.1 of the report) and how this would cross reference to QPC regularly. AM also pointed out that whilst the report stated falls had decreased, the position was that the number of falls had increased but the harm from falls decreased. MH responded there was lots of evidence of better, safer, patient care and examples from clinicians and he needed to make the link. SH supported the point and added visibility of care had improved but a slicker review of evidence was needed.

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

199/20 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

RG reported the Committee had spent some considerable time reviewing details on the status and success of digital projects and were satisfied that all were being delivered. The Committee had focused on capacity and resources within MH's team and ensuring people were being looked after properly. There was a need to think about wider system issues and how digital working could extend across the community.

With regard to the finance agenda, RG confirmed KJ's report had been an accurate summary of the position and he could only add his significant assurance on the quality of the dialogue in the Committee.

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

200/20 QUALITY AND PERFORMANCE REPORT

The Board noted the discussions on quality and performance that had taken place as part of other agenda items and it was agreed the report would be taken as read.

The Chair asked RdC, AdA and SH if they had any additional concerns that they wished to raise or alert to the Board and they all replied there were none.

RESOLVED: The Board RECEIVED the report as assurance that the Executive Team and Divisions fully understood the levels of non-delivery against performance standards.

201/20 LEARNING FROM DEATHS

AdA presented the report on learning from deaths for Q4 and reminded the Board that all deaths were reviewed, families had an opportunity to meet with teams and all Serious Incidents (SIs) had action plans. AdA highlighted the positive assurance from the National End of Life Care audit.

The Chair queried the increase in the Hospital Standardised Mortality Ratio (HSMR) and AdA explained that due to COVID-19 there had been fewer admissions overall, but those more seriously ill patients had still presented and died, which meant the HSMR had gone up. AdA continued that the Dr Foster reporting would be able to report without COVID-19 impact, but Dr Foster themselves acknowledged the complexity and there may maybe a delay to receive this underlying data.

MN asked in relation to mortality rates when and where the Board would learn about those investigations underway referred to on Page 2 of the report. AdA responded they would be included in the next report although early indications were that the issues related to coding of palliative care cases.

DL stated she arrived at the Trust when the HSMR was uncomfortably high and data had been assigned as the issue which turned out not to be the case for the whole excess death position. She asked to what extent fractured neck of femur was skewing the current HSMR and what actions were being taken at service line/pathway levels to understand and interrogate the data to avoid deaths being generally attributed to COVID-19 if they weren't. AdA identified that the four areas where it was felt data was out of kilter with expectations and merited a deep dive were: acute renal failure, stroke, fractured neck of femur and Chronic Obstructive Pulmonary Disorder (COPD). AdA added there had been an increase in palliative care coding more recently and the data will improve, although it does not mean there wasn't still an issue in December and January which may include fractured neck of femur and this would be followed up. AdA confirmed that the Trust Mortality Group was actively looking into all four areas of concern.

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

202/20 LEARNING FROM PATIENTS' STORIES

The report was taken as read and SH invited questions from board members.

BH referred to Imran's story and asked if the learning about experience of patients for whom English was a second language and the bathroom cleanliness issues had been addressed. SH advised that there had been a change to allow visiting in "special circumstances" rather than on "compassionate" grounds and this now felt different. The bathroom issues were being followed by estates and SH confirmed side room facilities were better in the new estate. SH also added that in relation to the reference in Imran's story to interface with community services and access to oxygen: this was now being covered through the oximetry monitoring service.

RG asked if there would be some methodology of following up actions reported to the Board, acknowledging some things would not happen quickly. SH reported that this was monitored and progressed through the Quality Delivery Group who in turn provided assurance to the QPC and there was a Board update three months after each Board story.

EWa referred to Marie-Clare's story and her specific comment on how she had been told she had cancer. EWa had since spoken to a number of people who had received positive news but all had been shocked that they could have had bad news. EWa asked if the national cancer patient survey would cover these people. SH confirmed it would not as the survey was for confirmed cancer patients however added that Marie-Clare's experience had been shared as learning with the Breast Care Team.

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

203/20 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE REPORT

AM presented the report and highlighted the further work undertaken at the QPC's request in indicators that were RED and MP had clearly explained those areas covered and reviewed by the Hospital Standardised Mortality Ratio (HSMR) Committee.

The Committee had noted and commended the cancer performance, and received a powerful presentation from a Respiratory Care clinician.

A significant amount of discussion had taken place on unscheduled care and the Committee had been assured that an external review of the process and experience had been unable to identify any additional measures to those in place.

Three specific examples of patient experience had been identified; food/hydration, warmth and analgesia. It was agreed these areas of focus should be owned across the system.

RESOLVED: The Board RECEIVED the report as assurance of the

scrutiny and challenge undertaken by the Quality and Performance Committee.

204/20 MINUTES OF THE COUNCIL OF GOVERNORS ON 19 AUGUST 2020

RESOLVED: The Board NOTED the minutes of the Council of Governors held on Wednesday 19 August 2020.

205/20 GOVERNOR QUESTIONS AND COMMENTS

AT echoed NED colleagues comments on the discussions at QPC and felt the presentation on respiratory care to the Committee had been exceptional.

AT confirmed he attended both QPC and HSMR committees where learning from deaths was discussed. He reflected from his professional background as a trainer that individual learning happened but organisations were not good at doing this systematically, though when it worked, it really worked well.

AT commended and welcomed the Engagement and Involvement Strategy and agreed there were other ways of presenting detail to make it more concise. AT issued a plea for clarity on the terms “co-production, co-design and shared decision making” as they would all involve the patient and welcomed DL’s suggestion of a “schematic” to set out how decisions were made and by whom.

206/20 NEW RISKS IDENTIFIED

There were none.

207/20 ANY OTHER BUSINESS

The Chair, on behalf of the Board, thanked all colleagues across the Trust for their work and for rising to the challenges week after week and noted his personal thanks to DL and the Executive Team.

There were no other items of any other business.

[Meeting closed at 15:00]

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

Signed as a true and accurate record:

Chair
10 December 2020

Public Trust Board – Matters arising – December 2020

Minute	Action	Owner	Target Date	Update	Status
12 NOVEMBER 2020					
192/20	**TRUST RISK REGISTER**				
	Discuss further what RG would like to see on the Trust Risk Register report.	EW	December 2020	The Deputy CEO/ Director of People and OD and Corporate Risk Manager met with Rob Graves to discuss possible improvements to the TRR. It was agreed more detail on the risk distribution and dynamics could be provided for assurance processes to the Audit and Assurance Committee (AAC) once reviewed at Risk Management Group. A new report with the detail will be provided to AAC on 26 January 2021.	**CLOSED**
196/20	**ENGAGEMENT AND INVOLVEMENT STRATEGY**				
	Use graphics, visuals and real examples to communicate the strategy, particularly the shared decision making process to be clear when stakeholders are influencing and when they are part of the decision making.	JB	December 2020	Work is underway to deliver this and includes development of cases studies. Linked to this, the Trust is developing a model to demonstrate how involvement and engagement is used within “decision-making” and the output from this will be reported to back via People and OD Committee.	**CLOSED**

TRUST PUBLIC BOARD – 10 DECEMBER 2020
Microsoft Teams, Commencing at 12:30

Report Title
UPDATE FROM THE CHAIR
Sponsor and Author(s)
Author: Sim Foreman, Trust Secretary Sponsor: Peter Lachecki, Trust Chair
Executive Summary
The Trust moved to virtual meetings for Board, Committee and Governor meetings from April 2020. The paper reconfirms the current arrangements and proposes their continuation until the end March 2021.
Recommendations
The Board is asked to APPROVE that Board, Committee and Governor meetings continue to be held virtually until 31 March 2021.
Impact Upon Strategic Objectives
There is no impact on the strategic objectives from this paper.
Impact Upon Corporate Risks
There is no impact on corporate risks from this paper.
Regulatory and/or Legal Implications
Decisions and actions must still be taken in a manner that is legal and compliant with regulation although it is recognised that there may be changes to statute and regulatory frameworks due to the pandemic. The proposed arrangements provide for the continuation of Trust governance processes.
Equality & Patient Impact
There are no direct implications on equality and patient impact.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

BOARD – SEPTEMBER 2020

UPDATE FROM THE CHAIR

1. Purpose

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

2. Executive Summary

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

3. Board and Committee meetings

3.1. Board and Board Committee meetings have been held remotely using MS teams since April 2020. Originally these meetings had shortened agendas to focus on key business and assurance items and in June 2020, it was AGREED to extend the length of the meetings to allow more business to be transacted.

3.2. In September 2020 it was AGREED that meetings would continue to be held remotely until 31 December 2020 with a review in early December to assess the situation.

3.3. Social distancing and restrictions of movement continue to apply and are expected to do so for a number of months yet. Therefore it is proposed that the Trust continues to convene Board, Committee and Governor meetings virtually until 31 March 2021.

3.4. It is hoped that the increase in the number of external observers, staff members and governors continues at these meetings, due to the accessibility afforded by the technology and removal of travel time.

3.5. The next review will take place in early March 2021.

4. Recommendation

4.1. The Board is asked to APPROVE that Board, Committee and Governor meetings continue to be held virtually until 31 March 2021.

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

TRUST BOARD - DECEMBER 2020

REPORT OF THE CHIEF EXECUTIVE

1 Operational Context

1.1 The operational context for the Trust remains largely unchanged from last month with a continued focus on elective recovery, preparations for winter and managing the increase in the number of patients with suspected and confirmed COVID-19. The number of COVID positive patients in our hospitals peaked at 166 in the week ending 4 December and have been maintained at this level; this compares to a peak of 148 during the first wave of the pandemic. Numbers in critical care remain considerably lower, as a proportion of total COVID positive patients, than during the first wave although this is beginning to rise and stands at 12 as of today. This picture is in line with our expectations and reflects the lag between rising community transmission and subsequent hospital admissions, and latterly rising critical care admissions.

1.2 In respect of community transmission and the impact of lockdown, the County has seen a reduction in the rate of infections in the seven days to 24 November from 171.1 per 100,000 population to 93.9 per 100,000 in the most recent week which, whilst positive, still reflects a high level of circulating infection with 598 new cases being confirmed in the most recent week; again positively, the highest rates remain in those aged under 60. The Trust has been at the forefront of local communication regarding a “cautious” approach to the festive period in order to guard against a third spike of infections in January. The Facebook Live events are now into their sixth and final week and have been very well received, with more than 45,000 engagements each week and it is clear that the COVID update is a welcome part of this approach.

2 Key Highlights

2.1 This month came the much awaited announcement that the UK has the first COVID-19 vaccine licensed for use in the world; this is a huge feather in the cap of UK science and industry. The vaccine, developed by pharmaceutical companies Pfizer and BioNTech, and manufactured in Belgium, was made available for use by the NHS, on the 8th December and Gloucestershire Hospitals was one of the 50 sites chosen to mobilise the vaccine in this first phase. The Trust is the lead organisation in Gloucestershire for the Mass Vaccination Programme and Steve Hams, Director of Quality and Chief Nurse is the Senior Responsible Officer (SRO). The priorities for roll out have been set by the national Joint Committee on Vaccinations and Immunisations (JCVI) Primary care (GPs, practice nurses, dentists etc.) and other healthcare professionals will be at the forefront of delivering the vaccine to the public, with a network of sites being established, throughout Gloucestershire, to support local access. Huge thanks to Steve Hams, and his team, for their phenomenal efforts to mobilise this on behalf *One Gloucestershire*.

2.2 In preparation for the COVID-19 vaccination programme, the Trust had a final push to ensure as many staff as possible were vaccinated by the end of November and achieved 87% which is a phenomenal performance and the best in the region. Staff who have had a flu vaccine are required to wait seven days before receiving their COVID vaccine.

2.3 Until the vaccine has changed the nature of viral transmission, measures to reduce the risk of infection remain vital and one such measure is the regular testing of all patient

facing staff to detect the present of COVID-19 in the small number of staff who have no symptoms but who turn out to be carriers of the virus, and thus potentially transmitting to both patients and colleagues. Using new technology (Lateral Flow Devices) that enables a rapid result to be achieved by staff that self-swab, twice weekly and report their results online. The Trust commenced roll out of its programme at the end of November and to date around 75% of eligible staff have commenced testing. To date, the detection rate has been 1.96% which is on the lower end of nationally reported rates and as such, a positive reflection on the Trust's infection prevention and control practices. Staff that test positive using the LFD, must have their result confirmed via the standard PCR Test.

2.4 This same technology is also being rolled out in care homes throughout the country including Gloucestershire. This is a huge development in enabling the longed for ability of carers and family members to visit residents, many of whom have not seen loved ones since the start of the first lockdown in March 2020. A HUGELY welcome development.

2.5 A significant focus of the ICS is understanding and responding to the health inequalities that have worsened, or presented, as a result of the pandemic. Following the national publication into the impact of COVID-19 on mortality rates amongst people with a learning disability, *One Gloucestershire,* has replicated the national evaluation and although the small numbers require interpretation with caution, positively the inequalities seen nationally are not evident in Gloucestershire. Equally, the work done during wave one of the pandemic to look at the impact of COVID on BAME communities has been replicated for the period September 1st to 30th November with comparable findings i.e. access to hospital care as expected and mortality lower than expected.

2.6 On the 26 November NHS England published The next steps to building strong and effective integrated care systems across England, which builds on previous publications and the route map set out in the NHS Long Term Plan for health and care joined up locally around people's needs The document signals a renewed ambition for how NHSE wish to support greater collaboration between partners in health and care systems to help accelerate progress in meeting the most critical health and care challenges. It is based on the experience of the earliest ICSs and wide input from colleagues across the NHS, local government and wider partners.

The proposals are designed to serve four fundamental purposes:

- improving population health and healthcare
- tackling unequal outcomes and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

In practice this means that from April 2021 all parts of the health and care system nationally will be working together as integrated care systems. Four Sustainability and Transformation Partnerships in the South West Region were awarded ICS status this week and therefore six of the seven systems in the region are now operating as ICSs; Devon are hoping to achieve this status early in 2021. The role and expectations of ICSs have also been refreshed and restated as below;

- stronger **partnerships in local places** between the NHS, local government and others, with a more central role for primary care in providing joined-up care
- **provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale
- developing strategic **commissioning** through systems, with a focus on population health outcomes
- the use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

In addition to setting out expectations for how integrated care systems will work from April 2021, the document also describes options for giving ICSs a firmer footing in legislation likely to take effect from April 2022 (subject to parliamentary decision).

NHS England are consulting on the proposals until 8 January 2021 and One Gloucestershire ICS will respond formally on behalf of member organisations but individuals are equally welcome to respond.

2.7 Relationships with partner University of Gloucestershire (UoG) continue to go from strength to strength with two more exciting developments in train. Following the cessation of the Operating Departing Practitioner (ODP) degree at Oxford Brookes University, the Trust became concerned about the loss of benefits associated with being a training institution as well as becoming concerned about the impact on the future employment pipeline. Sally Beamish, Senior ODP and Practice Educator in our theatres has led the work with UoG to develop a degree programme which will take its first cohort in January and offers both traditional and apprenticeship pathways. The programme has been established in under 18 months which given the context this year, speaks to the responsive of both Trust and University teams who have worked together on the programme. Additionally, reflecting where else we have recruitment challenges, we are also on track to establish a degree programme for biomedical scientists that will see the UoG and Trust delivering degrees in all the main healthcare disciplines with the exception of medical training.

2.8 Since my last report we have continued working with our partner David Weaver Consulting (DWC) who have been engaged to help us develop our approach to inclusion and in particular to expedite our progress on improving the experience of BAME colleagues in the Trust. DWC have been facilitating discussions with a wide range of staff groups and hosted another Facebook Live session with myself and two BAME colleagues - Mr Noel Peter, Trauma Surgeon and Coral Boston, Equality, Diversity and Inclusion Lead. The session, aimed at Trust staff, was well received with more than 4,500 views and some positive follow through on Twitter. Inevitably, given the current challenges, engagement has been more limited than we would have liked and therefore we will be welcoming DWC to provide some initial findings to the Board in January before they return to have further conversations with colleagues after the winter months. The commitment to this agenda from the Board remains one of “action over action plans”.

2.9 Excellence in nursing continues to define Gloucestershire Hospitals and last month I reported that , from a field of many hundreds of nominations, three of our nurses were shortlisted for the *Florence Nightingale Award for Outstanding Contribution by a Nurse*

or Midwife in this year's Health Quality Improvement Partnership (HQIP). Phillip Lort, Nursing Accreditation and Assessment Scheme (NAAS) lead and Sarah Simmons and Katy Murphy, Advanced Neonatal Practitioners. I am delighted to share the news that Sarah and Katy with the WINNERS of this year's national award!

2.10 Finally, as is becoming our monthly tradition, last week we celebrated the contribution of our fabulous ward clerks; this invaluable group have yet to achieve national recognition and so we filled this obvious gap with a day of celebration of the 26 November. Often the back bone of a busy ward, and a key point of contact for relatives and other visitors, the contribution of this group of staff cannot be understated. Steve Hams and/or myself visited every ward in GRH and CGH to hand deliver a "goodie bag" packed with essential stationery items which turned out to be more exciting to this group of colleagues, than any bar of chocolate might have been (although there was a small one of those too!). We are now developing plans for World Admin Day on the 21 April and hoping our recently appointed staff Governor, for this group of colleagues, will work with us to develop a day to be remembered!

Deborah Lee
Chief Executive Officer

9 December 2020

TRUST PUBLIC BOARD – 10 DECEMBER 2020
Microsoft Teams, Commencing at 12:30

Report Title							
TRUST RISK REGISTER (TRR)							
Sponsor and Author(s)							
Author: Lee Troake, Corporate Risk, Health & Safety Sponsor: Emma Wood, Deputy CEO and Director of People & OD							
Executive Summary							
Purpose The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. **Key issues to note** • No new risk have been added to the Trust Risk Register in this reporting period • One Trust risk score has been revised • There have been no proposed downgrades • No risks on the Trust Risk Register have been closed • The Trust Risk Appetite has been revised and the recommended changes noted for approval							
Recommendations							
To note the changes to the Trust Risk Register. The Board is asked to **APPROVE** the changes to risk appetite and tolerance.							
Impact Upon Risk – known or new							
The Risk Management Group and Trust Risk Register 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		**X**	Information Management & Technology				X
Human Resources		x	Buildings				**X**
Action/Decision Required							
For Decision		For Assurance	X	For Approval	x	For Information	
Date the paper was presented to previous Committees							
Divisional Board		**Trust Leadership Team Sub-group**		**Other (Specify)**			
		5th December 2020		Risk Management Group 4 November 2020			
Outcome of discussion when presented to previous Committees **To accept changes recommended**							
Risk register entry amendments were agreed							

TRUST BOARD - December 2020

TRUST RISK REGISTER (TRR)

1. Revised Trust Risk

C3169COVID - Risk of the Trust being unable to deliver or maintain its usual range of comprehensive, high quality services with consequent impact on patient safety, experience and staff wellbeing due to the second wave of COVID-19 Pandemic and winter pressures.

The Safety score was revised to C3 x L4 = 12 and Quality score revised to C3 x L5 = 15 following weekly Executive Review to recognise the increase in COVID-19 inpatients and the pressure on services.

This risk is reviewed on a weekly basis by the Executive Team.

2. Trust Risk Appetite

2.1 The Board considered its risk appetite during two strategic risk sessions in October and November 2020.

2.2 The initial session focussed on the revision of the domain and appetite definitions, which have been agreed as shown in the document below:

Risk Appetite Chart - November 2020.docx

2.3 During the second session consideration was given to the current operating environment and strategic objectives and reviewed risk appetite and tolerance against the new definitions.

2.4 In reviewing the appetite against the definitions the Board agreed to reduce its appetite for Environmental Risk **from open to cautious.** This reflects the fact that the Trust has declared an Environmental Crisis and aims to reduce its impact on the environment. All other domains remained reflective of the Trust's current risk appetite and risk tolerance and no amendments were made.

2.5 The board will review the Risk Appetite on an annual basis or sooner if considered necessary.

2.6 The Trust Risk Appetite is as follows:

	0 - None	1- Minimal	2 - Cautious	3 - Open	4 - Seek	5 - High
		10	12	15	16	20
Safety						
Quality						
People						
Operational						
Regulatory						
Finance						
Environmental						
Reputational						

2.7 Once approved by Board, the following steps will be taken:

- Realign the Trust Risks on the Trust risk register for Public Board
- Review the Risk Strategy and associated policies to support the new Risk Appetite/ Tolerances

Risk Appetite

	None (Completely risk adverse)	Minimal (Highly risk adverse)	Cautious (Moderately risk adverse)	Open (Risk Neutral)	Seek (Moderate risk Tolerance)	Significant (High Risk Acceptance)
	0	**1**	**2**	**3**	**4**	**5**
Safety	We have **no appetite** for decisions that may compromise patient, staff or public safety. We believe that all safety risks are unacceptable and unjustifiable.	We are **highly risk adverse** in relation to safety. We will not take risks unless absolutely critical and, only then, will take as little risk as possible. Safety risks must be reduced regardless of cost, time and effort. E.g. we may risk minor harm to achieve a highly beneficial long term outcome.	We are prepared to take **calculated** safety risks where there is clear and established evidence of a benefit to life / patient outcome, or where further risk reduction is not practical and/ or the cost is disproportionate to the benefit. E.g. we may risk moderate to major harm where there is a clear favourable longer term outcome *and* the risk of this harm is remote or unlikely. We will not tolerate preventable and unjustified patient harm, public and employee health and safety.	We are willing to accept safety risks which are **likely** to materialise and could result in life limiting injuries or long term harm in order to achieve our major objectives.	We are willing to accept safety risks which are **very likely** to materialise and could result in life limiting injuries or long term harm in order to achieve our major objectives or manage our budget and resources to achieve significant savings.	We are prepared to accept **a consistently high level of** risk such as the loss of multiple lives or the very high likelihood of a catastrophic incident that could affect many people in order to make modest cost savings and/or achieve our objectives
Quality	We have **no appetite** for decisions that may have an impact on quality of care thereby affecting patient experience and/or clinical outcomes even if they deliver other benefits e.g. cost savings	We are **highly risk adverse** in relation to anything that may impact upon our quality of care thereby affecting patient experience and/or clinical outcomes, unless there are considerable greater benefits e.g. to the safety of staff and patients	We are prepared to take **calculated** risks in relation to the quality of care where multiple benefits in other areas can be achieved.	We are prepared to accept risks that could result in **more frequent** negative patient experiences and/or clinical outcomes in specific areas of the Trust (or in relation to specific clinical activities) where there is no long term impact on the patient(s), staff or service e.g. the risk is considered tolerable given the time, money or effort to resolve the issues is not considered proportionate to the benefit of doing so.	We are willing to **consciously impact** adversely on the quality of care for many patients to deliver on other objectives we consider to be of greater importance e.g. the delivery of significant cost savings or the pursuit of other objectives which may be detrimental to quality.	We are prepared to accept **a consistently high level** of impact on the long term quality of care where we consider the alternative to be less palatable or the gains to be worthy of the consequent impacts.

People	We have **no appetite** for decisions that could have a negative impact on staff recruitment, retention, development, experience, wellbeing, inclusion or morale All such risks will be resolved regardless of cost or effort.	We are **highly risk adverse** in relation to our people and anything may have a negative impact on staff recruitment, retention, development, experience, wellbeing, inclusion or morale We are prepared to prioritise investment of time and resources into our people to ensure delivery of our wider objectives.	We are prepared to take **calculated** risks with regard to our people. We accept a degree of risk where recruiting, retaining or developing staff is impacted by unavoidable budget constraints or shortages of skills in the employment pool. We will not accept risks that have the potential to impact on the delivery of high quality care or staff wellbeing and morale. E.g. we may risk investment in longer term skill development by adding costs to revenue budgets whilst staff are in training	We are **willing** to accept risks in relation to staff recruitment, retention, development, experience, wellbeing, inclusion or morale to achieve other imperatives e.g. cost savings providing they do not jeopardise the delivery of safe care or impact significantly of the wellbeing of our staff.	We are **willing** to accept risks which, if they materialised, would adversely affect staff recruitment, retention, development, wellbeing, inclusion or morale but would result in delivery of other major objectives e.g. financial balance	We are prepared to accept **a consistently high level** of risk to staff recruitment, retention, development, experience, wellbeing, inclusion or morale in pursuit of other objectives even where there is very high likelihood of long term adverse consequences including reputational damage
Operational	We have **no appetite** for decisions that may impact on our agreed operational model or services. We believe that all operational risks are unacceptable and unjustifiable. We will prioritise investment to maintain the status quo	We are **highly risk adverse** in relation to our operational activities and capability. We are prepared to invest significant time, effort and financial resources into maintaining them and will not consider trialling new operational approaches unless exceptional circumstances present e.g. we are unlikely to consider being a pilot site for a new initiative	We are prepared to take **calculated** risks in relation to our operational model or activities where the risk is relatively minor to our operations and/or from which we are confident we can recover easily and quickly in order to achieve a greater goal for patients or staff.	We are **willing** to accept operational risks where this relates to manageable or tolerable operational issues with no long term impact on the patient(s) or staff and where the time, money and effort to resolve the issues would not be proportionate to the benefit of doing so. We are willing to consider all potential delivery options and may well consider factors such as reward or reputational benefit when weighing up the benefit if taking a risk.	We are willing to accept operational risks which are **very likely to** materialise and which will adversely affect specific specialities or division or activities in order to pursue long term improved performance, quality or safety benefits providing these do not impact on the short term safety of patients and staff.	We are prepared to accept **a consistently high level** of operational risk in pursuit of a higher priority and accept a high level of risk of a severe delay or catastrophic failure of our services and /or a long term impact on operational capabilities from which recovery could take years
Regulatory	We have **no appetite** for decisions that may compromise compliance with statutory, regulatory of policy requirements. We will avoid anything which could be challenged, even unsuccessfully.	We are **highly risk adverse** to regulatory risk. We will not knowingly engage in illegal activity and will take immediate steps to address any identified breach of a regulatory requirement regardless of cost and will achieve compliance before time by horizon scanning and allocating funding and resources.	We are prepared to take **calculated** risks in relation to regulatory compliance where the opportunity cost of not doing so is intolerable. We will not knowingly engage in illegal activity and will seek to comply with all absolute statutory requirements. Where the laws, regulations and standards are about the	We are willing to accept regulatory risk/ action which is **likely** to materialise as long as we can be reasonably confident we would be able to justify and defend this successfully if challenged and such actions are not outside the Trust's values and expected behaviours.	We are willing to accept regulatory risks that will likely result in regulatory intervention or one-off litigation, enforcement or breach of contract but will yield higher rewards in other areas of our organisation.	We are prepared to accept **a consistently high level** of regulatory risk and will consistently push back on regulatory burden. We understand the threat / consequences of repeated civil litigation, criminal prosecution / enforcement, or breach

			delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations, unless there is strong evidence or argument to challenge them. Where regulatory changes allow for best practice or are not retrospective we will form a balanced judgement on what is reasonably practicable to achieve.			of contract but consider the benefits to be greater than the adverse consequences.
Finance	We have **no appetite** for decisions or actions that may result in any level of financial risk, loss or liabilities. The Trust must meet its statutory financial duties each financial year. The Trust must deliver against agreed budget plans whatever the impact on patient safety, care quality and staff wellbeing.	We are **highly risk adverse** to financial risk. Financial balance is our primary concern and we are only willing to accept financial risk or overspending where to do so would prevent the jeopardising of the safety and/or the quality of care.	We are prepared to take **calculated** risks in relation to Finance. The Trust must meet its statutory financial duties each financial year. We will strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate intolerable risks to safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.	We are willing to accept financial risks which are **likely** to materialise if this allows the Trust to support investments for potential greater return. We accept a material level of risk for investments which may further the organisation's strategic objectives providing there is a clear route back to financial balance.	We are willing to accept financial risks which are **very likely to** materialise and when there is no clear guarantee of return but a potential return that is considered of significant value to delivery of then organisations goals.	We are prepared to accept **a consistently high level** of financial risk to speculate against future opportunities of uncertain delivery but great benefit
Environmental	We have **no appetite** for environmental risk and will prioritise sustainability regardless of costs or practicality. We intend to take stringent measures across the Trust to achieve this, opting for the best solution rather than value for money.	We are **highly risk adverse** to environmental risks. We will prioritise sustainability by tackling all aspects of sustainability. For example by limiting our use of non-renewable energy sources, prioritise a significant reduction to our carbon footprint and atmospheric pollution, reduce our level of contaminated waste, increase recycling and invest heavily in sustainable buildings and systems, regardless of costs or	We are prepared to take **calculated** risks relating to low level environmental damage, accepting that our finite resources and budget will constrain our desire to improve against all aspects of sustainability. However, we will endeavour to ensure that our practices are as sustainable as possible, with the time and resources available to us.	We are willing to accept moderate environmental risks which may result in a significant impact on the environment where investment in mitigation is high cost and/or other objectives and goals may be put at risk.	We are willing to accept environmental risks which are **very likely** to result in a significant impact on the environment. Investment in sustainability will be actively minimised in order to ensure finite resources are diverted to other objectives and goals. We will invest if absolutely necessary to avoid enforcement action.	We are prepared to accept **a consistently high level** of environmental risk and accept our practices may result in catastrophic environmental damage, that we may be a significant contributor to environmental pollution and that our estates is not sustainable. We have no desire to prioritise environmental risks.

		practicality.				
Reputational	We have **no appetite** for reputational risk and will not knowingly take risk in relation to even minor issues. We will not tolerate any decisions that could jeopardise the positive reputation of the Trust in the eyes of the public, partners, patients or media.	We are **highly risk adverse** to reputational risk. We will tolerate only very minor isolated cases of adverse attention with minimal external or internal reputational damage in order to achieve importance goals.	We are prepared to take **calculated** risks with our reputation when the benefits outweigh the potential adverse impact. However, these must be no more that the risk of a small cluster or sporadic episodes of adverse attention where no effort is required to recover and mitigations are place for any undue interest.	We are willing to accept reputational risks which are **likely** to expose the organisation to additional scrutiny/interest but would incur no more than short-term interest. Reputational damage that would impact on the medium term goals of the organisation would be actively avoided.	We are willing to accept reputational risks where a course of action is considered to be the right one to take to improve the safety or quality of care and/or deliver enhanced value for money which is in the longer term interests of the Trust even if the organisations reputation is negatively impacted in the short to medium term.	We are prepared to accept **a consistently high level** of scrutiny or interest in the organisation and will take little account of external or internal views or representation in pursuit of our goals. We will take difficult and unpopular decisions which may lead to serious damage public and staff confidence in our Trust where we feel this is necessary.

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead title	Title of Strategic Group	Title of Operational Group	If other, please specify name of Operational Group	Title of Assurance Committee / Board	Date Risk to be reviewed by	Operational Lead for Risk	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	Review, Assess and enact agreed future actions/controls	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	Estates and Facilities Contract Management Group, Infection Control Committee	Other	Opened by Strategic Group	Quality and Performance Committee, Trust Leadership Team	04/12/2020	Akin Makinde	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.	Duct cleaning only possible when ward is fully decanted. Implement ward closure programe to provide access to undertake the works. Ward 3B being assessed for ability to undertake works this Summer	Corporate, Gloucestershire Managed Services	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	Chief Operating officer	Divisional Board - Corporate / DOG, Emergency Preparedness and Resilience Group, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		Executive Management Team, GMS Board, Trust Board, Trust Leadership Team	30/10/2020	Steve Rowe	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	Refurbish the roof outside and make safe To undertake a comprehensive structural survey of the external elevations of Centre Block to identify all areas requiring repair or replacement and to undertake those works Planning permission for investigatory works	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	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee			GMS Board, Trust Board, Trust Leadership Team	04/12/2020	Akin Makinde	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls	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	Divisional Board - Corporate / DOG, Quality Delivery Group	Other	Falls and Pressure Ulcers Group	Quality and Performance Committee, Trust Leadership Team	30/10/2020	Craig Bradley	Trust Risk Register
C3169MDCOVID	Risk of the Trust being unable to deliver or maintain its usual range of comprehensive, high quality services with consequent impact on patient safety, experience and staff wellbeing due to the second wave of COVID-19 Pandemic and winter pressures.	Safety & Quality • Winter pressure plan in place • RED ED flip / RED surge Plan • Empty two green bays on 8a to create red capacity • Paediatrics red area • Following National Guidance across all domains / reviewing guidance and applying according to local circumstances • Fit testing programme • PPE training provision, training, information and PPE Safety Officers / social distancing guardians • Action cards published for staff • Pathways for trauma for COVID and non COVID for all specialties • COVID testing on admission, testing on day 5 • Outbreak MDT meetings - clinical staff, ICP and Safety • COVID Secure programme & working group • Provision of social distancing materials / guidance and PPE • All staff to wear masks if within 2m of others • Patients to be required to wear mask	Establish IMT to manage response	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	COVID-19 Task and Finish Group, Risk Management Group	COVID-19 Incident Management Team, Case and Bed Modelling (Bronze COVID Group), Communications (Bronze COVID Group), Digital and Virtual Care (Bronze COVID Group), Impact on Elderly and Vulnerable (Bronze COVID Group), Staffing (Bronze COVID Group), Supplies and Equipment (Bronze COVID Group)		People and OD Committee, Quality and Performance Committee, Trust Board, Trust Leadership Team	30/11/2020	Felicity Taylor-Drewe	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value £60m), resulting in patients and staff being exposed to poor quality care or service	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 Ongoing escalation to NHSI and system	Corporate, Gloucestershire Managed Services	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Finance	Divisional Board - Corporate / DOG	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	31/12/2020	Akin Makinde	Trust Risk Register
C3253PODCOVID	Risk to the health of staff working in the healthcare setting who are extremely clinically vulnerable,	1. Risk assessment templates provided to managers to support a personal risk assessment for each member of staff	To set up SD guardians Risk Assessment Audit for NHSE/I	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical,	Safety	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	Deputy CEO and director of People	Trust Health and Safety Committee	COVID-19 Incident Management Team, Staffing (Bronze COVID Group)		People and OD Committee	31/12/2020	Alison Koeltgen	Trust Risk Register
C3224COOCOVID	Risks to safety and quality of care for patients with increased waiting in relation to the services that were	• RAG rating of patients in clinical priorisation & Clinical Harm Reviews • Movement of the acute take from	Incremental step up of elective activities, including through the independent sector	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Infection Control Committee, Planned Care Delivery Group, Trust Health	COVID-19 Incident Management Team, Case and Bed Modelling (Bronze COVID Group), Communications		Quality and Performance Committee, Trust Leadership Team	31/12/2020	Felicity Taylor-Drewe	Trust Risk Register

	suspended or which remain reduced	CGH to GRH (see issues outlined in gaps below) ED dept at CGH will	Continued review of clinical waiting lists	Children's						and Safety Committee	(Bronze COVID Group), Digital and Virtual Care (Bronze COVID			
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	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	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab	Medical	Safety	Major (4)	Possible - Monthly (3)	12 8 -12 High risk	Medical Director	Capital Control Group, Centre of Excellence Delivery Group, Divisional Board - Medical	Medical Devices Group, Medical Equipment Fund	Service Review Meetings	30/12/2020 Joseph Mills	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	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties	Statutory	Major (4)	Likely - Weekly (4)	16 15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - D & S	Pathology Management Board		31/12/2020 Jonathan Lewis	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 illness, behavioural, emotional and social difficulties, with potentially	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	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to 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	Other	Safeguarding Adults Operational Group, Safeguarding Children Operational Group / Board		31/12/2020 Vivien Mortimore	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.	Monitoring and ensure all areas received the approrpaite training and drills to evaucate patients safely	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	Divisional Board - Corporate / DOG, Emergency Preparedness and Resilience Group, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee	GMS Board, Trust Board, Trust Leadership Team	28/08/2020 Alison McGirr	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	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key speciailities to support f/u clearance of backlog	Medical, Surgical	Quality	Moderate (3)	Almost certain - Daily (5)	15 15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Quality Delivery Group	RTT Task Group	Trust Leadership Team	31/12/2020 Felicity Taylor-Drewe	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	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	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	Digital Care Board, Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Systems Safety Group, Resuscitation and Deteriorating Patient Group	Quality and Performance Committee, Trust Leadership Team	30/10/2020 Ben King	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	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	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	Divisional Board - Corporate / DOG, Finance and Digital Committee, Trust Health and Safety Committee, People and OD Delivery Group	Quality and Safety Systems Group	Finance and Digital Committee, People and OD Committee, Trust Leadership Team	07/12/2020 Lee Troake	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	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Major (4)	Likely - Weekly (4)	16 15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Planned Care Delivery Group	Out Patient Board	Quality and Performance Committee, Trust Leadership Team	31/12/2020 Felicity Taylor-Drewe	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	Fire extinguisher training Simulation training to evaluate hoverjack and slide sheets Discuss estates option for creating adequate fire escape facilities Purchase of twenty sliding sheets order oxygen cylinder holders Evacuation practice	Gloucestershire Managed Services, Surgical	Safety	Catastrophic (5)	Rare - Less than annually (1)	5 4 - 6 Moderate risk	Chief Operating Officer	Divisional Board - Surgery			13/01/2021 Rebecca Offord	Trust Risk Register
		RN identified for ambulance assessment corridor 24/7 Identified band 3 24 hours a day for	Complete CQC action plan Compliance with 90% recovery plan											

M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	third radiology corridor with identified accountable RN on every shift Additional band 3 staffing in ambulance assessment corridor 24 hours a day - improvement in NEWS compliance and safety checklist Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH)	Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Director of Safety	Divisional Board - Medical, Trust Health and Safety Committee	Resuscitation and Deteriorating Patient Group		Trust Leadership Team	30/11/2020	Tiffany Cairns	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	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	26/02/2021	Carole Webster	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	Replacement, or upgrade of windows. 100 windows need replacing throughout the Tower Block. Decision to be made as to whether each window needs to be replaced, or whether each window is replaced on a ward first at a cost of £30, 000 per ward Review, assess and enact agreed future actions/controls	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	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Trust Health and Safety Committee	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	04/12/2020	Akin Makinde	Trust Risk Register
C3295COO	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred	No Further actions	Corporate	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Operating officer	Divisional Board - Corporate / DOG			Trust Leadership Team	31/12/2020	Felicity Taylor-Drewe	Trust Risk Register
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Medical	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of Quality and Chief Nurse	Divisional Board - Medical, Emergency Care Delivery Group	Emergency Care Operational Group		Emergency Care Board, Trust Leadership Team	31/12/2020	Anna Blake	Trust Risk Register
S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends	Deliver the agreed action fractured neck of femur action plan Develop quality improvement plan with GSIA Review of reasons behind increase in patients with delirium Development of parallel pathway for patients who fracture NOF in hospital	Surgical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	medical Director	Divisional Board - Surgery				30/10/2020	Diana Thomas	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	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	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	Infection Control Committee			Quality and Performance Committee	30/10/2020	Craig Bradley	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.	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Diagnostics and Specialties	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - D & S	Pathology Management Board			17/12/2020	Linford Rees	Trust Risk Register
			1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions														

C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at 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.	3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group		Trust Leadership Team	30/10/2020	Craig Bradley	Trust Risk Register

TRUST BOARD – 10 DECEMBER 2020

Report Title
BOARD ASSURANCE FRAMEWORK
Sponsor and Author(s)
Author: Sim Foreman, Trust Secretary Sponsor: Emma Wood, Deputy CEO and Director of People and OD
Executive Summary
To present the Board Assurance Framework (BAF) as at the end of Q2 2020/21. The principal risks to the Strategic Objectives set out in "Our Journey to outstanding 2019 – 2024" are reviewed on a quarterly basis by the Lead Executives and updates presented for review by the relevant board assurance committee that holds oversight for the risk. The Audit and Assurance Committee receives the BAF in its entirety. The assurance committees agree the final level of assurance rating for each objective for Q2 2020/21 after considering the levels proposed by the Executive. Those principal risks that are rated RED are presented to the Board along with the agreed assurance ratings. There are **26** principal risks on the BAF. There are NO new risks and NO risks proposed for closure.
Recommendations
The Board is asked to: a) **REVIEW** the controls and assurances in place for those principal risks reported to the Board and assure itself that these are adequate; b) **APPROVE** the BAF and NOTE the updates and agreed assurance ratings for Q2 2020/21.
Impact Upon Strategic Objectives
The BAF is an assurance framework relating to the delivery of all Strategic Objectives.
Impact Upon Corporate Risks
Related risks from the Trusts Risk Register have been identified and mapped to each principal risk.
Regulatory and/or Legal Implications
As a Foundation Trust it is important that the BAF works as a tool to support the Board's assurances in terms of self-certification on compliance with its Terms of Authorisation. The Care Quality Commission (CQC) well-led domain requires a robust management of risk and assurance framework of all good and outstanding Trusts.
Equality & Patient Impact
The management of risk and assurance that the Trust is being managed effectively to deliver the strategic objectives will positively impact upon patient safety and experience and the equitable provision of services.

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

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
18 November 2020	26 November 2020	24 November 2020	*22 December 2020			Estates & Facilities 26 November 2020

Outcome of discussion when presented to previous Committees
Committees NOTED the updates to the principal risks assigned to them and APROVED the any changes to risk scoring. The Committees AGREED the proposed assurance ratings for each Strategic Objective. **Due to the meeting cycle the People & OD Committee will not review its BAF until December meeting.*

Board Assurance Framework

1. Introduction

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

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

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

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

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

The Board last reviewed the whole BAF in September 2020 and it was agreed as part of that process that oversight of principal risks previously allocated to the Board should be transferred to assurance committees. The Board holds overall responsibility for the BAF with detailed challenge and assurance of the whole document taking place within Audit & Assurance Committee/

2. Key Points to note

There are **26** principal risks on the BAF.

There are NO new risks and NO risks proposed for closure.

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

The Board is asked to note the assurance on SO-07 "Financial Balance" was rated as LIMITED (RED) at the time of the review at the end of September 2020, due to the impact of the coronavirus pandemic on the NHS funding regime. The Director of Finance reported to the Finance and Digital Committee that the Q2 assessment had taken place whilst the finance team were still finalising the second part of the year and the plan has not been signed off, but would reflect her increased certainty on the deliverability of the plan in the Q 3 update to reduce the assurance rating back to AMBER.

The Estates and Facilities Committee agreed a RED assurance rating for SO-8 Effective Estates as it was felt more work was needed in relation to assurance on backlog maintenance. The next update will include more details on this work to address the assurance gap.

Board Assurance Framework

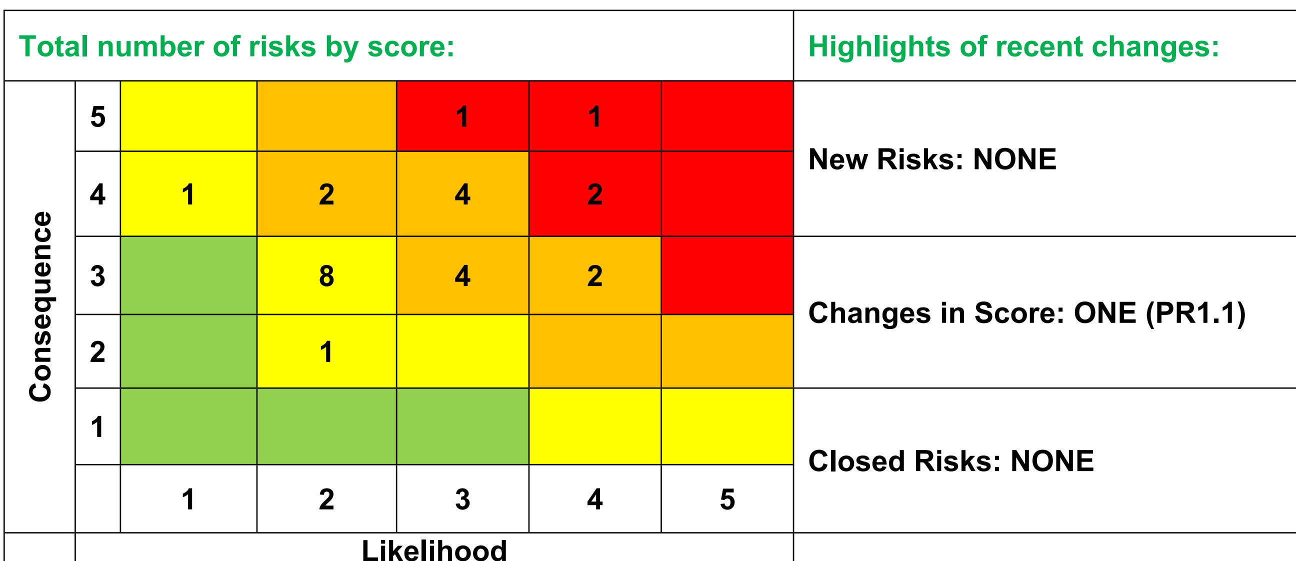
The Audit and Assurance Committee commented on the GREEN assurance rating for SO-05 Involved People and the work required to implement and deliver the Engagement and Involvement Strategy and agreed this would be discussed at the People and OD Committee. It was also agreed the Audit and Assurance Committee would in future receive the BAF after committee reviews had taken place (mindful that one bi-monthly committee will always be out of step).

3. BAF Summary

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

Table 1 shows the risk profile for Q2 2020/21 and provides a summary of any changes made to the BAF affecting the risk profile.

Table 1: BAF Risk Profile Q2 2020/21



Total number of risks by score:							Highlights of recent changes:
Consequence	5			1	1		New Risks: NONE
	4	1	2	4	2		
	3		8	4	2		Changes in Score: ONE (PR1.1)
	2		1				
	1						Closed Risks: NONE
		1	2	3	4	5	
	Likelihood						

4. Recommendation

The Board is asked to:

a) **REVIEW** the controls and assurances in place for those principal risks reported to the Board and assure itself that these are adequate;
b) **APPROVE** the BAF and NOTE the updates and agreed assurance ratings for Q2 2020/21.

Appendices

1) Summary of the BAF risk and assurance ratings for 2020/21
2) Risk and Assurance Ratings
3) Principal Risks (RED rated) where (Red text indicates updates)

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

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

Appendix 3 – Principal Risks and Quarterly Progress Update

Assurance Ratings

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

Risk Ratings

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

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

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

<table>
<tr><td>Principal Risk ID</td><td>7.1</td><td colspan="5">Risk that we lack the capacity and capability needed to identify and/or deliver transformational, sustainable savings schemes</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>3 x 2</td><td colspan="2">Current Score
(C x L)</td><td>5 x 3</td></tr>
<tr><td colspan="2">Risk Owner
(Executive Director)</td><td colspan="2">Director of Finance</td><td colspan="2">Oversight/Assurance Committee</td><td>Finance and Digital</td></tr>
<tr><td colspan="3">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="4">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="3">1. Operational plan
2. Cost Improvement Programme
3. Engagement on CIP through Involve, CEO weekly blog, 100 Leaders, Extended Leadership Network
4. Improved engagement with budget holders on budget setting process
5. Capability development (Count Me In programme; PMO support to divisions)</td><td colspan="4">1. Monthly CIP update to Finance and Digital Committee
2. Programme Management Office record and monitor the CIP progress
3. Financial Sustainability Delivery Group scrutiny of CIP delivery
4. Executive reviews with divisions include focus on financial recovery and CIP delivery
5. Audit reports</td></tr>
<tr><td colspan="2">Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td colspan="2">Update</td></tr>
<tr><td colspan="2">Finance strategy</td><td>Strategy under development</td><td>KJ</td><td>September 2020</td><td colspan="2">Strategy publication date amended to allow stabilisation of senior finance function.
Update given to F&D on contents and timeline in August, draft strategy due to F&D in November with final version planned for December.</td></tr>
<tr><td colspan="2">Appetite to generate transformational ideas</td><td>To promote and encourage the generation of transformational ideas across the Trust, and within Divisions in particular</td><td>Execs/SL</td><td>September 2020</td><td colspan="2">KJ identified need to establish where ideas coming are from and to encourage other areas to engage and submit proposals.
A positive outcome of the pandemic has been the speed in which we have implemented change, some of the change is transformational and is being picked up by the Silver lining documentation. The challenge will be how we</td></tr>
</table>

				drive out the inefficiencies and push towards being a financially sustainable organisation.
Organisational culture re: financial sustainable improvement not fully embedded.	Strengthen organisational awareness to the need for financial sustainability	KJ	June 2020	Build on the Count Me In programme to ensure more staff become aware and engaged in the need to ensure the Trust is financially sustainable Senior finance team now in place and the focus is understanding the drivers of our deficit/spend Implementing a budget management statement due to be rolled out in August. Looking to develop a communication strategy around how we energise the organisation to drive and own their efficiencies. Having the right tools to give staff will enable them to own their position and make the right decisions to improve services and drive out waste and inefficiencies.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**

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

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

Principal Risk ID	**7.3**	Risk that the commissioner funding does not address structural funding deficit over the strategic period		
Principal risk to Achievement of the Objective *Including target and current risk score*	**Target score (C x L)**	4 x 3	**Current Score (C x L)**	5 x 4
Risk Owner (Executive Director)	Director of Finance		**Oversight/Assurance Committee**	Finance and Digital

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Contract negotiations with commissioners informed by 'drivers of deficit' report	1. Financial performance report to Finance and Digital Committee and to Board 2. ICS Board

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Finance strategy	Strategy under development	KJ	October 2020	Strategy publication date amended to allow stabilisation of senior finance function. Progress being made and still working towards the Sept deadline. Update given to F&D on contents and timeline in August, draft strategy due to F&D in November with final version planned for December.
Limited influence over commissioner funding	Work with the ICS to develop new approaches to contracting and a sustainable funding settlement	KJ		Contract envelope agreed for 20/21, where growth is managed across the system. Risk share approach needs to be agreed. This has been superseded by the change in the financial framework due to COVID-19. New financial framework for the rest of 2020/21 continues to encourage system working. Large pot of system resource to be allocated across the system. Good system discussion and prioritisation. Beyond 2020/21 is unknown although it is likely that contractual agreements will continue to encourage system working.
Limited influence over	Five year system planning	RDC/SL/KJ		The Trust has no influence over the level of

commissioner funding				funding the commissioner receives however it will have some influence as part of the ICS about how that funding is apportioned out across the provider sector.
Ability to explain the structural deficit in a clear way		KJ		This has been presented to F&D for discussion however the pandemic took priority. A further discussion will be needed. The Trust has refreshed the drivers of the deficit which will be discussed at F&D Committee during November.
Funding for 2020/21 unknown	Regular ICS discussion about how we collectively get an understanding about what drives spend across the system. To proactively engagement with regional colleagues to keep up to date on national changes	KJ	August 2020	The current funding arrangement will cease from 31 July. New arrangements in place by 1 August. Work ongoing around the drivers of our costs across the system. This becomes more challenging for the Trust and a significant call on resources as we have limited service line reporting. The financial regime continued until End of Sept. New financial regime remains on a block but key message is to breakeven which requires the system to make significant efficiencies in order to deliver this.
Future funding arrangements for 2021 and beyond not clear	ICS Finance group already established to understand the new guidance when it is published. To proactively engagement with regional colleagues to keep up to date on national changes	KJ		Although the issue is being raised nationally, no guidance or indication on what next year looks like has been shared. Regular regional conference calls are in place to keep abreast of current and future plans.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
ICS – Strengthening				

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

Related Risks from the Trust Risk Register		
Code	Risk description	C x L Score (Domain)
F3269	There is a risk that the Trust spends more than it receives as income, resulting in the Trust missing its control total for 2020/21 and, therefore, receiving additional grip and control requirements from NHSI.	*3 x3*
F3270	There is a risk that the Trust is unable to return to pre-Covid-19 levels of business as usual (BAU) for activity-based contracts, for example as a result of social distancing on clinical wards or in diagnostic / outpatient services, or that the Trust loses control of its finances in trying to regain BAU following Covid-19, and that this results in the Trust missing its control total for 2020/21.	

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

<table>
<tr><td>Principal Risk ID</td><td>7.4</td><td colspan="4">Risk that we do not have sufficient capital funding for transformation including the Centres of Excellence Programme and the Strategic Site Development Programme and/or cash flow risk due to phasing of the programmes</td></tr>
<tr><td colspan="2">Principal risk to Achievement of the Objective
Including target and current risk score</td><td>Target score (C x L)</td><td>2 x 2</td><td>Current Score (C x L)</td><td>4 x 4</td></tr>
<tr><td colspan="2">Risk Owner (Executive Director)</td><td colspan="2">Director of Finance</td><td>Oversight/Assurance Committee</td><td>Finance and Digital</td></tr>
</table>

<table>
<tr><td colspan="2">Key Controls
What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups</td><td colspan="3">Sources of assurances on Controls
What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment</td></tr>
<tr><td colspan="2">1. Capital plan
2. NHSI funding bids
3. Estates Strategy
4. Strategic Site Development Programme Outline Business Case</td><td colspan="3">1. Financial performance report to Finance and Digital Committee and to Board
2. Capital update to Finance and Digital Committee
3. External audit
4. Business cases (for Centres of Excellence Programme and for the Strategic Site Development Programme) presented to Finance and Digital Committee and to Board for approval
5. Oversight of Strategic Site Development Programme at Estates and Facilities Committee</td></tr>
<tr><td>Gaps in Controls
The control is not in place or not effective, due to the design of the control or the likelihood of it being effective</td><td>Actions for gaps</td><td>Owner</td><td>Date</td><td>Update</td></tr>
<tr><td>Strategic capital funding options</td><td>Finance and Digital Committee oversight; Estates and Facilities Committee input</td><td>KJ</td><td>April 2020</td><td>Address by April 2020 for Fit For the Future (FFtF)
Due to impact on COVID-19 the allocation of capital has changed. Systems are now given an allocation and they need to live within that. There are not alternative capital pots to be claimed against.
Although each system had an allocation at the start of the year there have been further opportunities to bid for targeted capital money during the year. The Trust has been successful in achieving significant additional money which has allowed the Trust to accelerated schemes ahead of plan.</td></tr>
</table>

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

Finance strategy	Strategy under development	KJ	September 2020	Strategy publication date amended to allow stabilisation of senior finance function. Update given to F&D on contents and timeline in August, draft strategy due to F&D in Novemeber with final version planned for December.
Capital backlog maintenance	Identify and implement plans to address £60m backlog.	KJ	June 2020	Confirmed that Trust can't apply for general loan as in previous years. It has to be through emergency capital. This could slow investment and delay ambition to strategic projects linked to Centres of Excellence. New capital funding regime for 2020/21 that gives an allocation to systems as mentioned above. The Trust is looking at developing a refurbishment programme as the backlog maintenance will continue to be an issue for the Trust. The Trust was successful in bidding for funding targeted to reduce the critical infrastructure risk of over £2m. Although this doesn't clear the backlog it does allow the Trust to reduce the risk.
Equipment asset register may not capture everything	Develop and strengthen full asset register for capital equipment	KJ		No update, no progress to date Currently working with IT regarding compatibility our current asset register with our current software.
No long term capital allocation from the centre.	Review plans to mitigate the impact of no central long term capital allocation.	KJ	October 2020	Hopeful to receive more information from the Autumn Statement. Due to COVID, unlikely to get any long term capital allocations in the foreseeable future.
Gaps in Assurances *Cannot get evidence whether controls are effective due to the design of the assurance or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
Related Risks from the Trust Risk Register				

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

Code	Risk description	C x L Score (Domain)
F2522	*Risk that available capital is insufficient to support requirements associated with buildings maintenance, equipment renewal and backlog maintenance resulting in major operational impacts and increased costs. To remain at 4x4 due to the level of risk around the Trusts backlog maintenance programme.*	*4 x4*

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

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

Key Controls *What existing controls are in place to manage the risk? Include both external and internal controls. E.g. Strategies, Policies, Action plans, Events, Delivery groups*	**Sources of assurances on Controls** *What sources of assurance are there to provide assurance that the controls are effective? Include both external and internal sources. E.g. reviews, reports, inspections, audit, benchmarking, surveys, visits, KPIs, accreditation schemes, feedback, self-assessment*
1. Capital programme priorities informed by Trust and Divisional risk registers 2. Develop pre-emptive business cases in anticipation of national calls for capital bids 3. Operationalise GHFT Estates Strategy to produce a Development Control Plan 4. Develop Managed Equipment Service (MES) Business Case 5. £39.5M Strategic Site Development Programme (SSDP) 6. Investigate and develop alternative sources of capital funding	1. Capital programme update to Finance and Digital Committee and Trust Board 2. SSDP FBC to Finance and Digital Committee, Estates Committee and Trust Board 3. Progress on operationalising Estates Strategy reported to Estates Committee 4. MES business case to Finance & Digital Committee and Trust Board 5. Monitor and respond to national calls for capital bids 6. Use Estates Strategy and Development Control Plan to prioritise investment 7. All GHFT enabling strategies being approved by appropriate Board committees and then presented to Trust Board for assurance

Gaps in Controls *The control is not in place or not effective, due to the design of the control or the likelihood of it being effective*	**Actions for gaps**	**Owner**	**Date**	**Update**
SSDP Full Business Case	FBC under development	Director of Strategy	FBC – Dec 2020	SOC – approved by Board in Nov 2018 OBC – approved by Board in Feb 2020
Finance strategy	Strategy under development	KJ	~~September 2020~~ December 2020	Update given to F&D on contents and timeline in August, draft strategy due to F&D in November with final version planned for December.

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

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

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

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

TRUST PUBLIC BOARD – 10 DECEMBER 2020
Microsoft Teams commencing at 12:30

Report Title
Emergency Preparedness, Resilience and Response (EPRR) Assurance Report 2020-21
Sponsor and Author(s)
Author: Dickie Head, Head of Resilience and EPRR Sponsor: Rachael de Caux, COO
Executive Summary

Purpose
To provide assurance to the Trust's Board with regard to the Trust's performance in achieving the set Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

The attached letter from CCG formally confirms their assessment of the Core Standards that have been met and the overall standard achieved – **SUBSTANTIALLY COMPLIANT** for 2020-21.

Key issues to note
In contrast to previous years and in acknowledgement of the unique circumstances of the COVID19 pandemic NHSE / I requested a simple statement of assurance concerning the Trust's performance in EPRR. They have requested that there be a focus and update on:

1. **Progress of partially or non-compliant EPRR Core Standards within the Trust**
   - The Trust assesses and has supplied evidence that five of the previous 11 Partially Compliant Core Standards have now reached Fully Compliant Status.
   - A general self-assessment of those Core Standards that were compliant in the previous year indicates that they remain compliant this year. This assessment is reinforced by the activity that COVID19 has generated in EPRR across the Trust.
   - The Trust therefore self-assesses that it is fully compliant with regard to 58 Core Standards out of 64 and has therefore achieved **Substantially Compliant** status for 2019-20, improving on last year's Partially Compliant assessment.

2. **The identification and application of learning from the first wave of the COVID-19 pandemic**
   - A significant amount of Lessons Identified came out of the first wave of the COVID-19 pandemic. These have manifested themselves in a number of ways including:
     - IMT
     - Dashboard
     - Extensive Divisional Learning and Action Plans
     - A robust approach to Task and Finish.
   - Much work has taken place to transition Lessons Identified in to Lessons Learned.

3. **Incorporating progress and learning into winter planning**
   - An extensive and wide ranging Winter Plan has been formulated and attached as evidence. Concurrent Threats have been addressed including COVID 19; influenza; inclement weather; and EU exit.

4. **Chemical Biological, Radiological and Nuclear (CBRN) Audits**
   - The Trust's self-assessment is that it is Fully Compliant in all aspects of CBRN other

than the use of a rota system which drops the assessment to **Partially Compliant**.

Conclusions

- The EPRR Recovery Plan that has been put in place has proved effective in making positive and embedded improvements resulting in a rise in self-assessed status.
- The introduction of EPRR Leads in Divisions has proven instrumental in implementing improvements. This has proven to be a highly successful model.

Implications and Future Action Required

- The Trust EPPR strategy will build on the use of the EPRR Recovery Plan, expanding it to cover all EPRR Core Standards and integrating it into Business As Usual.
- EPRR has a higher profile than in previous years – much due to its importance during COVID19 crisis planning. The Trust must build on the progress made in the last 12 months. The raised profile and progress must be used to embed EPRR practices and procedures into the Trust's DNA.
- A formal Trust-wide EPRR Strategy for 2020-21 will be drafted by end-Nov 20 in order to ensure progress is maintained and the drive towards Full Compliance is continued.

Recommendation

The Trust Board are requested to NOTE the report for assurance compliance.

Impact Upon Strategic Objectives

Supports overall objective of 'Journey to Outstanding'. Supports 'Outstanding Care'; Involved Staff. Demonstrated 'Quality Improvement'.

Impact Upon Corporate Risks

A spectrum of corporate risks have been mitigated. These are actively monitored and reported on by GMS; the Security Management Group; the Fire Safety Committee; the EPRR Assurance Team; and EPRR Group.

Regulatory and/or Legal Implications

Regulatory Implication: A significant move up from Partially Compliant to Substantially Compliant. The subsequent target is 100% Fully Compliant status.

Equality & Patient Impact

Equality Impact: Not applicable
Patient Impact: A safer and more secure environment.

Resource Implications

Finance	NA	Information Management & Technology	NA
Human Resources	NA	Buildings	NA

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)
24 Nov 20	NA	NA	NA	NA	NA	4 Nov 20	NA

Outcome of discussion when presented to previous Committees/TLT

DOAG approved the submission of the initial document that was submitted to CCG. The document has since been slightly amended following a construct Confirm and Challenge Process on 21 Oct 20. The document was subsequently passed through TLT on 4 Nov 20 and then approved by the Audit and Assurance Committee on 24 Nov 20 for onward submission to the Trust Board.

**Note this paper contains embedded documents as evidence of assurance; details have been made available through Committee review process and requests for specific detail should be directed to the Corporate Governance team.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST EPRR ASSURANCE 2020-21

EPRR/Assurance/2020-21/GHNHSFT Response

27 October 2020

References:

A. EPRR Annual Assurance Process and Winter Planning for 2020/21 from NHSE / I dated 20 August 2020
B. South West Assurance Process 2020/21 from NHSE / I – South West Regional team dated 25 August 2020

Introduction

1. As requested and in line with Refs A and B the Gloucestershire Hospitals NHS Foundation Trust (GHFT) is mandated to submit an annual EPRR assurance statement to the NHS Gloucestershire Clinical Commissioning group (CCG). Notwithstanding the impact of COVID19 on Business As Usual and the desire of the Gloucestershire CCG to conduct the process to demonstrate progress that has been made in EPRR across the Trust. This letter supplies an overview of progress since the last assurance process and an update to those specific areas defined in Ref A. including the supporting evidence to corroborate and assure the assessment of compliance made by the Trust.

Overview

2. In the last year the overall rise in awareness, relevance and hence application of EPRR good practice has improved dramatically across the Trust. Our general self-assessment is that there has been a significant step-change in the practical application of good EPRR working practices Trust-wide. While the impact of COVID19 is clearly regrettable the rise in the awareness and application of EPRR must be viewed as a consequence that will have a positive impact when handling future crises. The Trust will strive to ensure such lessons are embedded in to our DNA through a combination of a set of Trust-wide common processes and procedures; a structured and rolling series of exercises and training; and an engagement and involvement strategy aimed at raising the profile and understanding of EPRR amongst the Trust's staff.

3. Following the last round of EPRR Assurance when the Trust was found to be Partially Compliant a formal EPRR Recovery Plan was instigated to address some of the many challenging long-term issues. Notwithstanding the impact of COVID19 the Trust has made significant inroads into addressing those issues where it was found wanting. As part of the Recovery Plan the EPRR Assurance Group was established meeting formally on a regular basis every two weeks, and connecting informally on a daily basis. EPRR leads at Deputy Divisional Level have been formally appointed, with deputies, by each Division to lead in this critical area. The impact of the team and its regular drumbeat of activity is not to be underestimated in providing leadership, assurance, and raising the profile of EPRR across the Trust.

4. The Leadership function in EPRR has been further reinforced by the recent appointment of a Head of EPRR and the forthcoming appointment of a Senior Manager of Resilience and EPRR demonstrating the Trust's long term commitment to this functional area.

5. The deployment of an Incident Management Team (IMT) throughout the COVID19 first wave has been instrumental in delivering organisational resilience and an agile response. This development is covered in detail in Paragraph 10.

6. Infrastructure improvements have included the identification and creation of a series of modern and capable Incident Control Centres (ICC). These will include multiple workstations; new telephony (both digital and analogue for resilience); smart screen and videoconferencing facilities; mapping; and both electronic and hard copies of Action Cards and contingency plans. Work is still underway, but a Primary ICC located in GRH Tower Block reached Initial Operating Capability (IOC) on 14 October 2020. Full Operating Capability is anticipated for late Nov 2020. A Secondary ICC will also be located at GRH Chestnut House to reach IOC by mid-Dec 2020, with a tertiary planned for CGH to reach IOC in early 2021.

Progress of partially or non-compliant EPRR Core Standards within the Trust

7. In 2019 the Trust self-assessed that it was Partially Compliant in 4 Core Standards. NHSE/I assessed that a further 12 Core Standards were also Partially Compliant. Subsequently, with the submission of further evidence, this was reduced by five, leaving a sum total of 11. These 11 Core Standards are addressed in detail in the table below demonstrating:

    a. The Core Standard
    b. Progress made since the last Assurance Process
    c. Evidence to support elements of that progress
    d. The previous assurance assessment and the Trust's self-assessment as at mid-Oct 2020.

Table 1.
Note:
  a. Evidence is embedded electronically in this document.
  b. Much of the evidence that gives assurance can be found in the GHFT EPRR Recovery Action Plan which focuses on key Core Standards that were Partially Compliant in 2018/19. The cover page gives an overview of the Trust, with the subsequent pages giving a detailed breakdown by Division. Readers should look for the corresponding Core Standard in the action plan in order to gain a more detailed understanding of what has been progressed.

a.		b.	c.	d.	
Core Standard		Progress	Evidence	2019	2020
CS5	EPRR resources	Recruitment of Head of EPRR (Band 8C) and Resilience August 2020. Secondment EPRR Manager (Band 8A) March 2020 into the IMT and subsequently into the EPRR Team until March 2021. Internal secondment of EPRR support (Band 5) GHNHSFT until February 2021.		PARTIALLY COMPLIANT	COMPLIANT

		Step change in approach to delivery of EPRR assurance.			
CS20	Evacuation and Shelter Plan	Standardised Fire folders have been developed and rolled out across all areas. These have been audited by EPRR divisional Leads in July / August. All departments conducted local table top fire evacuation exercises - completed end of July. Regular evacuation exercises are being held throughout the year to assure full compliance of staff. A live fire evacuation exercise was planned for 9 Oct 20 but postponed. As we approach a challenging Winter our intent is to conduct a series of smaller, discrete event that will practice procedures and deliver lessons. However, there is still the aspiration to conduct a significant fire evacuation exercise in the medium term. See evidence. Assurance is provided by evidence of compliance which is monitored monthly by each EPRR Divisional lead and centrally through the Fire Safety Management Committee reporting to the Emergency Planning Resilience and Response Group. Evidence attached. A draft Evacuation and Shelter Plan is in the process of being produced. This will be ratified by the Security Management Group and then EPRR Group – by NLT Dec 20. The trust self-assesses that it has improved this Core Standard considerably over the last 12 months however, the lack of a revised Evacuation and Shelter Plan and an overall sense that there is still considerable work to be done to instil a sense of confidence in staff about fire procedures leads the Trust to assess it still sits at **Partially Compliant**.	Draft Fire Safety Committee Mins 20.8.: FINAL INSTRUCTION FOR EXERCISE VULC/ FSMC Risk Summary Sheet (1).xlsx Fire AT August_ (2).xlsx Fire Trg Record.xlsx	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS21	Lockdown	The Trust site Lockdown plan and action cards have been reviewed by Trust security lead, EPRR lead and the security management committee. The Trust EPRR lead with the support of the Trust security lead will provide training and support in the delivery of Lockdown exercises which are being planned locally and to test changes in plan. To be put in place once Policy ratified Divisional EPRR leads have assured all departments have local lockdown action cards in place. Lockdown Cards have been revised and are attached. An updated Lockdown Policy is in the process of being drafted. This will be approved by the Security Management Group and then ratified by the EPRR Group by NLT Nov 20. While Lockdown training has been challenging to achieve recently the Trust by the very nature of the threat posed by COVID19 has conducted a large number of lockdown operations. Evidence of these events can be found attached. Therefore it is assessed the Trust is well practiced in the process of a deliberate Lockdown. However, it is also assessed that the Trust will require further training and exercising in reactive Lockdowns. EPRR divisional Leads have audited Incident Folders and Fire Folders contents list for both are provided. Evidence of compliance is being monitored monthly by each EPRR divisional lead and centrally through the Security Management Committee reporting to the EPRR Group. It is for that reason that, while noting some considerable gains, the Trust self-assesses that this Core Standard	Lockdown incident commander (2).docx Lockdown incident commander (1).docx 00 GHT EPRR Lockdown Action Car(CGH Lockdowns (March to April) 2020 GRH Lockdowns (Feb - June) 2020.docx Contents Page SR19.docx	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT

		remains at **Partially Compliant**.	Incident Folder Contents.docx		
CS27	Training and Exercises	An Initial Outline Annual Training Plan for 2020-21 is attached. This is a living document that is to be worked through the EPRR Group that will assess the feasibility of conducting training during COVID19 restrictions. Notwithstanding the challenges presented by COVID19 the aspiration is to achieve as much as is possible using innovative means as well as more traditional methods. The Trust will also seek to initiate system-wide training to enhance capabilities, response, and resilience. Fire Evacuation Exercise Ex VULCAN PREPARE 20 was planned for 9 October 2020 but postponed due to flow pressure. The intent is to conduct a similar event in the future, most likely after Winter pressures have subsided. The instruction is attached. In the short and medium term smaller more discrete exercises will be run to provide momentum to the EPRR profile across the Trust. Planned Fire Training has gone ahead in June / July across some of the divisions with future training across the rest of the Trust. Initial Training for new telephony system NETCALL and CONFIRMER comms conducted on 8 September 2020. Further cascade training arranged for November 2020 as part of CBRN team call-back assessment. Self-assessed as **Partially Compliant.**	Initial EPRR Trainng Outline for 2020-21.c FINAL INSTRUCTION FOR EXERCISE VULC Fire Trg Record.xlsx	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS28	Tactical and Strategic Training	Strategic Leadership in a Crisis provided in March and June 2020. Tactical Crisis Management training was delivered to 87 delegates June 2020. The Trust will seek to incorporate and, if possible, lead on system-wide training. The LRF is viewed as an ideal forum for scoping such opportunities. Self-assessed as **Fully Compliant.**	GHT Training Record Master 030620.xlsx	PARTIALLY COMPLIANT	FULLY COMPLIANT
CS48	Business Continuity	This Core Standard requires the submission of Business Continuity Policy. At present the Trust has an extant and thorough Business Continuity Plan in place. It is suspected that this was simply not submitted last year. Close monitoring, assurance, and evidence provided by GHFT EPRR Recovery Action Plan which gives Trust wide picture of CS48 as well as focus on Divisions. A master list of Business Continuity Assurance has also been produced during the COVID19 first wave. This document remains live and is being improved and incorporated in to future plans. An Incident Management Review was conducted in May 20. The evidence attached continues to feed improvements and changes in processes. The linking in of Business Intelligence in to key management structures will ensure the Trust is well placed going forward. Structured Debriefs have been used when appropriate across the Trust. Examples can be found attached ranging from serious flooding to localise incidents. Feedback forms play a role in these debriefs. The Trust will explore formal training with regards to structured debriefs in the future. Self-assessed as **Fully Compliant**.	GHFT_BCM_Contingency_Plan_1_June__2 GHFT_EPRR_Recovery_Action_Plan_Mast Master list of Business Continuity A Flooding of CGH June 2020 v2.docx On Call Feedback 230620 - PW.docx	PARTIALLY COMPLIANT	FULLY COMPLIANT

			Example of Lessons Learned Feedback 20		
CS49	Business Impact Assessment	Close monitoring, assurance, and evidence provided by GHFT EPRR Recovery Action Plan which gives Trust wide picture of CS49 as well as focus on Divisions. Self-assessed as **Partially Compliant**.	GHFT_EPRR_Recovery_Action_Plan_Mast	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS50	NHS Digital Data protection and Security Toolkit	Associate CIO EPR, Health Records & IG have been working on a pan-Trust action plan to meet the required 95% for IG training compliance. The Trust has conducted a consolidated drive to ensure staff complete this mandated training for the end of September 2020. Levels of compliance have risen steadily from last year to the current 96%. Assurance is through an automated update through the Electronic Staff Record. Evidence supplied by GHFT Trg Compliance Report Attached. Therefore the rating now sits at **Fully Compliant**.	Training Compliance Report GHT 30 Septe	PARTIALLY COMPLIANT	FULLY COMPLIANT
CS52	Business Continuity Monitoring System monitoring and evaluation.	Revised governance and Business Continuity Monitoring System/framework established. Divisional leads identified and objectives set. These EPRR Leads are supported, and held to account through the use of: • A revised formal reporting template and process set. • A bi-Weekly working group Lead by EPRR and Manager and attended by Hd of EPRR. EPRR Group meets quarterly formerly fed Risks and issues by the Security, Fire, and EPRR Assurance Groups. Regular EPRR reporting is delivered and escalated by this group to the Medicine Executive Review group. Close monitoring, assurance, and evidence provided by GHFT EPRR Recovery Action Plan which gives Trust wide picture of CS52 as well as focus on Divisions. Self-assessed as **Partially Compliant.**	GHFT_EPRR_Recovery_Action_Plan_Mast GHT_EPRG_Min... EPRRG_Trust_Risk_Register_240920_Curr 280920 GHFT EPRR Group ToRs.pdf	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS59	CBRN capability 24/7: Rotas	ED now have staff on duty 24/7 that are IOR trained and trained to initiate a CBRN response, Evidenced on the Trust roster system. While this is an improvement it does not meet the Core Standard requirement of a formal rota system in place. See further comment below in CBRN. Self-assessed as **Partially Compliant.**	GHNSFT_CBRN_Assurance_Document_161	PARTIALLY COMPLIANT	PARTIALLY COMPLIANT
CS66	SWAST CBRN Audit: Training	CBRN Training was conducted in Sep and Nov 19. See evidence. Refresher training scheduled for March 2020 was delayed by COVID and took place on 16 October 2020 with training records, attendance list, and evaluation forms attached. Self-assessed as **Fully Compliant**	GHNSFT_CBRN_Assurance_Document_161 PRPS end of CSE Knowledge check que	PARTIALLY COMPLIANT	FULLY COMPLIANT

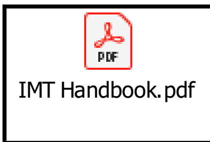
8. Assurance: Assurance for the above has been provided through a number of mechanisms. There has been a rigorous focus on achieving deliverables and targets by COO and Head of Unscheduled Care/DCOO. The use of senior staff to lead on the delivery of EPRR within Divisions has seen a step change in ownership of issues and meeting the necessary Core Standards. Through establishing improved processes an 'Internal Audit' has taken place throughout the year. Finally the recently appointed Head of EPRR has carried out spot checks of critical areas prior to submitting this document.

The identification and application of learning from the first wave of the COVID-19 pandemic

9. A significant amount of Lessons Identified came out of the first wave of the COVID-19 pandemic. These have manifested themselves in a number of ways. Some have developed from previous practices and procedures that have been taken, adapted and improved. Others have arisen directly from the impact of dealing with an extended Major Incident. These Lessons have arisen from both formal and informal debriefing of staff as individuals and as groups.

10. One of the most striking examples of agile and adaptive learning from the first wave has been implementation, development and use of the Trust's Incident Management Team. This became a critical component in ensuring preparedness, response, and resilience across the Trust. The team was activated toward the end of March using an extant concept but grew quickly to play a significant role in the Trust's response. It was shaped primarily to meet the organisational need of the Trust but also to respond to System and National calls and Requests for Information. The IMT reduced the need for the Trust to react at short notice to those issues it had within its control while simultaneously enabling it to react quickly to those issues outside its remit. Examples of good practice include the innovative development of the dashboard; an intelligent and predictive approach to oxygen supply levels using algorithms; and an ability to horizon scan capacity levels whether ward beds, PPE, clinical and non -clinical supplies pharmacy, workforce and or morgue capacity. This was critical to building resilience in to the organisation which enabled a sustained delivery of services over a lengthy period. All of the procedures, structures, and practices that were developed during this period were written into formal documents and can be viewed as evidence below. The IMT has remained in effect albeit at low personnel levels and is being prepared to be stood up using those procedures already developed, although ready to adapt to the next COVID-19 wave which may present new challenges.

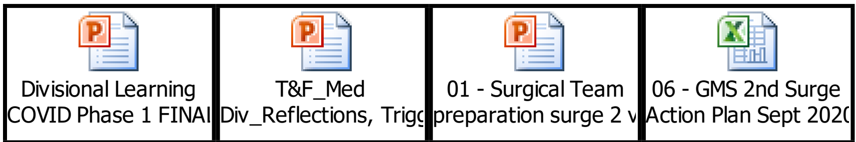
Evidence:



11. There has been a focus on Continuous Improvement throughout the Trust combined with a rigorous approach to Lessons Identified and Lessons Learned. A pan-Trust process was conducted that brought together Lessons Identified from the first wave and sought to transform them in to Lessons Learnt in preparation for the second wave. Much of this work was conducted by senior management conducting both formal and informal debriefs with staff and subsequently feeding this in to

management processes and committees to ensure pan-Trust sight of issues and senior leadership awareness and buy-in. An overview of the learning and improvement process that has taken place in all organisations following the first phase of the COVID19 response is attached as evidence. In addition the key issues from a couple of the Divisions are also attached including analysis of triggers for the next wave of COVID19 as well as a snap-shot of the surge action plan from Gloucestershire Managed Services. A number of examples of this work can be found below as evidence, including from Gloucestershire Management Services, who provide a critical support function to GHFT. While sitting outside the Trust's control they are also actively engaged with planning and horizon scanning.

Evidence:



Incorporating progress and learning into winter planning arrangements

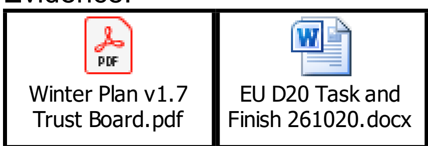
12. In addition and fundamental to preparing for the next phase of COVID19 the Trust has held weekly COVID/Winter Task and Finish Meetings across all functional areas lead by the COO and with full executive and senior management engagement since 16 June 20. This has ensured all Lessons Identified covered in Paragraph 2 have been embedded in to Trust management practices transforming them in to Lessons Learned.

13. In addition considerable work has taken place to embed such learning formally the evidence being that it has actively informed the preparation of the Trust Winter Plan (See below) . The plan has focused on a number of issues particularly the challenges posed by system given concurrencies of COVID19, Influenza and Norovirus.

14. The concurrent threat of Departure 20 (D20) is being closely monitored with steps taken to activate the previous team that had been established. Task and Finish Meetings have already taken (see evidence) with a Trust wide attendance. D20 responses are to be run through the Trust's IMT to ensure there is coherence in reporting.

15. Inclement Weather Plans are being revised, and linkages and options being scoped with the LHRP to seek out options that will mitigate the challenges of COVID19 in enabling staff to reach work locations in challenging conditions.

Evidence:



Chemical Biological, Radiological and Nuclear (CBRN) Audits

16. The Trust's SWAST Audit is booked for Mon 19 October 2020. Head of EPRR and GHFT Trust Lead for CBRN will represent the Trust.

17. The Trust renamed the CBRN(e) Team to Special Operations Response Team (SORT) in line with SWAST best practice, in order to ensure staff are fully aware that the team responds to not only CBRN(e) but also HAZMAT and various types of chemical suicide. At present the team consists of 21 personnel from across the Trust.

18. A key issue in last year's assessment was the lack of a rota system in place for SORT. At present a Recall to Duty, using a flash call to all team members, is in place and when used has resulted in a 70% successful recall rate. This approach has been adopted for three reasons. Due to the size of the present team a rota system would rotate at a frequency that is assessed as too high to be sustainable. Due to the irregular shift patterns that staff have within the Trust the implementation and management of such a rota is assessed as being unmanageable. Finally, the financial impact of such an On Call system is assessed as at being c£80K. GHFT acknowledge that they are an outlier in using such a Recall to Duty approach are engaging with SWAST and other Trusts to scope alternatives and seek out best practice.

19. Meanwhile, to mitigate the risk of the cascade approach the Trust will conduct a recruitment campaign to increase the numbers of those in the SORT group; make maximum use of the newly installed NETCALL and CONFIRMER telephony system; and actively manage the group over pinch periods (Summer Leave, Public Holidays, Christmas and New Year); and conduct routine test calls.

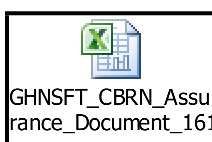
20. Training that was planned for March 2020 took place on 16 October 2020 and covered:

    a. Review of Initial Response Training
    b. Powered Respirator Protective Suits (PRPS) Training including
        a. Practical Dexterity Exercise
        b. Test/Approved in Suit
    c. Deployment of Mass Decontamination Kit including a serviceability check
    d. Review of Action Cards

Evidence of the type of training can be found below.

21. The Trust's self-assessment is that it is Fully Compliant in all aspects of CBRN other than the use of a rota system which drops the assessment to **Partially Compliant**.

    a. EPRR Decontamination Equipment Checklist: This is self-assessed. Refer to Assurance Document below pages: Equipment GRH and Equipment CGH. Spot checks conducted by Head of EPRR on 6 October 2020 are highlighted.
    b. CBRN training and any impact of COVID19 on training programmes.
    c. Status and stock levels of Powered Respirator Protective Suits (PRPS).



Summary

22. While the Trust acknowledges there has been considerable work done to update policies procedures training and action plans there has been a steady improvement in the levels of EPRR compliance over the last 12 months and more to be done. This has been in spite of the challenges posed by COVID19.

23. The Trust assesses that five of the previous Partially Compliant Core Standards have now reached Fully Compliant Status, leaving a further six to be improved.

24. **The Trust therefore self-assesses that it is fully compliant with 58 Core Standards out of 64 and has therefore achieved Substantially Compliant status for 2020-21**.

25. Moving forward the intent is to continue this upward trend and ensure good practice is embedded in to the Trust as we drive towards achieving Fully Compliant status.

Dickie Head
Head of Emergency Preparedness, Response, Resilience and Recovery (EPRR) GHNHSFT

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5220 Valiant Court
Gloucester Business Park
Brockworth
Gloucester
GL3 4FE

Tel: 0300 421 1739
Email: marion.andrews-evans@nhs.net

Gloucestershire Hospitals NHS Foundation Trust

Sent by email to:
Dr Rachael De Caux,
Accountable Emergency *Officer.*

23rd October 2020

EPRR Assurance 2020 – Gloucestershire Hospitals NHS Foundation Trust

Dear Rachael

I would like to thank you for the submission of your Emergency Preparedness, Resilience and Response (EPRR) annual assurance return. Also your attendance at a "Confirm and Challenge" meeting along with Alison McGirr, Dickie Head and Jill Oxley and the production of further evidence in line with assurance requirements for the CCG and NHS England and Improvement.

During the meeting, Gloucestershire NHS Foundation Trust's self-assessment was identified as "Substantially" assured. On review of the evidence submitted, Gloucestershire Clinical Commissioning Group has also assessed the organisation as:-

Substantially Assured.

Dickie has been sent feedback in relation to the meeting and Andy Ewens has also sent him his annotated notes to your original submission so you can make the small amendments we discussed. We ask that you forward the final assurance documentation as soon as possible so that this can be submitted to NHSEI to complete the "One Gloucestershire" return.

Please can I ask you to report on your assurance submission to your Trust Board or appropriate committee, along with this letter, to allow them to have sight and knowledge of the final assurance procedure. Following this, you are required to send Trudie Hook, Emergency Planning Administrator evidence of board minutes to complete the process for 2020.

Should you require further information, please contact my PA, Trudie Hook as below.
trudie.hook@nhs.net Tel: 0300 421 1605

I would like to thank you and your Trust's EPRR team for all they have done this year to reach such a good outcome to this assurance process.

Yours sincerely,

Dr Marion Andrews-Evans
Nurse Executive & Quality Lead / AEO

Cc Andy Ewens, EPRR Manager, GCCG
Dickie Head, Head of Emergency Preparedness, Resilience, Response, and Recovery

REPORT TO MAIN BOARD – DECEMBER 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 24 November 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**
Emergency Preparedness, Resilience and Response (EPRR)	NHSE assessment. Trust has moved from partially to substantially compliant status. Comprehensive evidence provided of improvement. Action plan, divisional EPRR leads in place, and recruitment to lead officer role. Committee commended the Exec lead for approach taken, progress and levels of momentum and improvement that have been achieved.	Is there a plan to repeat the fire evacuation exercise?	Not at this stage but yes, post COVID surge 2.	
External Audit	The Committee welcomed the team from Deloitte's, the Trust's new external audit provider. The team introduced themselves and gave a first briefing about the planned approach.	Had the timing of the procurement and appointment led to any problems for timings of external audit plan etc.? Are there any areas of work	There are no concerns re meeting timetables and deadlines. Relevant transition work has been well scheduled. All work now completed	

		outstanding from 2019/20 audit programme? Are there plans to review timings of Audit programme in terms of feasibility of running Trust and GMS Audits in parallel and staffing pressures in past? It would be valuable for Deloitte's to present to new CoG as soon as possible.	(GMS Audit) or concluding satisfactorily (Charity Audit). Additional staff have been recruited within Finance team and parallel Audits are judged to be the preferred approach to take. Agreed. In hand.	
Internal Audit	Regular progress report to Committee. Confirmed good progress against plan and some changes to sequencing of audits between years. Backlog Maintenance Final Report. Range of findings about data sources concerning the Trust's estate and the unreliability of survey data upon which maintenance programmes are based. Limited assurance given.	Was there Exec oversight of slippage of audit of Mental Capacity Act to 2021/22 plan from current year? Can Internal Audit be satisfied of the continuing quality of their work, given COVID working arrangements in which projects are conducted? Discussions that confirmed Exec and GMS awareness of problems and associated risks and mitigations that are in place. Estates and Facilities Committee will continue to exercise closer oversight of	Yes. Yes. Internal quality assurance approach well described. GMS attended and confirmed intentions to improve infrastructure database in Dec 2020.	

		progress of action plan arising from the report.		
Other items	A series of reports were received that confirmed continued improvement and good Exec oversight of: • Board Assurance Framework (BAF) • Risk assurance methodology and incident reporting • Losses and compensation payments to patients • Single tender waivers processed within Trust's procurement arrangements • Annual debt report	In each of these cases the Committee commended the Exec leads for evidence of continued and systematic improvement and compliance levels. The quality of reporting of itself was a source of assurance with transparency of reasons etc. Areas for further focus were identified. The Committee will return to the BAF in light of its consideration at next cycle of Assurance Committees		

Claire Feehily
Chair of Audit and Assurance Committee
November 2020.

REPORT TO TRUST BOARD – DECEMBER~~JANUARY~~ 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 26 November 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	The minutes of the last meeting stated that all actions arising from the Gleed's report on entry and egress repair works have been completed.	There are a number of claims on GMS outstanding from members of the public for injuries resulting from trips and falls in the Trust's car parks and premises. Are there are maintenance failures over and above the Gleed's findings that need to be addressed?	This requires further investigation by GMS.	Further assurance is required.
GMS Chair's Report	GMS currently have 23 apprentices covering a range of disciplines.	Are GMS staff eligible for Trust awards?	Yes they are.	
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	Are there any additional actions needed with cleaning to reduce the nosocomial infection rates that have been	The higher rates reported are largely as a result of higher rates of occupancy, more frequent moves within the Trust, etc., and not related to the standards and quality of cleaning.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	reporting period. Similarly, there are no performance issues with the PFI service contract.	reported into the Quality and Performance Committee?		
Security Services Update	GMS presented a paper on the implementation of the actions required to deliver on the Trust's Security Strategy for the physical security of the Trust's estate, including consultation with the porters for their expanded remit.	Are we on track to deliver? Are there any issues related to resources?	While the Security Manager had left GMS, we are drawing on resources from elsewhere in the ICS, demonstrating good cooperation. Also, while the Trust relinquished the local PCRO, there remains voluntary support and we are getting good support from GHC. The implementation is being overseen by the Security Management Group.	
Updated Service Standards and KPIs	The Trust presented the new suite of key performance metrics and targets that have been proposed to, and accepted by, GMS. They generally represent a raising and tightening of standards. GMS performance against these is being shadow-reported for the next few months with the aim that they become the contractual performance targets from April 2021. Cleaning has been split by site, there are new KPIs for energy performance	Are these KPIs reportable and deliverable, as there are gaps at present? This is very data-heavy. Do we feel that the focus is on the right things?	Further work is required to deliver the waste metrics and a new CAFM system is awaited to report the estate maintenance, but should all be in place for the new financial year. The Trust has the ability to triangulate the performance with other feedback and data points, such as Trust reports at the Q&P Committee, etc. GMS are also working on developing feedback systems to help them to develop their services in line with Trust needs.	Committee to see the final set in time for the new reporting year.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Year 3 GMS Business Plan Update at Q2	GMS presented the progress against their 2020/21 Business Plan, reporting that many initiatives are progressing but have been impacted or delayed by Covid-19. Revenue has been negatively impacted and there are further financial risks – GMS are therefore looking at other/new sources of income.	Is there still the intent to develop and train people? What other sources of revenue are being considered? Is GMS able to attract talent, as this was a key element of the original business case for GMS?	Yes, GMS remain committed to people development and recently provided an update to their own Board. There are plans to enhance the retail offerings. GMS are also looking at new business across and outside the integrated care system (ICS). This is also being tracked and will be reported at a later date. The financial performance of GMS is a risk logged on the Trust risk register and is being continuously monitored.	
Strategic Site Development Programme	Planning approval has now been received for the proposals at both sites. The Full Business Case (FBC) is now being worked and will be reviewed internally in December and the Deed of Variation for the PFI contract (for future operation of the new facilities) is nearing completion.	Have we factored in the possible impact of Covid restrictions on the project programme? The over scheme remains based on pre-Covid assumptions and parameters – will these be reviewed?	The phasing may need to be revised if restrictions continue. However, the key elements of the project will kick-off about July 2021, so there is plenty of time for the situation to improve. If it does not, then activities will be re-phased. The project team do plan revisit the overall scheme in terms of revisions to pathways. These risks are being monitored as part of the project's risk register.	
Estates Strategy	The Estates Strategy is one of eight enabling strategies	Is the ICS involved in this work?	The Trust is the most active member of the ICS Estates Group and so other	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Phases 1 & 2	needed to deliver on the Trust's Strategic Objectives. The Strategy was reviewed in 2019, but focused on phase 1. Phase 2 is required and will focus on the broader scope of the two hospital sites. This will involve a Master Plan for each hospital site to identify strategic priorities, a refurbishment programme and addressing backlog maintenance. This paper presented the outline timeline and activities required to deliver Phase 2 Plans.	The Government recently announced an additional £1.7 billion for upgrades to 70+ hospitals and 40 new hospitals. Will we be in line for additional funding?	partners are involved, and the working together is improving in recent weeks. The Trust is closely linked with the NHS region to ensure that our needs are recognised. The Trust will continue to be ready to bid for any available new capital funding.	
Trust Retained contracts	This paper addressed the major contracts that are retained by the Trust but managed by GMS: the PFI contract with GHP/Apleona, Parking with Saba, Energy with Vital and Staff Housing with Sovereign. The paper outlined the contractual arrangements, the key controls and current performance.	How does the Trust obtain assurance that GMS are doing an effective job of managing these contracts?	Trust managers also attend all key contract performance meetings and have access to the reports.	
Sustainability Update	Trust reported on progress on the sustainability agenda after declaring a "Climate Emergency" in December 2019 with the aim to be "net zero carbon" by 2050. More recently,	Progress has been low-key this year – are we moving quickly enough?	The Trust has appointed a Head of Sustainability, joined other similar-thinking Trusts to share best practice and learning and is using the NHS Sustainable Development Assessment Tool to define progress	It was agreed that the Board and all Committees should have a regular agenda item on sustainability.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	the NHS have published their own NHS Net Zero Report with the aim to achieve net zero by 204, so the Trust will now need to revise its target and plans. The Trust's new 5-year Sustainability Strategy, the Green Plan, will be published ahead of the next financial year.		and next steps. The Trust's Climate Emergency Response Group" is also very active with lots of ideas and initiatives being developed. A new network of Green Champions will also be launched shortly across the Trust and GMS. A dashboard will also be developed to update on carbon emissions, energy usage, waste tonnage, etc.	
Trust Board Assurance Framework	The overall strategic risks that may prevent delivery of the Trust's Strategic Objective for "Effective Estate" were reviewed, together with existing controls and assurances, plus any residual gaps.	There are significant gaps in controls and assurances: effective estates maintenance plans, site master plans and a new Trust Sustainability Plan are all current gaps. This reflects the position we are in, not the lack of effort or focus. The Committee view was that the overall assurance rating should be red.		Estates Maintenance Plans Site Master Plans Trust Sustainability Plan

Mike Napier
Chair of Estates and Facilities Committee
4th December 2020

TRUST PUBLIC BOARD – 10 DECEMBER 2020
Microsoft Teams, Commencing at 12:30

Report Title

Financial Performance Report
Month Ended 30th October 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 7 to the Board.

Key issues to note

The Trust reported a deficit £1m better than plan at Month 7 of £4.4m. This improvement was due to performing less activity than plan in Month 7 and hence incurring less variable cost.

Our activity was up 2% compared to month 6, while we had planned to increase by 13%. We have not assumed a financial penalty against missing activity targets within our financial position.

Forecast Outturn
Due to the improvement against plan in month of £1m, we are reducing our forecast outturn by the same amount, which means that we are now forecasting a deficit of £14.5m. The system forecast has not yet been updated to include the improvement to our Trust forecast.

Conclusions

The Trust is reporting a year to date deficit of £4.4m, compared to a plan of £5.4m deficit.

For the second half of the year, the Trust was expected to report a £15.5m deficit within a system deficit of £28.4m. As at Month 7, the Trust has adjusted its forecast deficit to be improved by the £1m improvement in Month 7. This amounts to a revised £14.5m deficit.

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 October 2020

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Director of Finance Summary

System Position as at Month 7

For Month 7-12, the Gloucestershire system has a funding allocation within which it is being asked to work. The system plans showed a very challenging position and although a balanced plan hasn't been submitted the system has submitted a realistic one. The system plan is currently showing a deficit position against plan of £28.4m, of which £15.5m is the Trust's element. Although this plan has not been formally approved by the Regional or National team there is a recognition that the majority of the gap is due to technical reasons or pressures outside of the system's control and until we are informed otherwise this deficit position is what the system will be working to deliver.

We are currently working through what our exit run rate will look like, in order to inform discussions moving into 2021/22. Funding for next year is unknown, but it is likely that system allocations will again play a part and systems will be encouraged to share risk.

Month 7 overview

At Month 7 we recorded a £4.4m deficit, compared to a planned deficit of £5.4m. This means that we were better than plan by £1m. The improvement in cost was due to performing less activity than plan in Month 7.

Our activity was up 2% compared to month 6, while we had planned to increase by 13%. No division achieved its planned trajectory of activity, some of the reasons for this were as a result of a broken piece of equipment, as well as a lack of availability of Roche supplies for use in our diagnostic services, and an availability of staff over the October half term.

We have not assumed a financial penalty against missing activity targets within our financial position.

All reporting in this presentation will refer to spend against the latest plan, with M1-6 being equal to cost as part of the breakeven requirement and M7-12 creating our £15.5m forecast deficit.

Forecast Outturn

We submitted a M7-12 plan that costed the delivery of required activity levels, alongside Winter pressures, but excluding any Covid 2nd surge, at £336m. Due to the improvement against plan in month of £1m, we are reducing our forecast outturn by the same amount, which means that we are now forecasting a deficit of £14.5m. This includes an annual leave provision, as required nationally. The system forecast has not yet been updated to include the improvement to our Trust forecast.

Capital

Capital plans have incurred £11.8m to date, with a forecast spend of £40.9m for the year. The year to date represents an underspend against the year to date plan profile of £1m. The project accountant is going to work closely with the project leads to support the timing of capital payments and to improve the capturing of spend.

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Month 7 headlines

Headline	Compared to plan	Narrative	Change from last month
I&E Position YTD is £4.4m.		Overall YTD financial performance is £4.4m. This is £1m better than plan.	
Income from patient care activities is £302.6m YTD.		YTD £0.4m better than plan, due to above-plan expected income for private patient activity in October, and pass-through drugs income and cost not forming part of the plan.	
Other operating income is £67.8m YTD.		YTD this is £0.3m ahead of plan. £0.2m of this is for the regional Covid testing centre income to offset costs. The funding source at plan submission was not known, so this was not included, however NHSI have asked us to assume income equal to cost in Month 7. There is also £0.7m of hosted services income which wasn't in the plan, offset by £0.7m of lower-than planned income in GMS, also linked to lower activity.	
Pay costs are lower than plan at £236.3m YTD.		YTD this is £0.7m lower than plan. This is due to lower activity than expected in October, and lower temporary staff costs.	
Non-Pay expenditure is worse than plan at £133m.		YTD this is £0.4m worse than plan. This is due to pass-through drugs costs not forming part of the plan, and offsets relevant income over-performance.	
CIP schemes on plan for 20/21.		As long as we are within our overall plan for 2020/21, CIP is delivered for this year. The budget setting process has now started, and will be aiming to identify CIP for 2021/22	
Capital expenditure is £11.8m YTD		Capital spending is £1.0m behind plan YTD but forecasting to spend the full £40.9m by year end.	
The cash balance is £67.3m		Cash is £10.1m less than plan, mainly because we have been working to reduce our creditor days, and because we were expecting to have received additional PDC of £7.6m by this stage of the year. An application for the PDC is being made in Month 8.	

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YTD True-Up Funding agreed by NHSE

For Months 1-6 the Trust was under a retrospective top-up arrangement. This meant that the Trust was expected to breakeven and, in order to do so, had to assume retrospective top-up income equivalent to any overspend. In total for the first half of the year, the Trust applied for £21.9m. This was made up of £15.2m of Covid-19 costs, plus the Gen Med VAT provision of £4.2m, plus other overspends of £2.5m compared to the nationally-calculated block funding.

NHSE have not yet transacted a true-up provision for Gen Mad VAT – we will continue to push this. The balance of the Month 6 true-up has not yet been paid either, but have no reason to believe it will be rejected.

The Month 6 true-up validation is expected to be complete and payment made by December 15th 2020. To date we have received £12.6m, and expect to receive a further £5.1m on December 15th . The query is whether we receive the extra £4.2m in December, but we will continue to raise this with NHSE/I.

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 Paid	3,627
True-Up M05 Initially Applied	6,505
True-Up M05 Rejected - Gen Med VAT	(4,200)
True-Up M05 Rejected - PDC (error in accts corrected)	(733)
True-Up M05 Revised Paid	1,572
True-Up M06 Anticipated - Repeat of Gen Med	4,200
True-Up M06 Anticipated - new	5,145
Grand Total (Revised) True-Up YTD	**21,881**

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Month by Month Trend

If we excluded the medical dental pay award in Month 6, Pay costs month on month would be flat.

Looking at the trend of costs each month, it is clear that non-pay has been steadily growing month on month. Month 7 includes the Gen Med Vat impact of £4.2m.

Other non-pay is up month on month due to a credit £0.8m technical adjustment in Month 6 for PDC cost, and increase in drugs costs in Month 7 of £0.7m, and £0.3m additional cost on medical consumables, predominantly in theatres.

Covid costs are down again month on month. Where we see income for the first time, this is for SIREN study £0.04m, and the regional testing centre £0.148m.

Consolidated Run Rate Actuals	20/21 £'000							
	M01	M02	M03	M04	M05	M06	M07	YTD
Pay	31,304	32,153	32,248	31,799	33,422	34,020	33,654	228,600
Non Pay	16,407	13,842	15,572	17,228	20,921	17,340	23,324	124,634
Covid Costs	2,125	3,847	3,408	2,564	1,212	1,997	883	16,036
Non-operating Costs	855	991	1,072	946	271	129	745	5,009
Remove impact of Donated Asset Depreciation	(37)	(37)	(37)	(38)	(37)	(37)	(37)	(260)
Total Cost	50,654	50,796	52,263	52,499	55,789	53,449	58,569	374,019
Run Rate Funding / Billable Income	(48,897)	(49,027)	(48,452)	(48,872)	(50,015)	(48,304)	(54,153)	(347,720)
Total Deficit	**1,757**	**1,769**	**3,811**	**3,627**	**5,774**	**5,145**	**4,416**	**26,299**
True-up Funding	(1,757)	(1,769)	(3,811)	(3,627)	(5,774)	(5,145)	0	(21,883)
Grand Total Deficit	**0**	**0**	**0**	**0**	**0**	**0**	**4,416**	**4,416**

Covid	20/21 £'000							
	M01	M02	M03	M04	M05	M06	M07	YTD
Income							- 188	- 188
Pay	1,217	1,683	1,991	1,406	486	690	207	7,680
Non-Pay	908	2,164	1,417	1,158	726	1,307	676	8,356
Total	**2,125**	**3,847**	**3,408**	**2,564**	**1,212**	**1,997**	**695**	**15,848**

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M07 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

Plan is based on M1-6 actuals, plus M7-12 submitted plan.

The financial position as at the end of October 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 October the Group's consolidated position shows a £4.4m deficit. This is £1.0m favourable against plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION			GMS POSITION			GROUP POSITION *		
Month 07 Cumulative Financial Position	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	297,086	297,210	124	0	0	0	297,086	297,210	124
PP, Overseas and RTA Income	1,600	1,891	291	0	0	0	1,600	1,891	291
Other Income from Patient Activities	3,480	3,468	(12)	0	0	0	3,480	3,468	(12)
Operating Income	37,961	38,978	1,016	29,482	28,789	(692)	67,443	67,767	324
Total Income	**340,127**	**341,547**	**1,419**	**29,482**	**28,789**	**(692)**	**369,609**	**370,336**	**727**
Pay	225,005	224,165	839	11,925	12,114	(189)	236,930	236,280	650
Non-Pay	116,618	118,734	(2,115)	15,962	14,257	1,705	132,580	132,990	(410)
Total Expenditure	**341,623**	**342,899**	**(1,276)**	**27,887**	**26,371**	**1,516**	**369,510**	**369,270**	**240**
EBITDA	**(1,496)**	**(1,352)**	**144**	**1,595**	**2,418**	**823**	**(2,473)**	**1,066**	**967**
EBITDA %age	**(0.4%)**	**(0.4%)**	**(0.0%)**	**5.4%**	**8.4%**	**(3.0%)**	**(0.7%)**	**0.3%**	**(1.0%)**
Non-Operating Costs	4,200	3,324	877	1,595	2,418	(823)	5,795	5,742	53
Surplus/(Deficit) with Impairments	**(5,696)**	**(4,676)**	**1,020**	**0**	**0**	**0**	**(5,696)**	**(4,676)**	**1,020**
Less Fixed Asset Impairments	0	0	0	0	0	0	0	0	0
Surplus/(Deficit) excluding Impairments	**(5,696)**	**(4,676)**	**1,020**	**0**	**0**	**0**	**(5,696)**	**(4,676)**	**1,020**
Excluding Donated Assets	260	260	0	0	0	0	260	260	0
Control Total Surplus/(Deficit)	**(5,436)**	**(4,416)**	**1,020**	**0**	**0**	**0**	**(5,436)**	**(4,416)**	**1,020**

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M07 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals
NHS Foundation Trust

Month 07 Financial Position	M07 Plan £000s	M07 Actuals £000s	M07 Variance £000s	M07 Cumulative Plan £000s	M07 Cumulative Actuals £000s	M07 Cumulative Variance £000s	FY Forecast
SLA & Commissioning Income	47,519	47,643	124	297,086	297,210	124	532,182
PP, Overseas and RTA Income	205	496	291	1,600	1,891	291	2,624
Other Income from Patient Activities	104	92	(12)	3,480	3,468	(12)	6,366
Operating Income	5,596	5,921	324	67,443	67,767	324	95,577
Total Income	**53,425**	**54,152**	**727**	**369,609**	**370,336**	**727**	**636,749**
Pay							
Substantive	30,673	30,805	(132)	215,576	215,708	(132)	371,532
Bank	2,519	1,650	868	12,680	11,812	868	25,071
Agency	1,321	1,407	(86)	8,674	8,760	(86)	18,743
Total Pay	**34,512**	**33,862**	**650**	**236,930**	**236,280**	**650**	**415,346**
Non Pay							
Drugs	5,757	6,537	(780)	41,600	42,380	(780)	72,674
Clinical Supplies	4,127	4,008	119	25,915	25,796	119	44,632
Other Non-Pay	13,706	13,455	251	65,065	64,814	251	109,169
Total Non Pay	**23,589**	**23,999**	**(410)**	**132,580**	**132,990**	**(410)**	**226,475**
Total Expenditure	**58,102**	**57,862**	**240**	**369,510**	**369,270**	**240**	**641,821**
EBITDA	**(4,677)**	**(3,710)**	**967**	**99**	**1,066**	**967**	**(5,072)**
EBITDA %age	**(8.8%)**	**(6.9%)**	**(1.9%)**	**0.0%**	**0.3%**	**(0.3%)**	**(0.8%)**
Non-Operating Costs	797	744	53	5,795	5,742	53	9,869
Surplus/(Deficit)	**(5,474)**	**(4,454)**	**1,020**	**(5,696)**	**(4,676)**	**1,020**	**(14,941)**
Fixed Asset Impairments	0	0	0	0	0	0	0
Surplus/(Deficit) after Impairments	**(5,474)**	**(4,454)**	**1,020**	**(5,696)**	**(4,676)**	**1,020**	**(14,941)**
Excluding Donated Assets	37	37	0	260	260	0	445
Surplus/(Deficit)	**(5,437)**	**(4,417)**	**1,020**	**(5,436)**	**(4,416)**	**1,020**	**(14,496)**

SLA & Commissioning Income – Most of the Trust income continues to be covered by block contracts.

PP / Overseas / RTA Income – This was unexpectedly up in October, but is not expected to continue at the same level for the rest of the year.

Other Operating income – Includes additional income associated with services provided to other providers, including the regional Covid testing centre. This also includes the hosted income for GP trainees / shared services etc, and GMS income.

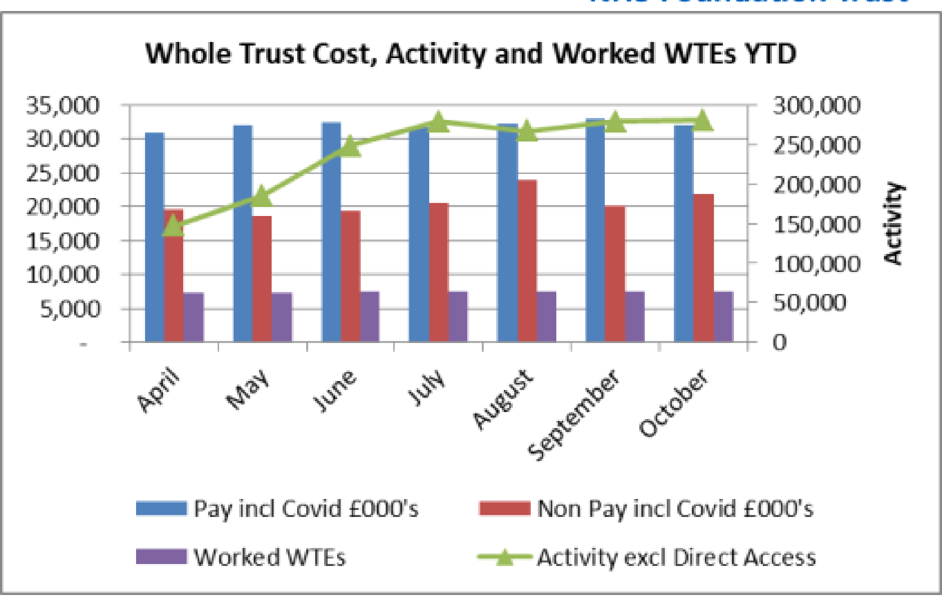
Pay – below plan due to availability of temporary staff over the October half term.

Non-Pay – above plan, mainly due to higher than expected drugs costs.

Cost, Activity and Worked WTE for the Trust

Gloucestershire Hospitals
NHS Foundation Trust

Trust Costs (excl GMS)	Q1 Average	Q2 Average	Month 7	Month on Month % Change
Pay	30,281	31,502	31,899	-2%
Non Pay	17,773	20,662	21,236	11%
Total	48,054	52,164	53,135	3%
Covid Costs				
Pay	1,500	793	207	-61%
Non Pay	1,402	896	676	-37%
Total	2,902	1,689	883	-45%
Total Trust Costs (excl GMS)				
Pay	31,781	32,295	32,106	-3%
Non Pay	19,174	21,558	21,913	9%
Total	50,956	53,853	54,018	2%
Activity				
Activity	**387,674**	**644,981**	**686,956**	**3%**
Activity excl Direct Access	**193,627**	**275,096**	**280,527**	**1%**
WTEs				
WTE Worked Non-Covid	7,137	7,390	7,510	0%
WTE Worked Covid	245	104	34	-26%
Total	7,383	7,494	7,544	0%



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 increased 10% month on month, and is up 160% since the start of the year.

KPI	M1	M2	M3	M4	M5	M6	M7
Agency WTE worked	118	103	97	133	139	149	156
Agency % Worked WTE	2%	1%	1%	2%	2%	2%	2%
Agency pay cost £000	917	989	973	1,194	1,099	1,254	1,208
Agency as % of pay cost	3%	3%	3%	4%	3%	4%	4%

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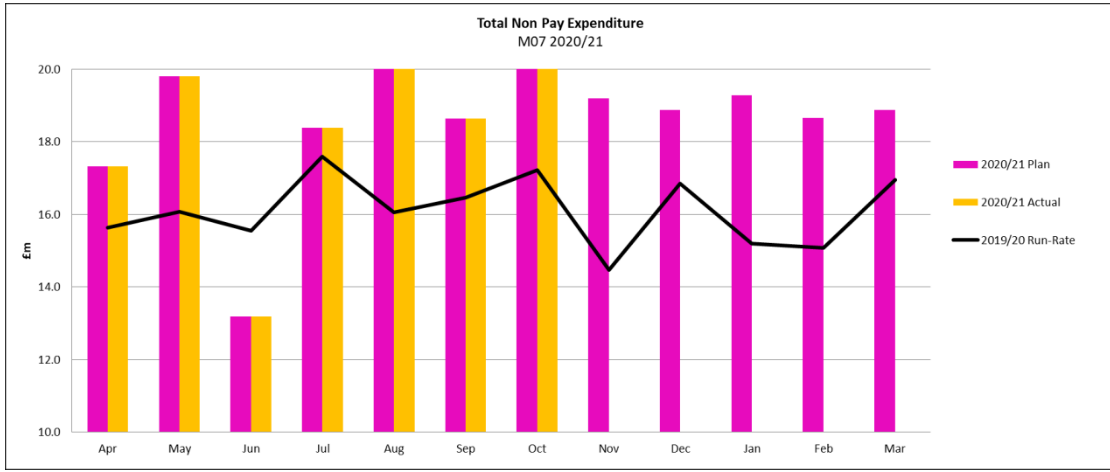
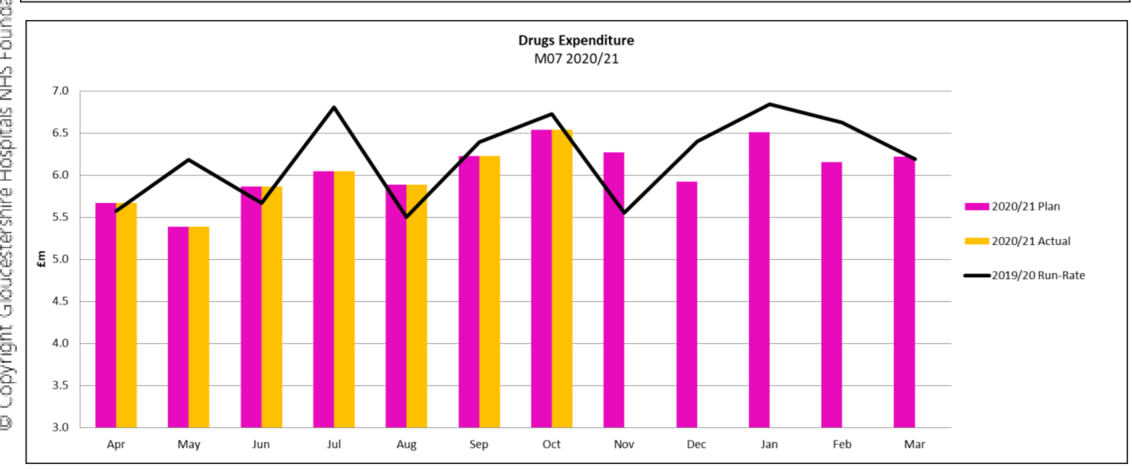
Non-Pay Expenditure (Group)

Non Pay Analysis	M07 Plan £000s	M07 Actuals £000s	M07 Variance £000s	M07 Cumulative Plan £000s	M07 Cumulative Actuals £000s	M07 Cumulative Variance £000s
Drugs	5,757	6,537	(780)	41,600	42,380	(780)
Clinical Supplies	4,127	4,008	119	25,915	25,796	119
Other Non-Pay	13,706	13,455	251	65,065	64,814	251
Total Non Pay	**23,589**	**23,999**	**(410)**	**132,580**	**132,990**	**(410)**





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

Overall non-pay year to date is £0.41m over plan. This is predominantly due to drugs, including pass-through drugs that weren't included in the plan. Clinical supplies and other non pay is down against plan due to activity not being as high as anticipated.

The graph for Total Non Pay shows the monthly run rate on expenditure alongside the plan. It demonstrates how low activity was in early months and how it has started to recover. Month 7 includes the Gen Med Vat impact.

Other non-pay is up month on month due to a credit £0.8m technical adjustment in Month 6 for PDC cost, and increase in drugs costs in Month 7 of £0.7m, and £0.3m additional cost on medical consumables, predominantly in theatres.

The graph for drugs expenditure shows the monthly run -rate alongside the plan, and the increase in costs over the year as activity has grown.

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Balance Sheet

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2020 £000	GROUP Balance as at M7 £000	B/S movements from 31st March 2020 £000
Non-Current Assests			
Intangible Assets	5,851	6,086	235
Property, Plant and Equipment	257,352	258,338	986
Trade and Other Receivables	5,889	5,814	(75)
Total Non-Current Assets	**269,092**	**270,238**	**1,146**
Current Assets			
Inventories	9,121	9,033	(88)
Trade and Other Receivables	31,268	40,908	9,640
Cash and Cash Equivalents	37,385	67,272	29,887
Total Current Assets	**77,774**	**117,213**	**39,439**
Current Liabilities			
Trade and Other Payables	(79,872)	(82,330)	(2,458)
Other Liabilities	(3,401)	(44,910)	(41,509)
Borrowings	(132,582)	(4,139)	128,443
Provisions	(170)	(170)	0
Total Current Liabilities	**(216,025)**	**(131,549)**	**84,476**
Net Current Assets	**(138,251)**	**(14,336)**	**123,915**
Non-Current Liabilities			
Other Liabilities	(6,484)	(6,265)	219
Borrowings	(40,609)	(38,152)	2,457
Provisions	(2,850)	(2,850)	0
Total Non-Current Liabilities	**(49,943)**	**(47,267)**	**2,676**
Total Assets Employed	**80,898**	**208,635**	**127,737**
Financed by Taxpayers Equity			
Public Dividend Capital	179,302	307,515	128,213
Reserves	29,891	29,891	0
Retained Earnings	(128,295)	(128,771)	(476)
Total Taxpayers' Equity	**80,898**	**208,635**	**127,737**

The table shows the M7 balance sheet and movements from the 2019/20 closing balance sheet, supporting narrative is on the following pages.

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Cash flow: October

Cashflow Analysis	Apr-20 £000s	May-20 £000s	Jun-20 £000s	Jul-20 £000s	Aug-20 £000s	Sep-20 £000s	Oct-20 £000s	Forecast Movement November 20 to March 21 £000s	Forecast Outturn £000s
Surplus (Deficit) from Operations	**818**	**954**	**1,035**	**908**	**967**	**92**	**(3,708)**	**4,397**	**5,463**
Adjust for non-cash items:									
Depreciation	1,509	1,509	1,509	1,509	1,509	1,509	1,509	**7,425**	**17,988**
Other operating non-cash	0	0	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**	**1,601**	**(2,199)**	**13,322**	**24,951**
Working capital movements:									
(Inc.)/dec. in inventories	221	232	(57)	(152)	116	(429)	157	**(81)**	**7**
(Inc.)/dec. in trade and other receivables	(4,178)	10,065	(797)	(7,991)	1,749	(2,843)	(4,979)	**(841)**	**(9,815)**
Inc./(dec.) in current provisions	0	0	0	0	0	0	0	**0**	**0**
Inc./(dec.) in trade and other payables	35,152	(5,229)	(44,038)	7,110	2,503	3,027	3,933	**(8,967)**	**(6,509)**
Inc./(dec.) in other financial liabilities	7,099	(4,559)	41,320	(1,168)	2,140	1,665	(4,988)	**(41,359)**	**150**
Net cash in/(out) from working capital	**38,294**	**509**	**(3,572)**	**(2,201)**	**6,508**	**1,420**	**(5,877)**	**(51,248)**	**(16,167)**
Capital investment:									
Capital expenditure	(1,667)	(1,667)	(1,729)	(882)	(1,737)	(2,149)	(1,417)	**(23,487)**	**(34,735)**
Capital receipts	0	0	0	0	0	0	0	0	**0**
Net cash in/(out) from investment	**(1,667)**	**(1,667)**	**(1,729)**	**(882)**	**(1,737)**	**(2,149)**	**(1,417)**	**(23,487)**	**(34,735)**
Funding and debt:									
PDC Received	0	0	0	353	0	127,860	0	**11,717**	**139,930**
Interest Received	11	0	0	0	0	0	0	**0**	**11**
Interest Paid	0	0	0	0	(658)	(525)	0	**(658)**	**(1,841)**
DH loans - received	0	0	0	0			0	**0**	**0**
DH loans - repaid	0	0	0	0	0	(129,180)	0	**(865)**	**(130,045)**
Finance lease capital	(95)	(95)	(95)	(488)	(488)	(488)	(488)	**(2,440)**	**(4,677)**
Interest element of Finance Leases	(17)	(17)	(17)	(12)	(12)	(12)	(13)	**(65)**	**(165)**
PFI capital element	(43)	(43)	(43)	(68)	(68)	(68)	(68)	**(340)**	**(741)**
Interest element of PFI	(182)	(182)	(182)	(38)	(38)	(38)	(38)	**(190)**	**(888)**
PDC Dividend paid						0		**(5,770)**	**(5,770)**
Net cash in/(out) from financing	**(326)**	**(337)**	**(337)**	**(253)**	**(1,264)**	**(2,451)**	**(607)**	**1,389**	**(4,186)**
Net cash in/(out)	**38,628**	**968**	**(3,094)**	**(919)**	**5,983**	**(1,579)**	**(10,100)**	**(60,024)**	**(30,137)**
Cash at Bank - Opening	**37,385**	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**37,385**
Closing	**76,013**	**76,981**	**73,887**	**72,968**	**78,951**	**77,372**	**67,272**	**7,248**	**7,248**

The cash flow for October 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.

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Capital Programme

Gloucestershire Hospitals
NHS Foundation Trust

Funding Sources			
Internally Funded	**Funding / MoU Received**	**Funding / MoU Awaiting**	**Total Forecast**
Depreciation less Finance Lease Repayments	16,628	0	16,628
Other internal capital cash	1,005	0	1,005
Capital loan repayments	(2,185)	0	(2,185)
Net Internally Funded	**15,448**	**0**	**15,448**

Additional Funding	Funding / MoU Received	Funding / MoU Awaiting	Total Forecast
UEC 20/21	4,400	0	4,400
Critical Infrastructure Risk	2,677	0	2,677
STP wave 3	2,330	1,387	3,717
Critical Care Beds	1,850	0	1,850
Adapt and Adopt	1,200	0	1,200
Diagnostic Screening	374	0	374
Other Central Programme	40	0	40
Interim Support Capital PDC		6,765	6,765
COVID - 19		2,094	2,094
Health System Led Investment		1,337	1,337
Total Additional Funding (excl Donated/Grants)	**12,871**	**11,583**	**24,454**
Donations		1,000	1,000
Grants		0	0
Total Donated/Grants	**0**	**1,000**	**1,000**
Total	**28,319**	**12,583**	**40,902**

Expenditure								
Capital Summary	**Internal YTD Plan £000's**	**YTD Spend £000's**	**YTD Var £000's**		**19/20 Full Year Plan £000's**	**FOT 19/20 Spend £000's**	**Forecast Variance £000's**	
Estates	2,865	2,362	(503)		5,280	5,280	-	
IT	2,455	2,211	(244)		6,487	6,493	6	
IT TrakCare	317	804	487		993	993	-	
Divisional Schemes (inc. Contingency)	3,302	1,734	(1,568)	1	15,519	15,014	(506)	2
Donated/Leases	-	23	23		1,500	1,500	-	
IFRIC12/PFI	532	531	(0)		911	911	-	
COVID19	1,599	2,031	432		2,094	2,094	-	
Strategic Site Development	1,726	1,834	108		3,717	3,717	-	
Urgent/Emergency Care	-	250	250		4,400	4,900	500	2
Overspend/(Underspend)	**12,796**	**11,780**	**(1,016)**		**40,902**	**40,902**	**-**	

1 Emergency Capital Projects, CTx4 & MRI Enabling works and the Cath Lab - unit replacement are awaiting official confirmation of funds and are behind plan.

2 £500k of the contingency allocation since been allocated to the Urgent/Emergency Care scheme.

Funding Sources

The Trust are awaiting reimbursement for the £2.1m COVID 19 expenditure, albeit confirmation that £1.2m will be reimbursed has been provided and the remainder is with the NHSIE National Team. The Trust expects the outcome of this to be finalised at the end of November.

The Trust are awaiting official confirmation on the interim support capital of £6.8m to fund the replacements of CT, MRI and Cath labs.

The Trust are seeking early draw down of c£1.4m in 20/21 for the Strategic Site Development scheme, having already secured £2.3m for the fees.

The MoU for the HSLI funding is expected during November.

Expenditure

The Trust are forecasting to spend the full planned allocation of £40.9m, subject to full receipt of the funding outlined above.

Under the stewardship of IDG, the newly appointed Project Accountant is working closely with project leads to improve the accuracy and reporting of the project forecasts to ensure that the capital programme delivers to plan.

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Recommendations

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £4.4m, £1m better than the planned £5.4m deficit. The position does not include any financial penalties for under-achievement of activity.
- Note that the system forecast deficit is £28.4m for the second half of the year, when there is no retrospective true-up. This does not yet include the improvement to our Trust forecast.
- Note that the GHFT deficit forecast for the second half of the year is £14.5m, improved by £1m for the Month 7 position. This includes an annual leave provision.

Authors: **Johanna Bogle, Associate Director of Financial Management**

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

Date: **November 2020**

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TRUST PUBLIC BOARD – 10 DECEMBER 2020
Microsoft Teams, Commencing at 12:30

Report Title
Digital Programme Report
Sponsor and Author(s)
Author: Nicola Davies, Digital Engagement Lead Sponsoring Director: Mark Hutchinson, Exec. CDIO
Executive Summary
<u>Purpose</u> This paper provides updates and assurance on the delivery of digital workstreams and projects within GHFT, as well as business as usual functions. The progression of this agenda is in line with our ambition to become a digital leader. <u>Key issues to note</u> • We have submitted a compliant data protection toolkit assessment for this year, exceeding expectations. • Order Comms is now embedded in adult inpatient wards and more than 110,000 requests have been made through Sunrise EPR during September and October. Updates on phases 3, 4 and 5 are contained in the report. • After a concerted effort to complete significant digital projects, 12 have moved to closure this month. A new process for digital project requests is being rolled out. • TrakCare optimisations continue and an MR10 upgrade is due in November. • Data quality improvements continue and as COVID-19 admissions increase, the business intelligence team will be supporting increased local, regional and national reporting. • Calls to the IT service desk continue to increase and be dominated by remote working kit requests and support for national NHSmail changes and MS Teams. • We expect increased demand for services as more staff work remotely. <u>Conclusions</u> The importance of improving GHFTs digital maturity in line with our strategy has been significantly highlighted throughout the COVID pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, but needs to continue at pace. <u>Implications and Future Action Required</u> Implementation of our digital strategy will realise quality and financial benefits across the organisation. As services continue to move online and with an increase in remote working, demand for digital support is increasing.
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

FINANCE AND DIGITAL COMMITTEE - NOVEMBER 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, information governance 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 in November.

2. Sunrise EPR Programme Update

The EPR roadmap has been agreed by the EPR Programme Delivery Group and provides a high level overview of the next phases of implementation. Our phased approach ensures that we focus on digital improvements that will;

- provide broad brush strokes of digital functionality
- improve safety and reliability of care
- focus on where paper is being used the most.

Functionality	Estimated Go-live	Delivered
Nursing Documentation (adult inpatients)	June 2020	November 2019
E-observations (adult inpatients)	June 2020	February 2020
Order Communications (adult inpatients)	December 2020	August 2020
Order Communications (W&C, theatres, outpatients)	February 2021	
TCLE live and integrated	April 2021	
Emergency Department (all functionality)	March 2021 (Cheltenham) Summer 2021 (Gloucester)	
Paper-lite outpatients	Summer 2021	
Electronic Prescribing (known as EPMA)	Autumn 2021	

2.1 Order Comms (Requests and Results) Project Summary

Phase 1 order comms (IPS results into Sunrise EPR) went live on 20th August.

Phase 2 order comms (pathology and radiology requests and results) went live on 26th August in all adult inpatient wards. This stabilised very quickly and an optimisation workstream is currently closing down the few remaining minor issues.

Phase 3 order comms to deliver requests and results to all other clinical areas, including outpatients, is underway. Digital Senior Leadership Team is currently reviewing the devices required to support the rollout out to phase 3 areas.

Phases 4 and 5 order comms is the implementation of TCLE within the labs. Due to the need to get a location live with ECDS in a single A&E location by end of March 2021, the TCLE go lives have been moved backwards to allow CGH to go live with EPR in ED first.

Emergency Department is progressing with current and future state data capture to enable the delivery of paper-lite clinical documentation recording within ED locations, order communications and ECDS data collection recording.

Electronic Prescribing and Medicines Administration (ePMA). Challenges exist around resourcing and funding to ensure that this project can be delivered on time. The same is also true of the Pharmacy Stock Control project which is an enabling project for ePMA.

Paper-lite Outpatients is kicking off with a proof of concept for the community palliative care team in October. Following a successful trial, further detailed planning and testing of our outpatient list solution with additional (non-community) specialities will commence with a view to creating a baseline future state which can be used across multiple areas in outpatients to streamline our clinical pathways.

2.2 Activity planned for the next period

Planning is underway for phases 3 to 5 of order communications rollout to all other clinical areas. Alongside this, we are preparing for full implementation of EPR into Emergency Department from spring 2021 onwards followed by electronic prescribing across the organisation.

2.3 Summary of activity underway

- Complete current state analysis for phase 3 and design future states. Redefine end user device requirements and place orders – complete initial audits and specify work to estates for network and power installation.

- For phases 4 and 5 complete SCM/ICE/TCLE build reviews and action items identified out of them. Complete the interface build between SCM/ICE/TCLE and testing of the catalogues between the three systems. Investigate solutions to the histopathology data requirements and implement.

- Emergency Department current and future state design will be completed and preparation for EPR configuration and build will have started.

- Pharmacy Stock Control project is being reviewed and any ongoing impact

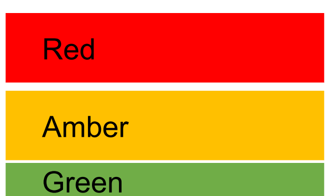
assessment on the electronic prescribing (ePMA) project will be completed.

2.4 Project risks

Current risks to the project timeline and success include:

- Increasing number of COVID-19 tests could remove pathology resources from EPR Programme during winter pressures.
- Histopathology system design and histopathology's data requirements remain a risk to TCLE integration – they are ongoing discussions to refine requirements and design a solution between labs, clinicians, Allscripts and InterSystems.
- Pharmacy resources and funding are still to be agreed and fulfilled – delays here will impact the delivery plan for ePMA.

2.5 Order Communications Workstream RAG status



Significant issues with the workstream – scope, time or budget is beyond tolerance level

Issue/s having negative impact on the workstream performance, workstream is close to tolerance level

On track

Workstream	Workstream Update	RAG Status
IPS Results into SCM	• Results from IPS to SCM went live on 20th August, however this was not widely communicated with the users.	**Complete**
Benefits	• The next level of benefits planning is underway	**Green**
Future State Design	• Phase 3 sessions are scheduled and are underway • ED current and future state work is in progress	**Amber**
Build	• Phase 3 + 4 and 5 build are progressing well with no major issues to report	**Green**
Testing	• Test planning across the EPR Programme is required but no resource is currently assigned	**Amber**
Reporting	• Phase 2 optimisations of BCP reports and labels have recently been deployed • Planning of the next round of delivery for all projects within the project is underway with BI	**Green**

Training	• No project specific training (aside from BAU) is currently underway. Trainers are attending future state workshops in preparation for the next round of training needs analysis and build	**Green**
Comms & Engagement	• Phase 3 communications are being distributed to prepare the trust for the project's requirements	**Green**
Clinical Site Readiness	• Phase 3 kit needs to be urgently redefined as the current suggest requirements exceed the budget available	**Red**
Interfacing / Integration	• ICNET requires a £30k PO to progress – there is a risk of delay to the TCLE project without agreement of the payment for the interface	**Amber**
TrakCare MR9 Upgrade	• Deployed to live on 19th August	**Complete**
TCLE	• Finalising go live approach – this will allow the correction plan dates to be agreed and this workstream to return to a green status	**Amber**

2.6 Additional Sunrise 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	• Activities are being planned by the EPR Configuration Team	**Green**
Pharmacy Stock Control	• Database build cannot complete this calendar year. Additional pharmacy resources are required to deliver this by January 2021. With the current resource level, delivery is predicted to be March 2021 but further work is ongoing with the correction plan • UAT and Training will be delayed and are being re-planned as part of the correction plan • Deployment and go live are also being re-	**Red**

	planned as part of the correction plan	

3. Sunrise EPR Quality, Benefits and Usage

This section provides a brief update on quality and benefits associated with Sunrise EPR.

3.1 Quality and usage update

We are working with nursing teams to make the most of the data now available on Sunrise EPR. This includes regular reporting to highlight usage and compliance by ward; reviewing audit requirements and increasing accountability. Reports are accessible by nursing teams from the Insights reporting system and an overview report is submitted on a monthly basis to Quality Delivery Group.

Usage reporting has helped identify additional training needs in certain areas and the EPR specialist nurses are supporting ward managers and matrons with improvements. For example, a recent engagement session held with nursing staff on AMU in Gloucestershire Royal Hospital helped us to better understand the way EPR is used by ward staff and identify the documentation they find difficult to complete. EPR nurse specialists provide dedicated training sessions to provide confidence and assurance.

Since launching with order comms (requests and results) at the end of August, we are monitoring the number of pathology and radiology requests made on Sunrise EPR and working closely with clinical teams to embed digital working. Initial headline figures show that more than 100,000 requests were made through Sunrise in the first two months.

EPR Orders

Month	Diagnostic Imaging	Pathology
September	4,532	57,199
October (up to 26th)	4,343	51,025
Total	**8,875**	**108,224**

3.2 Benefits next steps

The EPR implementation plan includes check points in the lead up to all go lives, to compare previous workflow and efficiencies with new digital workflow. This provides operational and finance leads an opportunity to continue identifying saving and improvement opportunities; and the time to baseline and capture the impact of Sunrise EPR.

In 2021 order comms will be rolled out across all specialities; we will upgrade the old labs system; upgrade the pharmacy stock control system and implement electronic prescribing (ePMA). We're also committed to delivering in EPR in ED across both sites, helping to alleviate pressures on urgent care teams.

Future benefits for all of these programmes are now being considered, but results from

other hospitals implementing similar systems demonstrate the potential for our next stage of EPR:

- Clinical decision support/ EPMA: Reduction in hospital acquired infection & decreasing sepsis mortality by 32%, Marina Salud Hospital de Denia.
- Clinical Decision Support / EPMA: Reduction of patients receiving sedating medication from 22% to 13%. Galway Clinic.
- EPMA: Reduction of drugs that requiring co-signing from 461 to 390 equating to roughly 15% of nursing time being saved, Galway Clinic.
- Physician Documents: Improved compliance with clinical documentation – entry of clinical notes for discharge summaries from 30% to 95%, Milton Keynes Hospital NHSFT.

4. Digital Programme Update

This section provides with updates on projects being delivered and overseen by the Digital PMO.

The PMO is now focussing attention on the development of processes and governance around project delivery, so that project work can be managed more effectively and we can provide a better service to operational and clinical colleagues. As digital transformation continues to embed, demand for digital resource and project management is growing. The new project request process will help us to review, prioritise and seek funding for the requests coming in.

Since October's update, three projects have been completed and closed and two projects have gone into closure to be completed by the end of November. These projects will be handed over to BAU with the relevant project closure documentation and lessons learned. Two projects are causing concern and these are detailed, along with mitigating actions below.

4.1 Key Projects Update

The current status of projects that report to the Digital Care Delivery Group is as follows:

Capital Funded Project	Other Key Projects	Primary Care / CCG Projects	Projects Complete or in closure	On Hold	Pipeline	Red Rated Projects	Amber Rated Projects	Green Rated Projects
3	9	3	10	3	3	4	5	6

Status	Description
Red	Significant issues with the project – scope, time or budget is beyond tolerance level
Amber	Issue/s having negative impact on the project performance, project is close to tolerance level
Green	Project is on track
Blue	Complete & Closed

4.2 Projects Closed This Period

- Pharmacy Robot
- Varian/Aria Upgrade

4.3 Projects in Closure/Handover to BAU

Project	Project Update	Go Live Date	
		Planned	Actual
Fax Eradication	• The project is in closure.	**March 2020**	**October 2020**
MDT Video Conferencing	• The project is in closure.	**May 2020**	**August 2020**
Server Replacement Medisight	• The project is in closure.	**June 2020**	**July 2020**
Blood360 Upgrade	• The project is in closure.	**July 2020**	**September 2020**
New Text Messaging for GHT (Education & Development)	• The project is in closure.	**August 2020**	
Marybrook and Culverhay Merger	• The Project is in closure	**August 2020**	
Cinderford New Build	• The project is in closure.	**September 2020**	
N3 to HSCN Migration Countywide	• The project is inn Closure (with BAU activity to confirm no remaining dependencies on the legacy network before ceasing).	**September 2020**	
Network Remediation Phase 3	• This project is now entering closure, the technical products having been delivered on 22nd September.	**September 2020**	
Windows 10	• A closure report has been completed and a stakeholder meeting convened (9th November) where the project's products can be accepted into BAU.	**October 2020**	

4.4 Areas of Concern & Mitigating Actions

Next Generation Telephony
The lack of confidence in and assurance from the supplier required for the migration of the Trust inbound call services and the potential risk of this has forced a re-baselining of the project to enable the required level of due diligence to be undertaken regarding the plan and impact.

Wi-Fi Replacement

Deployment of access points has been halted and an exception report issued, following an issue with connectivity affecting CGH Phlebotomy label printers. This requires resolution before recommencing the roll out of Access Points. A solution has been provided. This issue placed the project in RED but once the solution is implemented, delivery will commence w/c 2nd November and the project will revert to GREEN.

5. TrakCare Update

This section provides an update on TrakCare optimisation workstreams.

5.1 TrakCare Optimisation

The priority for the TrakCare Optimisation Programme from April through to October 2020 (and into late November 2020) has been the delivery of three 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. Additionally the most recent maintenance release (MR10) due to go live mid-November is required for submission of Maternity Services Dataset 2 (MSDS2) a requirement within the CNST (Clinical Negligence Scheme for Trusts) with significant financial implications.

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. Remote UAT is planned for MR10 and on-site meetings are now being organised when required and safe to do so.

Two significant issues identified post MR9 go-live have been escalated with ISC and work-rounds have been developed whilst awaiting resolution.

The programme focus after the go-live date of MR10 (18 November) will switch to a programme close-down phase and this will involve activities to conclude developmental activities, stabilise processes currently undertaken by the team, grow capabilities within substantive BAU teams, and highlight to the Trust risks associated with lack of capacity or capability for critical functions. Funding has been approved recently to form a substantive team to undertake many of the Trak-op processes and the presence of a "receiving team" for this knowledge transfer has lowered this risk considerably.

Whilst programme reporting going forward will measure progress against explicit deliverables set as at October 2020, it is intended that in March 2021 programme closure reporting will include a review of all items delivered within the two year programme to enable reliable and complete value for investment assessments.

5.2 Status reports

At present deliverable due dates are set for 31st March 2021 until the programme further explores milestones and associated timelines. The change to programme reporting against explicit deliverables has created difficulties with status reporting as many potential resource conflicts or obstacles against this much narrower focus have not yet been fully explored.

The table below presents a high level view of current project/deliverables status. To account for the current absence of detailed analysis against all deliverables, the

project deliverable statuses for this report are set according to the following rules:

- GREEN: milestones to achieving deliverables are well understood and there are no known impediments to achieving a 31 March delivery date.

- AMBER
  a) milestones to achieving deliverables are well understood and obstacles to eventual delivery are present but all efforts to overcome obstacles have not yet been fully exhausted.
  b) insufficient understanding exists at time of reporting of milestones on the path to delivery within the context of the much narrower focus of an explicit deliverable.

- RED: obstacles to eventual delivery are present and all efforts to overcome these have been exhausted.

Project	Deliverables	Status
RTT/WL		
	Reduce new weekly DQ issues by further 10% on 5 priority DQ issues from end September numbers.	
	IPT processes	
Maternity		
	MSDS2	
	PbR Review	
Outpatient		
	Deliver new appointment process into Palliative care	
	Recording of interventional radiology activity	
Upgrades/ Maintenance		
	Delivery of Maintenance release 10	
	T2020 plan	
Enhancements		
	CPIS	
	e-RS API	
	Vetting details screen for inpatients	
	OP waiting lists to ensure we can see the hospital field on the vetting list	
	Mandating discharge destination	
	Add questionnaires to discharge summaries	
	Red wristband printing	
	IP scheduling & Bed booking by hour – proof of concept	

	Task-lists	
Theatres		
	Mandatory fields wish-list	
	WHO checklist	
	Anaesthetics Alerts	
	Theatres Brief and Debrief	
	Trauma list	
	Procedure change warning	
	Body site and secondary procedure functionality	
	POAC package	
	Peri-operative workflow	
	POAC swab testing	
Emergency Department		
	ECDS in collaboration with EPR	
Deep Dives		
	CBO	
	Three specialties with the GHFT highest priority issues	
Unplanned Items		
	Virtual Appointments Project	
	OP Follow-up book-now process	
	Central Testing Resource for external projects	
	Security Group reviews – overbook capability	
	JUYI interface with TRAK	
	Bed management workstream	
	New wristband functionality	
Transition to BAU		
	CCR Support	
	TrakCare Intranet page ownership	
	RTT & WL DQ reporting and management	
	Tier 3 TrakCare Support Calls	
	Letter templates change for linked care provider	

	Anaesthetic QRG created or revamped	
	Linkage of multiple procedures	
	ED Coding performance management	
	Theatres booking - use of single room checkbox	
	Management of non-live environments	
	Resolution of any issues within Audiology RTT return to reporting	

5.3 RTT (Referral to treatment) and waiting lists

An intensive assessment of remaining RTT and waiting list data quality issues took place in October. The aim of this assessment was to estimate reductions possible in weekly new data quality issues prior to 31 March 2021. It considered benefits achievable through user engagement and training, minor system changes, tackling poor timeliness in data recording, further exclusions to RTT reporting, specialty specific process review, and exploring use of RPA automation to correct problem records. The assessment concluded that a further 10% (from end of September volumes) reduction to the current weekly levels of new priority DQ issues was achievable within the timeframe. The weekly reporting of: DQ issues, productivity of the validation team in resolving known issues, the timeliness of data entry and incomplete outcome recording has been developed into a stable process which is ready for transition to BAU teams.

This work will now be reported under the transition to BAU project. Support activities which may be required when national guidance mandates the resumption of Audiology RTT reporting has been added to the transition to BAU project.

The inter-provider transfers (IPT) workstream has previously seen the full development of incoming IPT but technical issues remain preventing the final adoption of out-going IPTs. Automation of outgoing transfers is proving technically difficult due to the requirement to attach original referral documentation. The team developed a manual process in collaboration with operational colleagues as a temporary work-around but this process also failed at the final stages of development due to an ISC bug preventing its successful implementation.

Clinical/Operational process consideration around consent, documentation requirements, aftercare arrangements, assessments on patient suitability for transfer, etc. have not yet commenced. The expectation is that the Trak-op team will engage with services to develop a suitable model and this will be signed off at appropriate levels.

5.4 Programme Risks

Currently programme risks are:

- Not securing OIA approval for MR10 downtime due to second wave COVID.
- Remaining non-compliant with MSDS2 despite successful initial phase of implementation of MR10 (into the development & test environments).
- Further unplanned items and concomitant resource requirements entering the programme due to shifting Trust priorities.

- Lack of capacity within BAU teams to accept hand-over or undertake stabilised BAU functions as projects approach closure.

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.

5.5 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 are managed routinely each month through data validation and correction. 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.

- The total number of issues monitored has continued to reduce, starting at 304,489 (07/01/2018), down to 95,611 (03/04/2019), and currently at 72,595 (02/09/2020) compared to the last reported figure of 71,043 (05/08/2020). The top 5 data quality indicators totalled 19,471 as at 03/04/2019 and are now 8,109 compared to 7,814 reported last month. This includes 2,681 records already validated as correct, leaving the total to be reviewed at 5,339.

- The number of new issues per week averages 1,084 for financial year to date 2020/21, compared to an average of 1,611 for October to March 2019/20. There was an increase during July 2020, with an average of 1,284, but this reduced to 1,149 in August.

6. Countywide IT Service (CITS) Monthly Report (September 2020)

September was an extremely busy month in the IT service as people returned from holidays. Many of the calls we are now receiving are related to NHSmail issues and new features being added to Teams as a national migration take place. This migration is happening gradually and will continue to impact users over the autumn. To support users we are issuing regular communications using global channels.

We are working hard to reduce the number of calls marked as open. The majority of these are users waiting for additional kit to support home working and video conferencing. Supply issues nationally have affected delivery times. We will reduce this significantly in October/November when stock is due in.

Key highlights for September are:

- Total open calls are up - but mainly delays in procurement with supplier timescales (demand for headsets and cameras increasing).
- Total calls received = 6544

- Calls answered within 90 seconds 36%
- No P1 or P2 SLA breaches (mainly p4) but all within SLA tolerance: still hitting plus 90%

As more staff work remotely, calls to the service desk will remain at high levels and requests for additional video conferencing kit will increase. Supporting our COVID-19 winter response will put additional pressure on IT resources as staff are required to work from home.

7. Information Governance

This section provides updates and assurance on the Information Governance Framework in operation within the Trust.

7.1 Data Security and Protection Toolkit (DSPT)

All organisations that have access to NHS patient data and systems must use the toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. We have submitted our annual assessment and received a calculated status of “Standards Exceeded”.

The toolkit is divided into ten sections which follow the national data guardian’s (NDG) data security standards. These are further subdivided into 40 mandatory assertions and a further four non mandatory assertions. The Trust’s 2019/20 self-assessment has been submitted with 41 of the assertions completed and evidence provided.

We are delighted to have achieved the mandatory requirement of 95% of staff completing annual Information Governance refresher training. Compliance has increased across all staff groups; however Medical and Dental Staff still lag behind with particular challenges in updating rotating junior doctors.

The 2020/21 toolkit has yet to be released, but is anticipated to require an adjusted submission by 30 June 2021. Guidelines on the requirement, to accompany the toolkit have been published and include a number of assertions that have been reworded and four additional. These are being reviewed and any changes in evidence required will be incorporated into this year’s IG programme of work.

7.2 Information governance incidents

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

Four incidents have been reported to the ICO during the 2020/21 reporting period to date.

8. Cyber Security

This section details cybersecurity activity for the reporting period (September 2020) in

relation to risk mitigation, current controls and ongoing work to protect Gloucestershire Healthcare Community information assets.

In summary:

- Two open audit findings remain, rated 'Moderate', relating to unsupported software and unsupported operating systems, due to be mitigated in Q4 2020.
- A Cyber Security Officer has been appointed to boost resource
- We are working with GHC to support a standardised cyber approach across Gloucestershire ICS.

Focus	AUGUST 2020	SEPTEMBER 2020	Explanation
1. CareCERT Advisories	GREEN	GREEN	One High Advisory reported. No open High Advisories.
2. CareCERT Threat Notifications	GREEN	GREEN	No threat notifications for the reporting period
3. Cyber Security Risks	AMBER	AMBER	2 Moderate findings remain open – on track to be closed within Q4 2020
4. Cyber Security Controls	GREEN	GREEN	Now tracking trends over last three months
5. Business Risks	AMBER	AMBER	4 'High' Business Risks
6. Cyber Services	GREEN	GREEN	Unified Cyber Risk Framework workshop to be organised by CITS Cyber function

Authors:
Anna Wibberley, Digital Programme Director
Nicola Davies, Digital Engagement Lead

Presenter: Mark Hutchinson, Executive Chief Digital & Information Officer

REPORT TO TRUST BOARD – December 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 on 26 November 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
Board Assurance Framework	Refreshed document presented with all risks reviewed and updated by Lead Executives.	Are controls adequate for major transformational programmes? Is there a risk of loss of momentum once smaller schemes successfully deployed?	Acknowledgement of the challenge and risk particularly in light of the complexity but confident that system working is closer and more effective.	Need for continued monitoring of progress of system wide initiatives
Financial Performance Report	Report covered the month 1 – 6 result which was break even reflecting national income actions. Month 7 a deficit of £4.4 million v a plan of £5.4 million resulting change in 2nd half overall deficit to £14.5 million. Update on breaking news covering the agreement between the Welsh Assembly and NHSE/I and potential consequences.	Detailed question on the relationship between Agency cost and reported hours? Is there clear understanding that penalties for missing activity level targets are not included in current estimates? What are the financial impacts of the Trust being a lead provider for mass vaccination?	Month to month variance reflects differing mix of Agency resource used. Overall grip of agency staffing is good Yes – NHSE/I is aware and the submission approach has been accepted Funding arrangements and cost basis are under discussion but expected to involve tranches of reimbursement	Will be the subject of further analysis as plans evolve

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Capital Programme Report	The Trust remains on track to spend its full in year allocation of capital - £40.9 million. At month 7 actual spend in £1 million behind the year to date plan. Resources deployed to monitor plan progress and minimise risk of underspend which would result in forfeiting allocated capital	With enabling works for Imaging project behind plan is there time to complete? Is greater support required to address areas where operational issues are impeding capital project progress?	Procurement working on the project and funding considered secure. Plan being prepared for review by the Infrastructure Delivery Group	 Progress to be reviewed at next F & D Committee
Cost Improvement Programme 2021/22	Routine in year reporting stood down as the usual methodology not applicable the under the current financial regime. Project management office focus now on 21/22 - methodology and related action steps described.	When will the committee be advised on divisional submissions?	In depth reports to be reviewed in January and March	
Budget Setting	Report outlining the methodology for 21/22 budget setting		Committee assured that the budget setting process has commenced and is following a methodology agreed by the Trust Leadership Team	
Finance Strategy	Early draft of the strategy document presented for review and comment	Would streamlining the document be better by moving supporting material to appendices?	Yes – structure and flow under review.	Committee members to follow up with inputs for the next iteration
Financial Risk Register	Updated Risk register presented	Given the importance and wide-ranging impact of a new ledger system		Date for review to be proposed

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		when should the committee be briefed on the plans to replace the current system?		
Digital Programme Report	Status report of all key projects reviewed. Notable are the successful embedding of the Order Communications module of the Electronic Patient Record system with c. 110.000 request during the first 2 full months of deployment. Trust has submitted a compliant data protection toolkit assessment. The IT service desk activity levels continue to rise	What is the status of the long running telephony project? When will Gloucestershire Health and Care Trust be re-involved with the Countywide Information Technology Service?	Experience of phlebotomy results being shared across wards reducing repetition and lost results. The project has been suspended for an extended period following identification of poor resilience and associated core network upgrades requirements. Resumption is expected shortly	Part of the wider issue of finding the right approach to IT systems across the ICS – this must be kept under review
Information and Coding	Report presented highlighting the progress made by the Business Intelligence Team. The team has been strengthened and achieved reduced reliance on contractors but recruitment remains a challenge. Data quality has improved.		Committee assured on the progress being made and the appropriateness of future plans.	
Digital Risk	31 risks on the register – 2		Committee assured on the	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Register	closed and no new risks		process	

Rob Graves
Chair of Finance and Digital Committee
3rd December 2020

PUBLIC TRUST BOARD – 10 DECEMBER 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 October 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 information in the QPR is intended to help us make informed decisions about the quality of care provided. As is good practice we are reviewing all the quality indicators and we are:

- analysing existing indicators and establishing whether they present a comprehensive picture of quality
- identifying the main purposes for which indicators could be developed and considering whether current indicators would help to achieve these aims
- establishing how existing indicators could be used to understand the quality of care received by different population groups as we are working on our protected characteristics data collection
- considering whether the process for developing new indicators could be improved
- looking at the most effective way of developing future indicators within our quality account reported improvement programmes.

Metrics/indicators and the review committee/group

Infection prevention and control committee
C Diff - There was an increase in community onset cases of C. difficile has been seen possibly due to increased use of antimicrobials in primary care. There are reduced face-to-face appointments with GPs and this may have resulted in more "just in case" antibiotic prescriptions.

QDG review of improvement programmes

Safe - preventing harm
Pressure ulcer prevention improvement plan - deep tissue injuries have increase. These cases are reviewed weekly at the Preventing Harm Improvement Hub. Factors contributing to increases are increased deconditioning of patients, particularly older more frail people. Lack of assessment of pressure ulcer risk and subsequently lack of evidence of mitigations in place. Equipment provision, especially pressure relieving cushions for chairs has also been a factor.

Falls prevention improvement plan- Falls have increased due to a number of factors; increased de-conditioning in patients that have endured months of lockdown, reduced visiting which decreases supervision, inability to fill enhanced care requests and lack of risk assessment completion. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub. Incidents resulting in moderate or severe harm are rapidly assessed for immediate remedial safety actions and presented to the weekly Preventing Harm Hub. Actions are recorded by risk managers. Serious incidents are referred up to the SI Panel.

VTE risk assessment - 89.8% for 1st VTE risk assessment is within the natural variation the system is capable of producing. The data ideally would be taken from Trakcare but is not currently working effectively and the electronic solution will be part of e-prescribing

Caring – person centred care
Urgent Care FFT
The unscheduled care FFT scores have shown a slight increase (1.7%) from September, with 624 responses. The Divisional and specialty teams are working with colleagues to triangulate data sources and develop a patient experience improvement plan, which will be monitored in division and at QDG. This includes setting up a patient experience network for medical matrons.

Inpatient FFT-
The inpatient score of 86.4% is a combined score of inpatients (82.77) and day case (96.07) FFT. This has remained stable since a decline in August. The Patient Experience Improvement team are looking at adding in more questions to the FFT as a pilot on some wards, which patients can answer while in the hospital to replace our real time surveys. This will give more insight about experience on wards vs discharge, and the opportunity to ask questions on more specific areas of experience that will be informed by trends emerging from comments in that ward area.

Maternity FFT
The data for October has shown a significant drop after an increase in the positive score in September. We will continue to monitor this to understand if there are any trends emerging. Detailed reports including all comments are shared with teams and departments to inform local improvement plans and triangulate with other data

Effective
Readmissions
The rate increased in March 2020 and was red in April 2020. This would be expected as the number of hospital admissions without COVID – 19 reduced dramatically. The elective workload has the lowest rate of emergency readmissions and this activity remains below pre-COVID time period and so would be expected to be higher. It is reasonable to expect the rate to fall as elective activity increases.

Learning from deaths
HSMR
These figures are showing as “higher than expected” when taking into the account of the COVID period, the months following the first wave show a reduction. The issue relates to similar or higher number of deaths but a greatly reduced number of episodes of care during that time, i.e. the rate increased. However, this does not suggest any degree of complacency as these are monitored at the Hospital Mortality Group (HMG), and four specific areas are having a deep dive.

Stillbirths
In October there were 4 term stillbirths and one case has been declared an SI; the other three have been reviewed at risk meeting and no trend discovered but will be re-reviewed in light of the cluster.

Year to date stillbirth (>37 weeks) is 3.89/1000 live births (target of <4.6/1000). QDG and the Q&P Committee will review the Maternity Improvement Action Plan.

Performance

During October 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 October was 68.96% with system performance total 80.21%. The Trust did not meet the diagnostics standard for October at 17.5%, 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 meet the standard for 2 week wait cancer at 95.9% in October and for the 62day standard at 85.1% this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance 69% in October, un-validated at the time of the report, and improved from the summer position. Our focus is to ensure that patients are risk stratified and we continue to step up to fully utilise our clinics and theatres during the next period as we continue to restore our services.

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	**Finance & Digital**	**Audit & Assurance**	**People & OD**	**Remuneration Committee**	**Trust Leadership**	**Other (specify)**

Committee	Committee	Committee	Committee		Team	
✓						
Outcome of discussion when presented to previous Committees						

Quality and Performance Report

Reporting Period October 2020

Presented at November 2020 Q&P and December 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 in place with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety.

During October the Trust 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 October was 68.96%, against the STP trajectory of 85.89%. The system did not meet the delivery of 90% for the system in September, at 80.21%. Note that the October 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 October at 17.50%. 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. MR and CT have recovered their waiting time position.

The Trust did meet the standard for 2 week wait cancer at 93.1% in October & 62 day cancer waits this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.14% (un-validated) in October, 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 1,290 in October. 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		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	145	159	127	161	105	105	61	57	88	78	166	140	152
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	2	3	11	10	5	2	0	0	5	1	36	21	42
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%
	Actual	86.36%	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%
	Actual	80.58%	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	79.30%	79.60%	80.00%	80.30%	80.60%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	81.33%	80.29%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	68.94%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	74	67	60	40	20	0	0	0	0	0	0	0	0
	Actual	62	45	39	28	14	33	156	366	694	1037	1233	1279	1300
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.98%	0.99%	0.98%	0.98%	0.98%	0.98%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	0.54%	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.67%
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%
	Actual	94.40%	94.60%	96.90%	95.10%	96.10%	95.10%	90.60%	99.10%	98.00%	96.50%	90.80%	95.20%	93.10%
2 week wait breast symptomatic referrals	Trajectory	93.00%	93.10%	93.20%	93.20%	93.20%	93.20%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	98.20%	96.00%	97.40%	96.30%	97.80%	98.40%	87.90%	97.80%	95.70%	96.40%	95.90%	93.40%	97.10%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.10%	96.10%	96.20%	96.20%	96.20%	96.20%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	91.40%	91.40%	93.00%	95.50%	94.30%	95.50%	96.60%	96.00%	95.30%	98.10%	96.70%	96.40%	99.30%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	99.00%	98.00%	98.90%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.00%	97.00%	100.00%	100.00%	100.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	95.10%	95.10%	95.10%	95.10%	95.10%	95.10%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	99.20%	94.80%	95.60%	96.70%	97.50%	100.00%	98.30%	96.70%	86.50%	83.00%	98.30%	97.30%	98.70%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	95.50%	95.40%	95.60%	94.80%	94.80%	94.80%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	100.00%	98.00%	90.20%	98.30%	97.40%	94.10%	98.20%	92.60%	81.30%	78.90%	87.20%	96.20%	96.80%
Cancer 62 day referral to treatment (screenings)	Trajectory	91.40%	91.40%	92.30%	90.60%	90.60%	90.60%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	96.40%	95.10%	91.10%	97.80%	96.70%	94.70%	90.90%	54.50%	60.00%	66.70%	77.80%	88.90%	100.00%
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%
	Actual	61.50%	83.30%	87.50%	69.20%	63.60%	76.50%	100.00%	88.90%	73.70%	91.70%	90.00%	91.70%	85.00%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.20%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	76.70%	71.40%	74.20%	68.00%	76.50%	78.20%	78.00%	69.00%	78.00%	85.60%	87.60%	81.50%	84.60%

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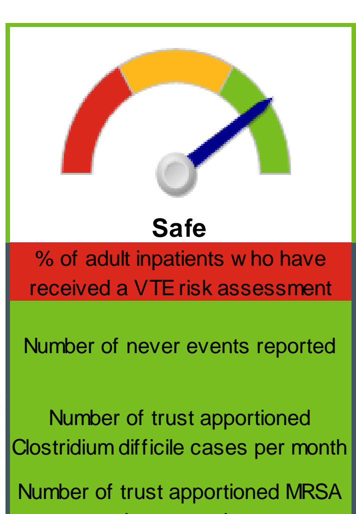
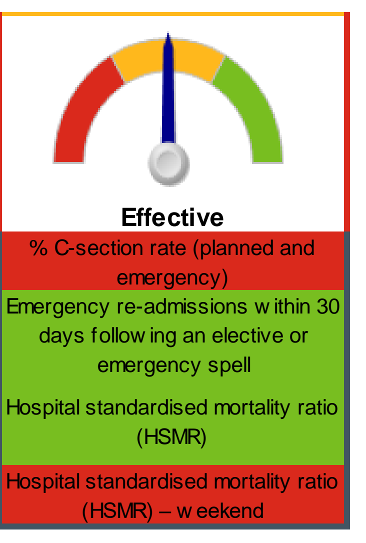
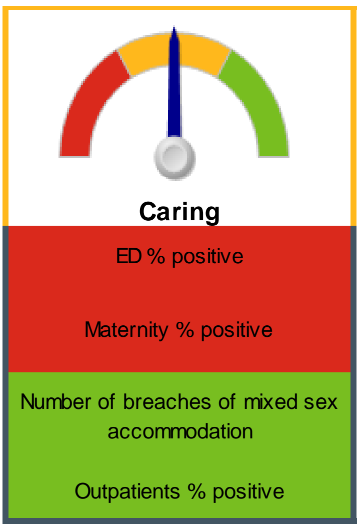
Summary Scorecard

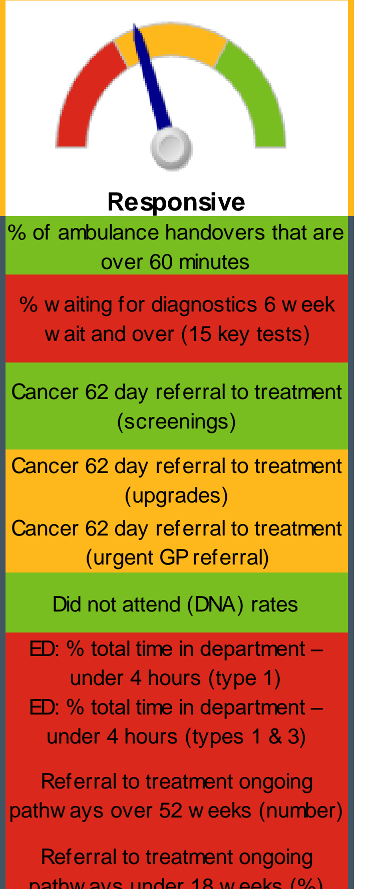
The following table shows the Trust's current monthly performance against the chosen lead indicators within the Trust Scorecard.

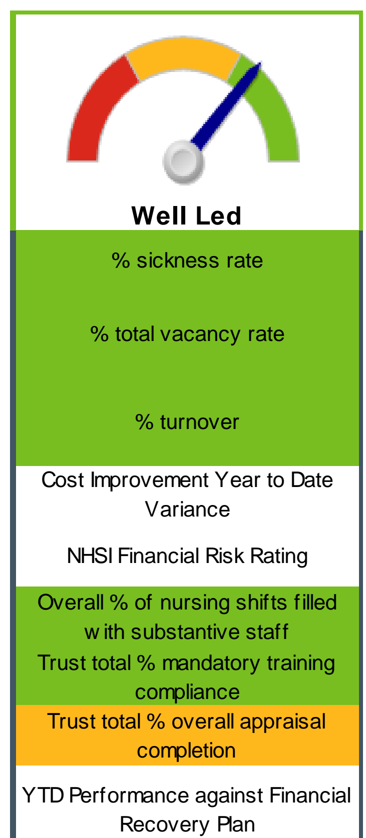
RAG Rating: Overall RAG rating for a domain is an average performance of lead indicators against national standards. Where data is not available the lead indicator is treated as red.











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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	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Monthly (Oct)	YTD
GP Referrals	11,836	13,356	11,169	10,191	9,595	7,888	3,076	3,946	3,185	8,119	7,784	8,181	8,746	-26.1%	-79.6%
OP Attendances	14,545	13,379	10,823	13,634	12,167	10,637	26,018	30,419	40,646	44,330	39,151	49,790	51,948	257.2%	360.7%
New OP Attendances							7,002	8,812	12,052	13,870	12,542	16,179	17,326		
FUP OP Attendances							19,016	21,607	28,594	30,460	26,609	33,611	34,622		
Day cases	7,142	6,578	6,228	7,067	5,304	4,216	1,473	1,786	2,721	3,467	3,109	4,414	4,586	-35.8%	-93.0%
All electives	8,275	7,690	7,155	8,039	6,294	4,966	1,780	2,183	3,252	4,242	3,965	5,366	5,640	-31.8%	-88.3%
ED Attendances	13,329	13,066	13,287	12,624	11,695	9,721	6,861	8,913	9,819	10,957	11,636	10,903	10,279	-22.9%	-45.0%
Non Electives	5,083	4,837	5,052	4,664	4,353	3,874	3,110	3,728	4,205	4,421	4,320	4,495	4,584	-9.8%	-24.8%

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Trust Scorecard - Safe (1)

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

	19/20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission								250	64	9	5	4	18	48	27	393	TBC	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission								68	7	1	1	0	1	3	2	81	TBC	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission								38	1	2	1	0	0	0	1	42	TBC	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission								33	4	1	1	1	0	0	2	40	TBC	
Number of trust apportioned MRSA bacteraemia	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days	.6																Zero	
Number of trust apportioned Clostridium difficile cases per month	97	11	12	7	8	6	5	4	7	2	7	0	4	8	23	44	2019/20: 114	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	5	10	3	5	4	6	2	1	4	1	2	6	1	1	9	16	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	45	1	9	2	4	0	3	3	3	1	5	6	3	7	14	28	<=5	
Clostridium difficile – infection rate per 100,000 bed days	28.8	37.9	42.4	24.4	29.7	21.5	17.6	25.6	38.6	9.9	30.3		15.7	29.2	14.9	20.6	<30.2	
Number of MSSA bacteraemia cases	18	2	1	2	1	1	2	1	0	3	1	1	0	1	1	6	<=8	
MSSA – infection rate per 100,000 bed days	5.3	6.9	3.5	7	3.3	3.6	7	6.4		14.9	4.3	4		3.6	2.7	4.5	<=12.7	
Number of ecoli cases	46	2	5	9	3	3	2	1	3	2	4	3	0	6	7	19	No target	
Number of pseudomona cases	9	1	0	0	3	0	1	0	2	0	0	0	0	0	0	2	No target	
Number of klebsiella cases	18	1	1	1	1	2	1	1	2	0	1	1	1	0	3	6	No target	
Number of bed days lost due to infection control outbreaks	1,264	0	240	276	100	13	0		0	0	4	0	0	5	4	9	<10	>30

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Trust Scorecard - Safe (2)

	19/20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of falls per 1,000 bed days	6.4	6.6	6.4	6.7	7.1	7	6.4	6	7.9	7.2	7	7.3	7.5	6.9	7.3	7.1	<=6	
Number of falls resulting in harm (moderate/severe)	4	7	1	4	5	5	0	2	4	4	3	4	3	6	10	26	<=3	
Number of patient safety incidents – severe harm (major/death)	6	7	3	3	6	5	2	4	1	5	2	7	4	5	13	28	No target	
Medication error resulting in severe harm	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	2	2	1	1	5	2	1	2	3	2	6	1	2	1	9	17	No target	
Medication error resulting in low harm	12	21	23	7	10	8	11	9	15	7	8	14	14	9	36	76	No target	
Number of category 2 pressure ulcers acquired as in-patient	30	24	31	29	27	12	23	13	15	16	9	24	13	23	46	113	<=30	
Number of category 3 pressure ulcers acquired as in-patient	5	4	4	2	2	3	1	0	1	0	1	3	4	5	8	14	<=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	5	2	4	6	3	3	4	7	4	5	9	7	18	32	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient		3	8	3	5	3	4	4	6	1	2	6	4	12	12	23	<=5	
RIDDOR																		
Number of RIDDOR	35	2	1	2	4	2	2	2	1	5	3	0	2	1	5	14	SPC	
Safeguarding																		
Level 2 safeguarding adult training - e-learning package		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	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Safety Thermometer																		
Safety thermometer – % of new harms	97.1%	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%			71.00%			68.00%			68.00%							>=90%	<50%
Serious Incidents																		
Number of never events reported	6	1	0	1	1	1	0	0	0	2	0	0	1	0	1	3	Zero	
Number of serious incidents reported	3	4	3	1	2	3	2	0	0	2	2	5	4	3	11	16	No target	
Serious incidents – 72 hour report completed within contract timescale	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%	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%	95.9%	91.8%	92.6%	90.1%	94.2%	92.7%		90.1%	94.0%	93.8%	90.7%	87.0%	89.8%	90.4%	90.8%	>95%	

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Trust Scorecard - Effective (1)

	19/20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	0.8%	62.0%	50.0%	37.0%	37.0%	86.0%	74.0%	67.0%	63.0%	68.0%	71.0%	71.0%	79.0%		73.0%	69.0%	>=90%	<70%
% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	29.4%	0.0%	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%			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%	0.40%	0.00%	0.10%	0.40%	No target	
% C-section rate (planned and emergency)	28.39%	25.97%	26.57%	31.30%	28.66%	30.23%	28.90%	27.73%	28.82%	25.94%	26.51%	27.80%	31.13%	32.91%	28.45%	28.66%	<=27%	>=30%
% emergency C-section rate	15.74%	13.70%	15.77%	13.48%	13.60%	16.36%	14.48%	12.73%	15.27%	12.08%	12.73%	16.20%	15.14%	19.50%	14.71%	14.81%	No target	
% of women that have an induced labour	28.65%	29.04%	29.59%	30.00%	27.20%	28.42%	27.98%	27.50%	28.60%	29.70%	35.49%	31.20%	32.41%	28.72%	33.03%	30.58%	<=30%	>33%
% of women smoking at delivery	10.95%	10.22%	13.63%	11.52%	13.18%	8.64%	12.39%	9.55%	10.97%	11.29%	9.39%	13.80%	11.30%	12.58%	11.52%	11.26%	<=14.5%	
% of women booked by 12 weeks gestation	88.9%	91.8%	92.2%	91.9%	90.3%	89.5%	89.7%	89.6%	93.1%	93.3%	93.0%	92.4%	95.0%	92.3%	93.8%	92.8%	>90%	
% stillbirths as percentage of all pregnancies > 24 weeks	0.22%	0.20%	0.43%	0.43%	0.21%	0.00%	0.23%	1.14%	0.00%	0.20%	0.42%	0.00%	0.21%	0.83%	0.21%	0.39%	<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	99.7	99.8	103.9	99.9	107.2	108	111.3	110.7	107.1	104.6				107.1	104.6	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	112.7	102.7	102.1	110.3	104.3	110.9	112.7	117.4	117.5	114.4	110.8				114.4	110.8	Dr Foster	
Number of inpatient deaths	1,964	144	152	212	215	167	192	252	126	112	120	143	147	139	410	1,039	No target	
Number of deaths of patients with a learning disability	15	0	0	1	4	0	0	4	2	0	1	3	4	1	8	15	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	6.7%	7.1%	6.4%	6.6%	6.7%	8.3%	9.6%	8.5%	7.2%	7.9%	8.5%	7.4%		7.9%	8.0%	<8.25%	>8.75%
Research																		
Research accruals		121	101	73	110	98											No target	

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Trust Scorecard - Effective (2)

	19/20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	49.5%	52.5%	39.4%	48.7%	45.2%	56.4%	46.2%	37.0%	53.0%	45.0%	63.5%	60.9%	52.9%	46.6%	59.1%	51.3%	>=50%	<45%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.7%	84.5%	81.1%	87.3%	88.5%	87.7%	90.4%	88.5%	78.0%	84.0%	95.1%	89.7%	94.3%			83.5%	>=80%	<70%
% of patients admitted directly to the stroke unit in 4 hours	54.80%	64.90%	41.40%	40.00%	38.40%	30.80%	49.30%	49.00%	21.00%	65.00%	74.50%	50.70%	51.60%	34.50%	58.90%	45.00%	>=80%	<72%
% patients receiving a swallow screen within 4 hours of arrival	70.70%	77.80%	71.20%	71.70%	69.20%	71.00%	65.20%	68.00%	76.00%	65.00%	78.60%	59.30%	62.70%	63.50%	66.80%	67.80%	>=90%	<80%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	55.7%	39.6%	56.1%	58.3%	73.1%	58.6%	48.6%	75.0%	62.4%	72.7%	56.7%	71.9%	63.6%	60.7%	62.1%	66.7%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	54.90%	37.90%	56.06%	58.30%	73.10%	55.20%	48.60%	53.10%	60.60%	70.91%	56.70%	70.20%	62.10%	58.80%	60.60%	62.00%	>=65%	<55%

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Trust Scorecard - Caring (1)

	19/20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	90.7%	90.6%	91.8%	90.2%	90.2%	90.5%	91.1%	90.0%	90.2%	91.9%	87.0%	86.0%	88.7%	86.4%	87.3%	89.3%	>=96%	<93%
ED % positive	82.1%	82.9%	87.9%	78.9%	79.9%	79.2%	79.6%	90.2%	85.8%	86.8%	81.8%	77.2%	73.0%	74.7%	77.3%	79.7%	>=84%	<81%
Maternity % positive	97.4%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	97.2%	100.0%	90.2%	100.0%	85.2%	93.9%	88.9%	91.4%	91.8%	>=97%	<94%
Outpatients % positive	93.0%	92.8%	93.8%	93.2%	93.1%	93.0%	94.3%	94.0%	93.6%	93.9%	93.7%	93.5%	92.8%	94.0%	93.3%	93.3%	>=94%	<91%
Total % positive	91.2%	91.1%	92.8%	91.3%	91.4%	91.1%	92.2%	92.9%	91.8%	92.4%	91.3%	90.0%	90.1%	91.5%	90.4%	90.9%	>=93%	<90%
Inpatient Questions (Real time)																		
How much information about your condition or treatment or care has been given to you?	79.00%	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%	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%	98.00%	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%	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%	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%	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%	100.00%	85.00%	96.00%	97.00%	93.00%	86.00%										>=90%	
MSA																		
Number of breaches of mixed sex accommodation	82	0	0	2	2	1	8	6	13	21	23	1	0	0	24	64	<=10	>=20

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Trust Scorecard - Responsive (1)

	19/20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait								53.9%	79.6%	77.9%	79.9%	79.4%	76.1%	77.1%	76.5%	74.3%	TBC	
Cancer – 28 day FDS breast symptom two week wait								91.4%	95.7%	98.6%	99.1%	80.6%	98.3%	77.1%	98.5%	97.8%	TBC	
Cancer – 28 day FDS screening referral								76.0%	50.0%	76.9%	100.0%	78.6%	65.4%	77.1%	76.9%	73.2%	TBC	
Cancer – urgent referrals seen in under 2 weeks from GP	92.5%	94.4%	94.6%	96.9%	95.1%	96.1%	95.1%	90.6%	99.1%	98.0%	96.5%	90.8%	95.2%	93.1%	94.3%	95.2%	>=93%	<90%
2 week wait breast symptomatic referrals	97.5%	98.2%	96.0%	97.4%	96.3%	97.8%	98.4%	87.9%	97.8%	95.7%	96.4%	95.9%	93.4%	97.1%	95.5%	95.2%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	93.4%	91.4%	91.4%	93.0%	95.5%	94.3%	95.5%	96.6%	96.0%	95.3%	98.1%	96.7%	96.4%	99.3%	96.9%	97.0%	>=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%	94.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	93.6%	100.0%	98.0%	90.2%	98.3%	97.4%	94.1%	98.2%	92.6%	81.3%	78.9%	87.2%	96.2%	96.8%	91.5%	90.8%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	94.9%	99.2%	94.8%	95.6%	96.7%	97.5%	100.0%	98.3%	96.7%	86.5%	83.0%	98.3%	97.3%	98.7%	97.5%	95.9%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	73.1%	76.7%	71.4%	74.2%	68.0%	76.5%	78.2%	78.0%	69.0%	78.0%	85.6%	87.6%	81.5%	84.6%	85.4%	81.6%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	95.4%	96.4%	95.1%	91.1%	97.8%	96.7%	94.7%	90.9%	54.5%	60.0%	66.7%	77.8%	88.9%	100.0%	80.0%	80.0%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	72.2%	61.5%	83.3%	87.5%	69.2%	63.6%	76.5%	100.0%	88.9%	73.7%	91.7%	90.0%	91.7%	85.0%	91.7%	89.3%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	170	15	12	6	5	4	3	4	8	8	21	2	3	3	16	40	Zero	
Number of patients waiting over 104 days without a TCI date	407	36	22	25	19	14	20	33	79	66	38	15	8	8	9	33	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	3.16%	0.54%	1.06%	0.94%	1.50%	1.16%	3.16%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	23.00%	17.50%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	825	756	763	835	853	803	825	1,035	1,230	1,367	1,465	1,569	1,648	1,665	1,648	1,665	<=600	
Discharge																		
Number of patients delayed at the end of each month	15	44	32	22	55	54	15	4	3	7	11	24	7	3	42	59	<=38	
Patient discharge summaries sent to GP within 24 hours	56.5%	58.0%	56.4%	56.2%	58.9%	59.4%	57.7%	55.4%	57.8%	60.2%	60.0%	57.5%	61.3%		59.7%	59.0%	>=88%	<75%

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Trust Scorecard - Responsive (2)

	19/20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	81.58%	80.58%	76.24%	72.91%	72.45%	72.41%	78.56%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	76.53%	79.29%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	87.40%	86.36%	83.41%	81.18%	81.02%	82.33%	85.08%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	85.16%	86.04%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	93.70%	95.54%	90.92%	88.74%	91.50%	93.02%	94.10%	95.42%	96.43%	98.93%	99.85%	99.91%	99.95%	99.84%	99.91%	98.54%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	81.59%	73.72%	69.25%	65.20%	63.30%	64.91%	71.69%	84.28%	80.59%	84.01%	84.46%	73.53%	71.74%	68.96%	76.53%	77.71%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2	0	0	1	0	0	1	0	0	0	0	1	0	0	1	1	Zero	
ED: % of time to initial assessment – under 15 minutes	71.2%	68.4%	66.5%	64.3%	68.0%	65.8%	70.1%	80.4%	77.0%	72.7%	72.5%	63.7%	61.3%	66.9%	65.8%	69.8%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	31.3%	28.3%	26.6%	26.0%	31.9%	29.0%	40.9%	68.0%	57.5%	52.0%	44.5%	31.4%	30.9%	38.1%	35.5%	44.3%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	2.40%	3.48%	3.71%	2.81%	3.76%	2.76%	2.87%	2.09%	1.74%	2.57%	2.04%	4.17%	3.67%	3.95%	3.30%	2.96%	<=2.96%	
% of ambulance handovers that are over 60 minutes	0.07%	0.07%	0.07%	0.24%	0.23%	0.13%	0.05%	0.00%	0.00%	0.15%	0.03%	0.90%	0.55%	1.09%	0.50%	0.42%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.03%	91.18%	64.71%	80.00%	88.89%	74.07%	74.03%	- 120.00%	100.00%	100.00%	94.00%	86.67%	94.74%	95.83%	92.00%	72.45%	>=95%	
Urgent cancelled operations	8	3	0	1	1	1	0	0	0	0	11	2	10	7	23	30	No target	
Number of patients stable for discharge	86	90	87	81	112	101	70	14	33	45	66	68	72	99	206	336	<=70	
% of bed days lost due to delays	3.10%	3.67%	3.19%	2.70%	4.69%	4.54%	3.10%	0.56%	0.58%	0.93%	2.00%	2.11%	1.41%	0.94%	1.84%	1.22%	<=3.5%	>4%
Number of stranded patients with a length of stay of greater than 7 days	423	380	406	403	431	427	358	204	213	248	288	332	325	379	315	284	<=380	
Average length of stay (spell)	5.14	4.84	4.95	5.25	5.68	5.36	6.16	5.22	4.49	4.54	4.69	4.66	4.79	4.86	4.71	4.74	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	5.35	5.56	5.77	6.43	6.07	6.9	5.37	4.75	4.81	5.13	5.15	5.34	5.44	5.21	5.15	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.67	2.83	2.65	2.87	2.42	2.62	2.66	3.74	2.2	2.64	2.47	2.32	2.47	2.58	2.42	2.54	<=3.4	>4.5
% day cases of all electives	85.59%	86.31%	85.54%	87.04%	87.91%	84.27%	84.90%	82.75%	81.81%	83.67%	81.73%	78.41%	82.26%	81.28%	80.97%	81.63%	>80%	<70%
Intra-session theatre utilisation rate	87.20%	88.20%	88.00%	87.40%	86.40%	87.50%	85.60%	91.80%	87.60%	84.05%	87.30%	88.60%	86.70%	85.70%	86.10%	86.70%	>85%	<70%

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Trust Scorecard - Responsive (3)

	19/20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.88	1.75	1.81	1.89	1.86	1.93	2.04	2.49	2.32	2.28	2.03	1.99	1.93	1.87	1.98	2.07	<=1.9	
Did not attend (DNA) rates	6.90%	6.70%	6.80%	6.90%	6.90%	6.40%	7.80%	4.20%	4.30%	4.70%	5.50%	6.10%	6.50%	6.30%	6.10%	5.60%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	81.01%	81.33%	80.29%	80.57%	81.06%	81.41%	81.01%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.14%	60.78%	64.31%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	1,833	1,650	1,792	1,790	1,658	1,653	1,833	2,719	3,794	4,967	6,226	7,155	7,748	8,573	7,043	5,883	No target	
Referral to treatment ongoing pathways 40+ Weeks (number)	912	1,312	824	1,263	1,298	1,203	912	1,615	2,522	3,312	4,460	5,398	6,541	6,642	5,466	4,356	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	33	62	45	39	28	14	33	156	366	694	1,037	1,233	1,279	1,290	1,183	866	Zero	
SUS																		
Percentage of records submitted nationally with valid GP code	99.7%	99.8%	99.8%	99.9%	99.9%	99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	>=99%	
Percentage of records submitted nationally with valid NHS number	99.7%	99.8%	99.9%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%		99.9%	99.9%				99.9%	>=99%	

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Trust Scorecard - Well Led (1)

	19/20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	20/21 Q2	20/21	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	82.0%	80.0%	82.0%	82.0%	83.0%	85.0%	85.0%	85.0%	85.0%	78.0%	80.0%	82.0%	84.0%	83.0%			>=90%	<70%
Trust total % mandatory training compliance	92%	91%	92%	92%	90%	90%	90%	90%	90%	90%	91%	91%	94%	93%	94%		>=90%	<70%
Finance																		
Total PayBill Spend		31.5	31.3	31.4	30.1	31.6	30.2	32.5	33.8	34.3	33.2	33.9	34.7					
YTD Performance against Financial Recovery Plan		.7	.6	.4	.3	.1	1.5	0	-.1	0	0	0	0					
Cost Improvement Year to Date Variance		1	1	-2	-2	-4	-8	0	0	0	N/A	N/A	N/A					
NHSI Financial Risk Rating		3	3	3	3	3	3	3	3	3	N/A	N/A	N/A					
Capital service		4	4	4	4	4	3	3	3	3	N/A	N/A	N/A					
Liquidity		4	4	4	4	4	4	4	4	4	N/A	N/A	N/A					
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3	3	3	3	3	3	3	N/A	N/A	N/A					
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	97.40%	98.40%	99.40%	98.30%	99.30%	98.30%				90.52%	100.77%	102.10%	93.82%	96.30%	98.88%	96.70%	>=75%	<70%
% registered nurse day	98.20%	99.40%	100.70%	98.70%	98.50%	98.10%				89.23%	100.82%	101.90%	93.04%	95.49%	98.52%	96.00%	>=90%	<80%
% unregistered care staff day	100.20%	101.40%	104.20%	98.60%	102.10%	100.20%				110.83%	120.86%	117.50%	106.50%	101.36%	114.98%	111.30%	>=90%	<80%
% registered nurse night	95.70%	96.40%	97.10%	97.50%	100.80%	98.60%				92.99%	100.69%	102.60%	95.27%	97.77%	99.53%	97.90%	>=90%	<80%
% unregistered care staff night	106.20%	108.60%	115.50%	105.40%	107.80%	109.70%				112.80%	131.01%	131.70%	114.61%	113.36%	125.68%	120.50%	>=90%	<80%
Care hours per patient day RN	4.7	4.7	4.8	4.9	4.6	4.7				6.2	5.8	5.6	5.2	5.2	5.5	5.6	>=5	
Care hours per patient day HCA	3	3	3	3	2.9	3				4.5	4.2	3.9	3.5	3.4	3.9	3.9	>=3	
Care hours per patient day total	7.7	7.7	7.8	7.9	7.6	7.7				10.8	10.1	9.5	8.6	8.6	9.4	9.4	>=8	
Vacancy and WTE																		
% total vacancy rate		7.00%	6.95%	7.00%	6.70%	6.15%	6.15%			5.97%	5.14%	7.10%	5.26%	5.34%			<=11.5%	>13%
% vacancy rate for doctors		2.25%	2.80%	2.80%	3.62%	1.24%				4.90%	2.70%	3.27%	1.54%	1.07%			<=5%	>5.5%
% vacancy rate for registered nurses		8.22%	8.30%	8.30%	9.92%	10.26%	10.26%			8.12%	8.44%	8.90%	10.01%	7.76%			<=5%	>5.5%
Staff in post FTE		6358.09	6354.32	6355	6351.41	6387.05	6422.86	6421.87	6549.97	6573.86	6485.99	6463.25	6548.39	6587.72			No target	
Vacancy FTE		478.95	474.24	475	457.45	418.47	418.47			416.06	358	494.04	365.97	371.63			No target	
Starters FTE		72.72	51.61	69.42	55.75	63.74	44.17	32.81	30.05	57.65	49.45	62.46	151.56	57.53			No target	
Leavers FTE		40.81	47.02	49.37	52.49	36.99	58.37	43.37	46.93	38.57	96.43	106.66	66.41	57.48			No target	
Workforce Expenditure and Efficiency																		
% turnover		11.6%	11.7%	11.5%	11.5%	11.3%	11.1%	10.8%	10.9%	10.4%	10.2%	10.3%	10.3%				<=12.6%	>15%
% turnover rate for nursing		11.09%	10.75%	10.93%	11.12%	10.92%	10.73%	10.59%	10.72%	10.14%	9.98%	10.34%	10.10%				<=12.6%	>15%
% sickness rate		3.9%	3.9%	4.0%	3.9%	3.9%	3.5%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%				<=4.05%	>4.5%

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Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment Standard: >95%		89.8% for 1st VTE RA is within the natural variation the system is capable of producing. The data ideally would be taken from Trakcare but is not currently working effectively and the electronic solution will be part of e-prescribing	Director of Safety
Number of community-onset healthcare-associated Clostridioides difficile cases per month Standard: <=5		An increase in community onset cases of C. difficile has been seen possibly due to increased use of antimicrobials in primary care. Reduced face-to-face appointments with GPs have resulted in more "just in case" antibiotic prescriptions.	Associate Chief Nurse and Deputy Director of Infection Prevention and Control

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Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of deep tissue injury pressure ulcers acquired as in-patient Standard: <=5		Deep tissue injuries have increase. These cases are reviewed weekly at the Preventing Harm Improvement Hub. Factors contributing to increases are increased deconditioning of patients, particularly older more frail people. Lack of assessment of pressure ulcer risk and subsequently lack of evidence of mitigations in place. Equipment provision, especially pressure relieving cushions for chairs has also been a factor.	**Deputy Nursing Director & Divisional Nursing Director - Surgery**
Number of falls per 1,000 bed days Standard: <=6		Falls have increased due to a number of factors; increased deconditioning in patients that have endured months of lockdown, reduced visiting which decreases supervision, inability to fill enhanced care requests and lack of risk assessment completion. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub.	**Director of Safety**

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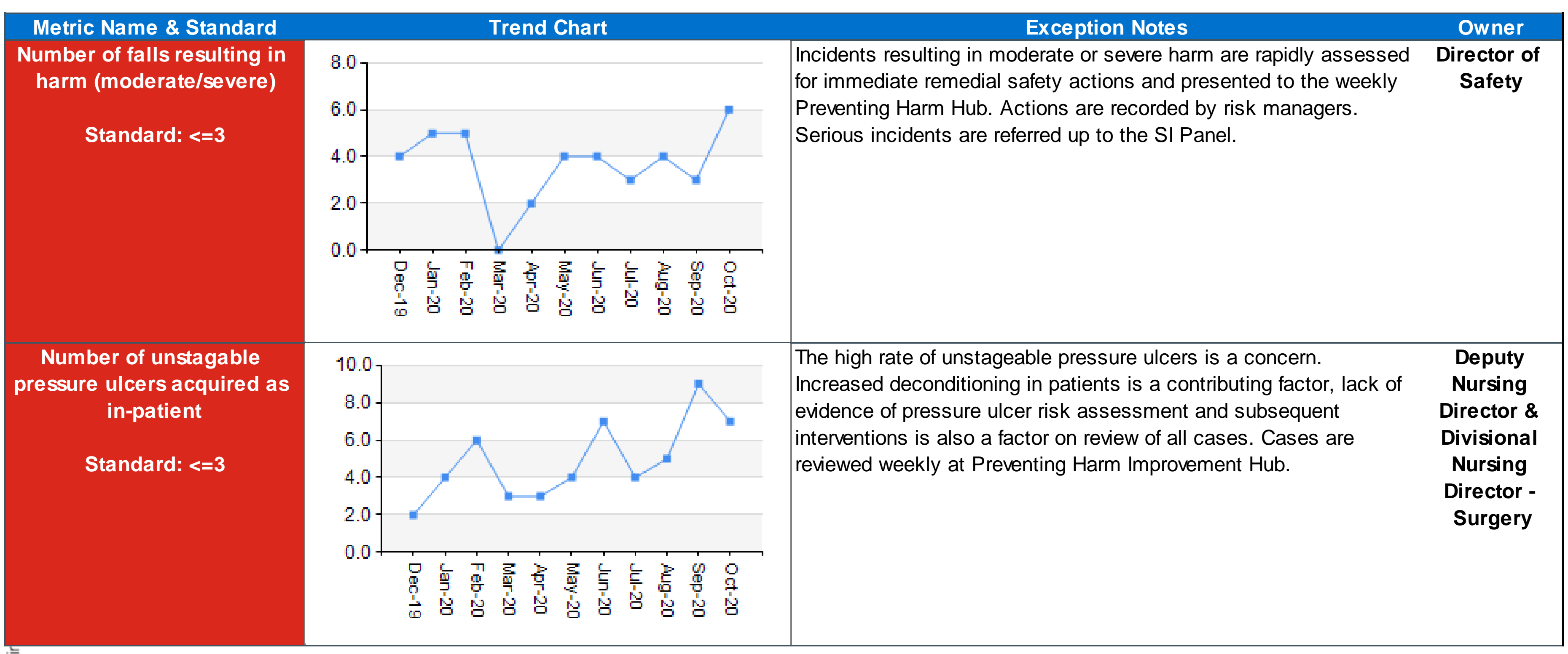
Exception Reports - Safe (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls resulting in harm (moderate/severe) Standard: <=3		Incidents resulting in moderate or severe harm are rapidly assessed for immediate remedial safety actions and presented to the weekly Preventing Harm Hub. Actions are recorded by risk managers. Serious incidents are referred up to the SI Panel.	Director of Safety
Number of unstagable pressure ulcers acquired as in-patient Standard: <=3		The high rate of unstageable pressure ulcers is a concern. Increased deconditioning in patients is a contributing factor, lack of evidence of pressure ulcer risk assessment and subsequent interventions is also a factor on review of all cases. Cases are reviewed weekly at Preventing Harm Improvement Hub.	Deputy Nursing Director & Divisional Nursing Director - Surgery

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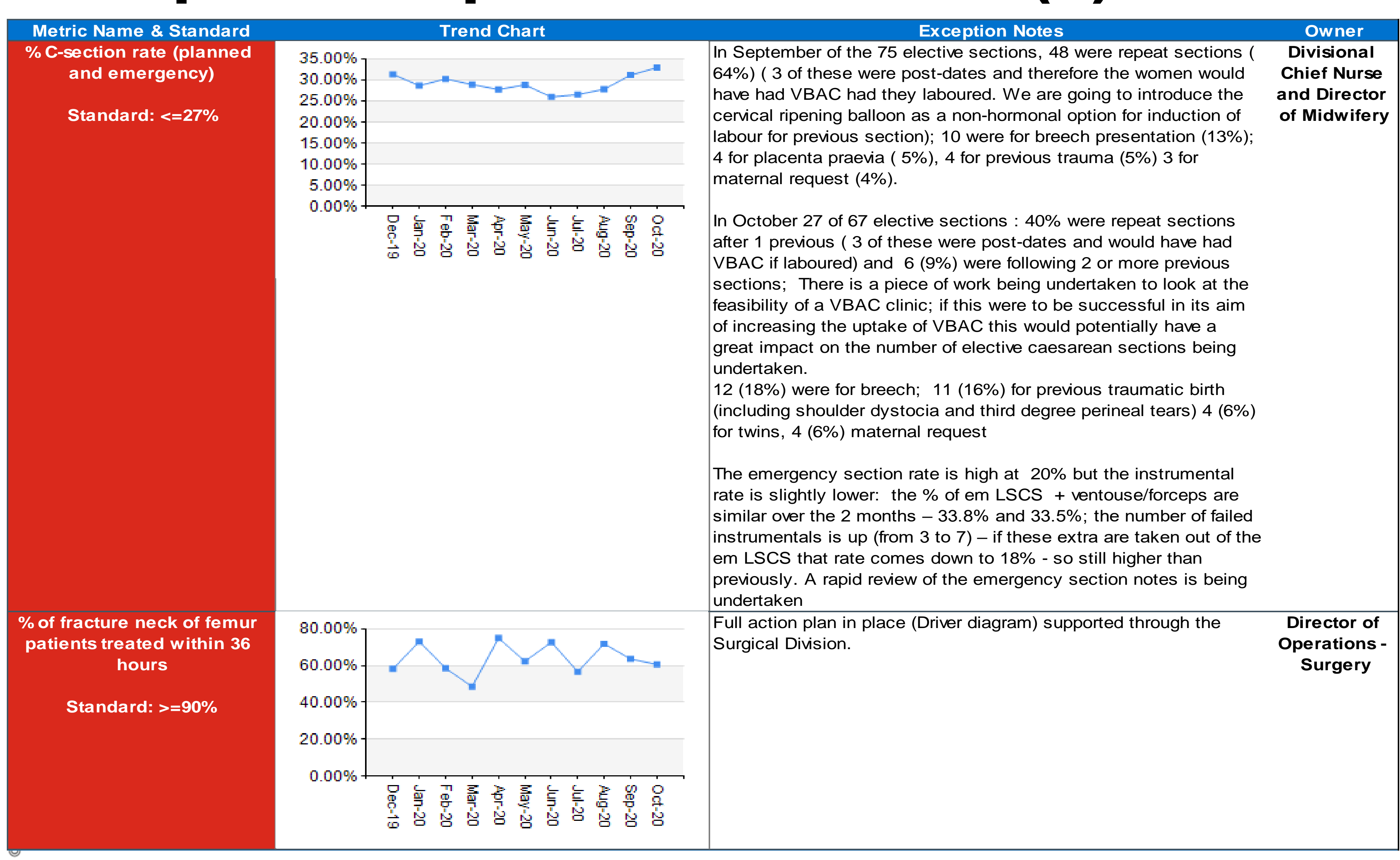
Exception Reports - Effective (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% C-section rate (planned and emergency) Standard: <=27%	35.00% 30.00% 25.00% 20.00% 15.00% 10.00% 5.00% 0.00% Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20	In September of the 75 elective sections, 48 were repeat sections (64%) (3 of these were post-dates and therefore the women would have had VBAC had they laboured. We are going to introduce the cervical ripening balloon as a non-hormonal option for induction of labour for previous section); 10 were for breech presentation (13%); 4 for placenta praevia (5%), 4 for previous trauma (5%) 3 for maternal request (4%). In October 27 of 67 elective sections : 40% were repeat sections after 1 previous (3 of these were post-dates and would have had VBAC if laboured) and 6 (9%) were following 2 or more previous sections; There is a piece of work being undertaken to look at the feasibility of a VBAC clinic; if this were to be successful in its aim of increasing the uptake of VBAC this would potentially have a great impact on the number of elective caesarean sections being undertaken. 12 (18%) were for breech; 11 (16%) for previous traumatic birth (including shoulder dystocia and third degree perineal tears) 4 (6%) for twins, 4 (6%) maternal request The emergency section rate is high at 20% but the instrumental rate is slightly lower: the % of em LSCS + ventouse/forceps are similar over the 2 months – 33.8% and 33.5%; the number of failed instrumentals is up (from 3 to 7) – if these extra are taken out of the em LSCS that rate comes down to 18% - so still higher than previously. A rapid review of the emergency section notes is being undertaken	Divisional Chief Nurse and Director of Midwifery
% of fracture neck of femur patients treated within 36 hours Standard: >=90%	80.00% 60.00% 40.00% 20.00% 0.00% Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20	Full action plan in place (Driver diagram) supported through the Surgical Division.	Director of Operations - Surgery

Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=80%**	80.00% 60.00% 40.00% 20.00% 0.00% Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20	Deterioration of 17.10% on October (51.6%). 55 patients breached the target in the month of October. Of these 55: • 5 patients experienced a delay in assessment as the Stroke team were not informed by ED. Led to breaches along the rest of the pathway elements • 23 patients were delayed due to lack of beds - Lack of HASU beds (shared space with Cardiology) • 25 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. • 3 patients were admitted to ITU due to acuity of the patient • 2 patients attended MIU in CGH and then had a delayed transfer over to GRH • 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% Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20	Improvement of 0.8% on September performance (62.70%). 41 patients breached the target in the month of October. Of those 41: • 14 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening. • 14 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. • 13 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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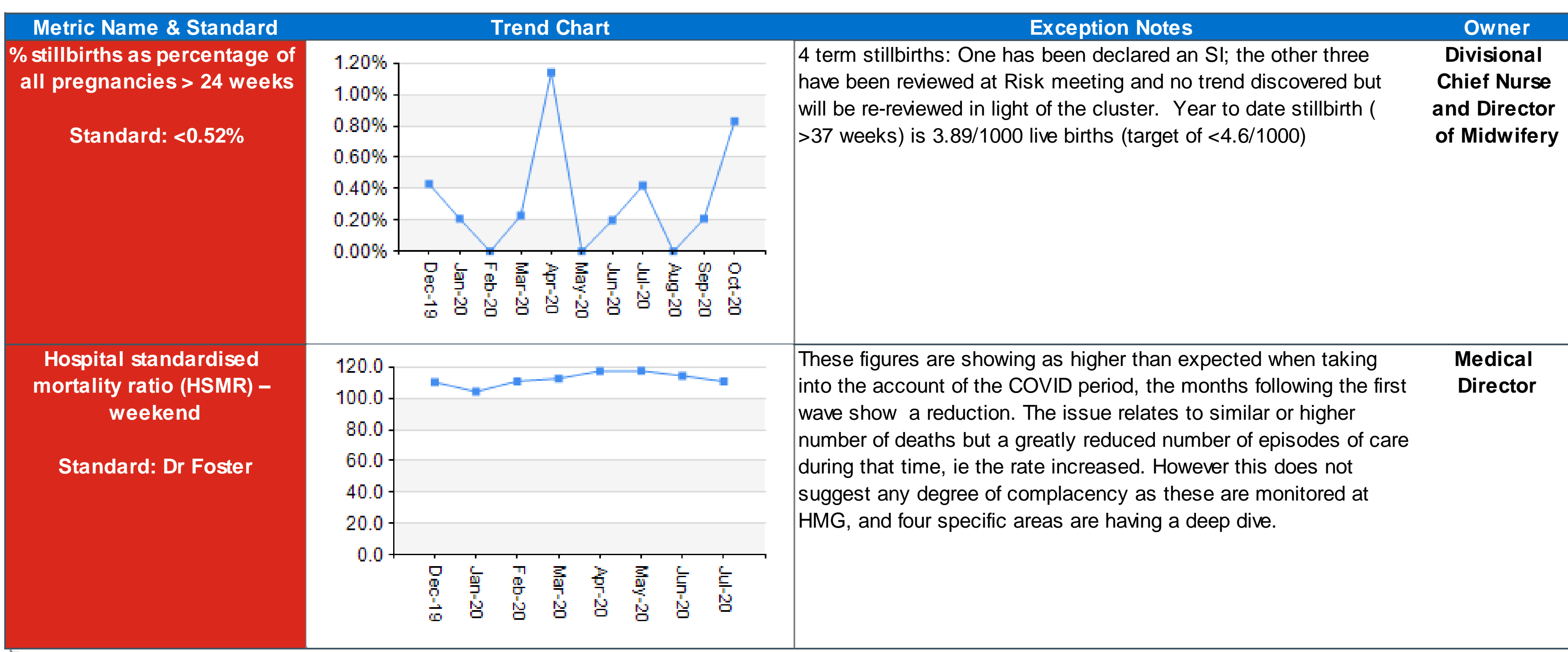
Exception Reports - Effective (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% stillbirths as percentage of all pregnancies > 24 weeks Standard: <0.52%	1.20% 1.00% 0.80% 0.60% 0.40% 0.20% 0.00% Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20	4 term stillbirths: One has been declared an SI; the other three have been reviewed at Risk meeting and no trend discovered but will be re-reviewed in light of the cluster. Year to date stillbirth (>37 weeks) is 3.89/1000 live births (target of <4.6/1000)	Divisional Chief Nurse and Director of Midwifery
Hospital standardised mortality ratio (HSMR) – weekend Standard: Dr Foster	120.0 100.0 80.0 60.0 40.0 20.0 0.0 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20	These figures are showing as higher than expected when taking into the account of the COVID period, the months following the first wave show a reduction. The issue relates to similar or higher number of deaths but a greatly reduced number of episodes of care during that time, ie the rate increased. However this does not suggest any degree of complacency as these are monitored at HMG, and four specific areas are having a deep dive.	Medical Director

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Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED % positive **Standard: >=84%**		The Unscheduled Care FFT scores have shown a slight increase (1.7%) from September, with 624 responses. The Divisional and specialty teams are working with colleagues to triangulate data sources and develop a patient experience improvement plan, which will be monitored in division and at QDG. This includes setting up a patient experience network for medical matrons.	**Deputy Director of Quality**
Inpatients % positive **Standard: >=96%**		The inpatient score of 86.4% is a combined score of inpatients (82.77) and daycase (96.07) FFT. This has remained stable since a decline in August, and will continue to be monitored through QDG. The Patient Experience Improvement team are looking at adding in more questions to the FFT as a pilot on some wards, which patients can answer while in the hospital. This will give more insight about experience on wards vs discharge, and the opportunity to ask questions on more specific areas of experience that will be informed by trends emerging from comments	**Deputy Director of Quality**
Maternity % positive **Standard: >=97%**		The maternity FFT data for October has shown a significant drop after an increase in the positive score in September. We will continue to monitor this to understand if there are any trends emerging. Detailed reports including all comments are shared with teams and departments to inform local improvement plans and triangulate with other data	**Deputy Director of Quality**

Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes Standard: <=2.96%		Ambulance handover delays increased in October. It is worth noting that ambulance handover delays are expressed as an absolute number. When reported as a percentage of ambulances arriving, it compares more favourably. Adhering to the new ambulance handover SOP and huddle protocol is enabling ambulance off loads.	Director of Unscheduled Care and Deputy Chief Operating Officer
% waiting for diagnostics 6 week wait and over (15 key tests) Standard: <=1%		Perforamnce has improved. Remaining areas relate to Endoscopy recovery.	Deputy Chief Operating Officer
ED: % of time to initial assessment – under 15 minutes Standard: >=95%		Average triage has shown an improvement with waiting has decreased by 20.7 minutes in October for walk-in patients. The trial of an additional triage nurse has improves performance for patients being triaged within 15 minutes of arrival, however still remains higher than the target of 15 minutes.	Director of Unscheduled Care and Deputy Chief Operating Officer

Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to start of treatment – under 60 minutes Standard: >=90%		The median wait to see a doctor has increase but still remains within target. A review of medical staffing is an area which Prof Cooke is reviewing which should help further improve this metric.	Director of Unscheduled Care and Deputy Chief Operating Officer
ED: % total time in department – under 4 hours (type 1) Standard: >=95%		October shows a deteriorated picture due to higher acuity of patients through the Emergency Department (ED) and the inability to discharge patients once medically fit for discharge. Overall performance for October is 74.23% compared to 76.7% in September. Total attendances in October decreased by 5.75% (-625 attendances), compared to September however admission rate increased against the previous month by 1.66% reflecting patient acuity.	Director of Unscheduled Care and Deputy Chief Operating Officer
ED: % total time in department – under 4 hours (types 1 & 3) Standard: >=95%		October shows a deteriorated picture due to higher acuity of patients through the Emergency Department (ED) and the inability to discharge patients once medically fit for discharge. Overall performance for October is 74.23% compared to 76.7% in September. Total attendances in October decreased by 5.75% (-625 attendances), compared to September however admission rate increased against the previous month by 1.66% reflecting patient acuity.	Director of Unscheduled Care and Deputy Chief Operating Officer

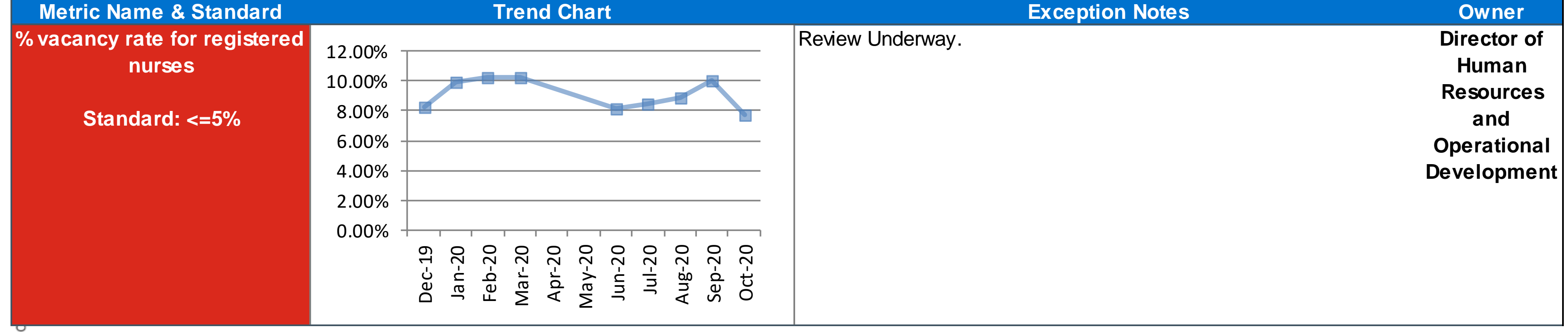
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		October shows a deteriorated picture due to higher acuity of patients through the Emergency Department (ED) and the inability to discharge patients once medically fit for discharge. Overall performance for October is 74.23% compared to 76.7% in September. Total attendances in October decreased by 5.75% (-625 attendances), compared to September however admission rate increased against the previous month by 1.66% reflecting patient acuity.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		MSFD numbers are up, with links to difficulties associated with COVID-19. Delays within partner organisations in realising social and home first pathways have led to an increase over the past period. Some improvement in this seen, but not able to keep up with demand in terms of admissions and referrals for onward care. Twice a day system flow calls continue with also twice weekly bronze calls to review the situation.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Specialty TCI recorded Urological 1 Haematological 1 Skin 1 Gynaecological 1 Grand Total 4 >104 day levels close to lowest levels since data began. 10 out of 11 breaches classified as unavoidable	**Director of Planned Care and Deputy Chief Operating Officer**

Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Performance remains poor despite showing some improvement, continues to be monitored at Divisional Executive reviews.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. The restoration and recovery phase continues and since the low of 55.8% in July, performance continues to creep up, with 60.1% in August, 66.3% for September and an unconfirmed position of 69.1% in October. As indicated in other metrics the long waiting cohort of patients has risen in recent 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 (17) in October following September's performance of 1648. 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**

Exception Reports - Well Led (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses Standard: <=5%		Review Underway.	Director of Human Resources and Operational Development

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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	September-20	0%–60% chart: Central And North West…, County Durham And…, University Hospitals…, Oxford University…, Portsmouth Hospitals…, Gloucestershire…, South Tees Hospitals…, University Hospitals Of…, England, Epsom And St Helier…, United Lincolnshire…, York Teaching Hospital…, Norfolk And Norwich…, Great Western Hospitals…, Western Sussex…, Worcestershire Acute…	51 / 162	2nd
Dementia	February-20	0%–100% chart: 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)

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
ED 4 Hour (Type 1 & Type 3)	October-20	100%, 95%, 90%, 85%, 80%, 75%, 70%, 65%; Moorfields Eye Hospital…, Western Sussex…, Epsom And St Helier…, Great Western Hospitals…, Oxford University…, South Tees Hospitals…, England, University Hospitals…, Worcestershire Acute…, County Durham And…, Gloucestershire…, York Teaching Hospital…, University Hospitals Of…, United Lincolnshire…, Norfolk And Norwich…	73 / 114	3rd
Cancer 62 Days GP Referrals	September-20	100%, 90%, 80%, 70%, 60%; Cumbria Partnership…, Epsom And St Helier…, Portsmouth Hospitals…, Gloucestershire…, South Tees Hospitals…, Oxford University…, County Durham And…, York Teaching Hospital…, England, Great Western Hospitals…, University Hospitals Of…, Worcestershire Acute…, University Hospitals…, Western Sussex…, Norfolk And Norwich…, United Lincolnshire…	42 / 138	2nd

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Benchmarking (3)

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
RTT	September-20	100% 90% 80% 70% 60% 50% 40% 30% 20% 10%; Berkshire Healthcare…, Gloucestershire…, Portsmouth Hospitals…, England, County Durham And…, York Teaching Hospital…, Epsom And St Helier…, Oxford University…, Great Western Hospitals…, United Lincolnshire…, Western Sussex…, Norfolk And Norwich…, South Tees Hospitals…, Worcestershire Acute…, University Hospitals Of…	71 / 159	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 - - - - **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 - 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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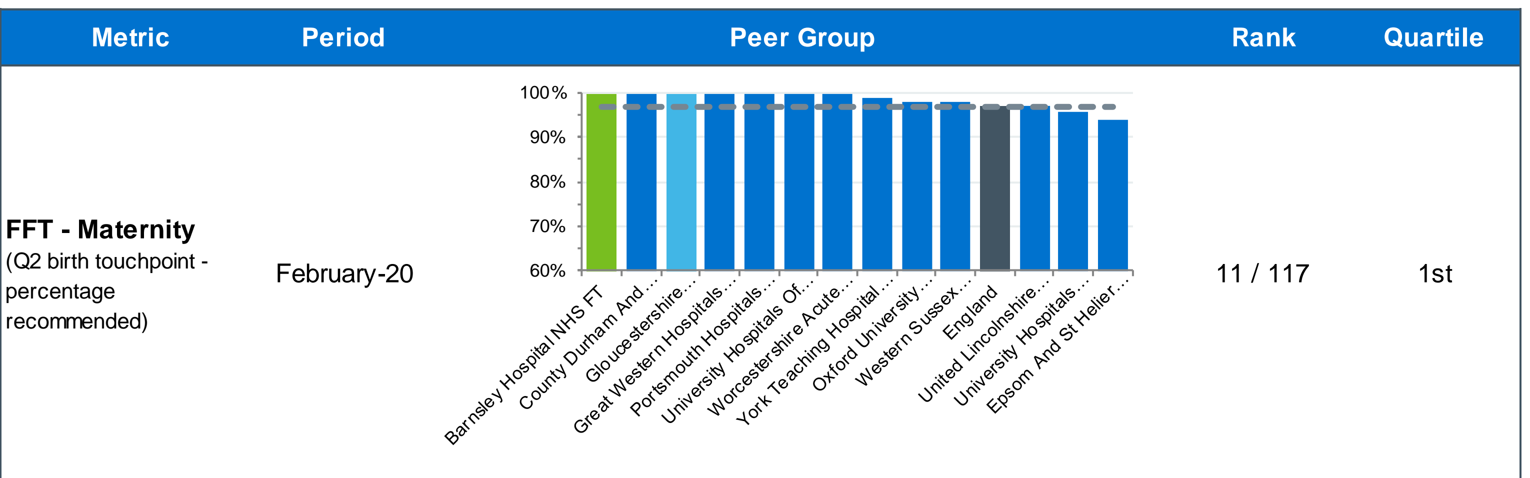
Benchmarking (5)

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 October 2020

Presented at November 2020 Q&P and December 2020 Trust Board

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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 in place with emphasis on how to continue to prioritise our patients clinically and enable secondary care intervention where needed for patient care and safety.

During October the Trust 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 October was 68.96%, against the STP trajectory of 85.89%. The system did not meet the delivery of 90% for the system in September, at 80.21%. Note that the October 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 October at 17.50%. 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. MR and CT have recovered their waiting time position.

The Trust did meet the standard for 2 week wait cancer at 93.1% in October & 62 day cancer waits this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.14% (un-validated) in October, 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 1,290 in October. 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	Oct-20	77.1%
Cancer	Cancer – 28 day FDS breast symptom two week wait	TBC	Oct-20	77.1%
Cancer	Cancer – 28 day FDS screening referral	TBC	Oct-20	77.1%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Oct-20	93.1%
Cancer	2 week wait breast symptomatic referrals	>=93%	Oct-20	97.1%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Oct-20	99.3%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Oct-20	100.0%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Oct-20	96.8%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Oct-20	98.7%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Oct-20	84.6%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Oct-20	100.0%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Oct-20	85.0%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Oct-20	3
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Oct-20	8
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Oct-20	17.50%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Oct-20	1,665
Discharge	Number of patients delayed at the end of each month	<=38	Oct-20	3
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Sep-20	61.3%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Oct-20	68.96%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Oct-20	80.21%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Oct-20	99.84%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Oct-20	68.96%

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	Oct-20	0
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Oct-20	66.9%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Oct-20	38.1%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Oct-20	3.95%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Oct-20	1.09%
Maternity	% of women booked by 12 weeks gestation	>90%	Oct-20	92.3%
Operational Efficiency	Number of patients stable for discharge	<=70	Oct-20	99
Operational Efficiency	% of bed days lost due to delays	<=3.5%	Oct-20	0.94%
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Oct-20	379
Operational Efficiency	Average length of stay (spell)	<=5.06	Oct-20	4.86
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Oct-20	5.44
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Oct-20	2.58
Operational Efficiency	% day cases of all electives	>80%	Oct-20	81.28%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Oct-20	85.7%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Oct-20	95.83%
Operational Efficiency	Urgent cancelled operations	No target	Oct-20	7
Outpatient	Outpatient new to follow up ratio's	<=1.9	Oct-20	1.87
Outpatient	Did not attend (DNA) rates	<=7.6%	Oct-20	6.30%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Sep-20	7.4%
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%		Oct-20	69.14%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Oct-20	8573	
RTT	Referral to treatment ongoing pathways 40+ Weeks (number)	No target		Oct-20	6642	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Oct-20	1290	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=50%		Oct-20	46.6%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=80%		Sep-20	94.3%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=80%		Oct-20	34.5%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=90%		Oct-20	63.5%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Aug-20	100.0%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Aug-20	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Oct-20	60.7%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Oct-20	58.8%	

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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 Sep 20 Oct 20

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

Commentary

31 day new performance (unvalidated) = 99.3%
Target = 96%
National performance = 94.5%

Currently 96.9% for annual performance 20/21. September will be the sixth month in a row of meeting the standard.

- 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 8 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

% waiting for diagnostics 6 week wait and over (15 key tests) - GHT Starting 01/04/18

50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20

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

Commentary

Perforamnce has improved. Remaining areas relate to Endoscopy recovery.

- 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.
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

The number of planned / surveillance endoscopy patients waiting at month end - GHT Starting 01/04/18

1,800
1,600
1,400
1,200
1,000
800
600
400
200
0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 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 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 (17) in October following September's performance of 1648. 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

Number of patients delayed at the end of each month - GHT Starting 01/04/18

60
50
40
30
20
10
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 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 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

DTOC has now stopped, so the improvement being shown is not accurate as related to data not captured anymore. As a trust we are seeing an increase in the number of days patients remain in our acute beds whilst MSFD, linked with delays in onward care pathways. Currently working with BI to capture this in a new way to replace DTOC in terms of understanding the impact of our MSFD delays. OCT are carrying out weekly 14 day reviews across all wards to pick up those with a long LOS, whilst daily rights to reside are also being captured. Twice Daily meetings with System partners focus on patient flow, whilst 'unblocking' specific patients by escalating within the System.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

Patient discharge summaries sent to GP within 24 hours - GHT Starting 01/04/18

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

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Performance remains poor despite showing some improvement, continues to be monitored at Divisional Executive reviews.

- Medical Director

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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, Sep 20, Oct 20

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

F

L

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 8 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

October shows a deteriorated picture due to higher acuity of patients through the Emergency Department (ED) and the inability to discharge patients once medically fit for discharge. Overall performance for October is 74.23% compared to 76.7% in September.

Total attendances in October decreased by 5.75% (-625 attendances), compared to September however admission rate increased against the previous month by 1.66% reflecting patient acuity.

- 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

Commentary

October shows a deteriorated picture due to higher acuity of patients through the Emergency Department (ED) and the inability to discharge patients once medically fit for discharge. Overall performance for October is 74.23% compared to 76.7% in September.

Total attendances in October decreased by 5.75% (-625 attendances), compared to September however admission rate increased against the previous month by 1.66% reflecting patient acuity.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 8 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

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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, Sep 20, Oct 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 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

CGH continues to perform well with 99.84% of patients seen and treated within 4 hours in October

- 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 GRH - 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, Sep 20, Oct 20

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

F
L

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There 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.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Commentary

October shows a deteriorated picture due to higher acuity of patients through the Emergency Department (ED) and the inability to discharge patients once medically fit for discharge. Overall performance for October is 74.23% compared to 76.7% in September.

Total attendances in October decreased by 5.75% (-625 attendances), compared to September however admission rate increased against the previous month by 1.66% reflecting patient acuity.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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Access:
SPC – Special Cause Variation

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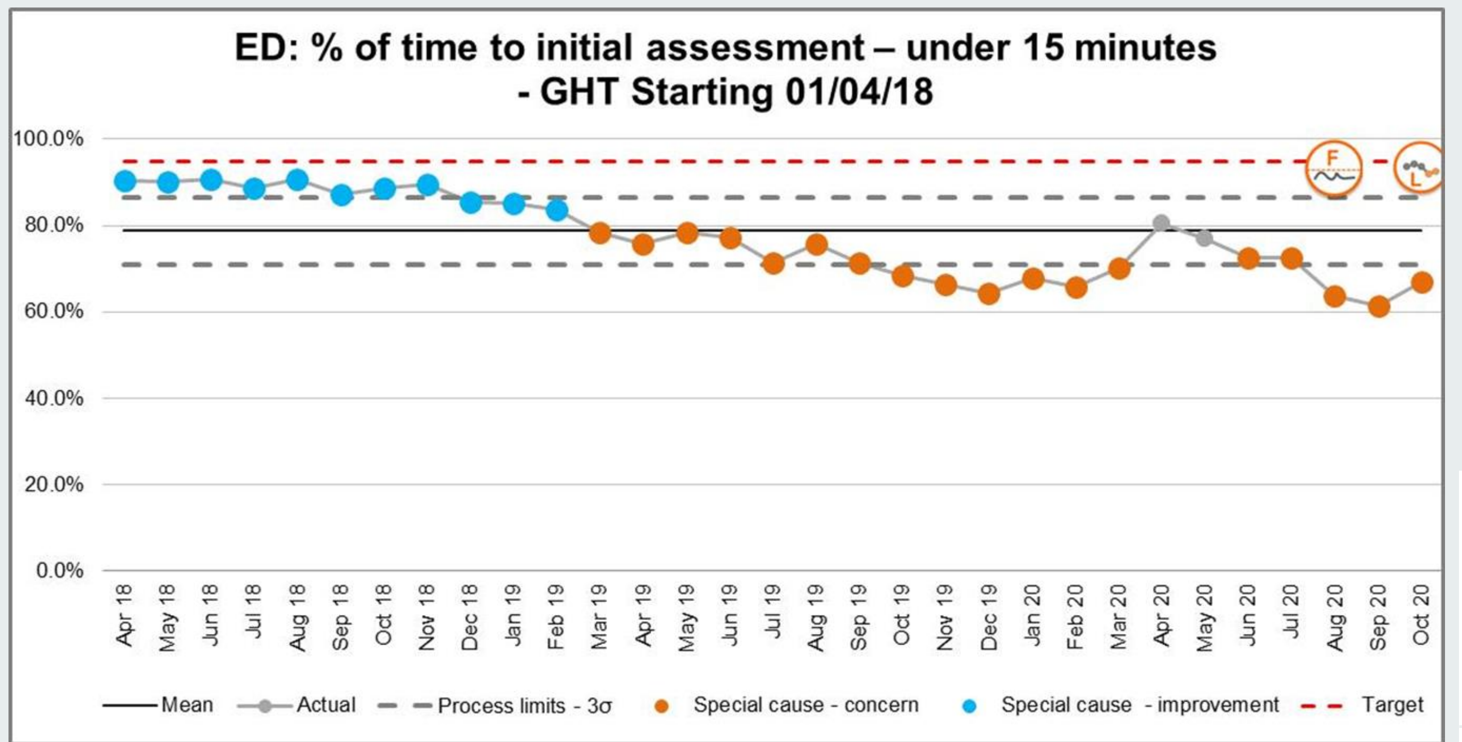

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 9 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

Average triage has shown an improvement with waiting has decreased by 20.7 minutes in October for walk-in patients. The trial of an additional triage nurse has improves performance for patients being triaged within 15 minutes of arrival, however still remains higher than the target of 15 minutes.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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SPC – Special Cause Variation

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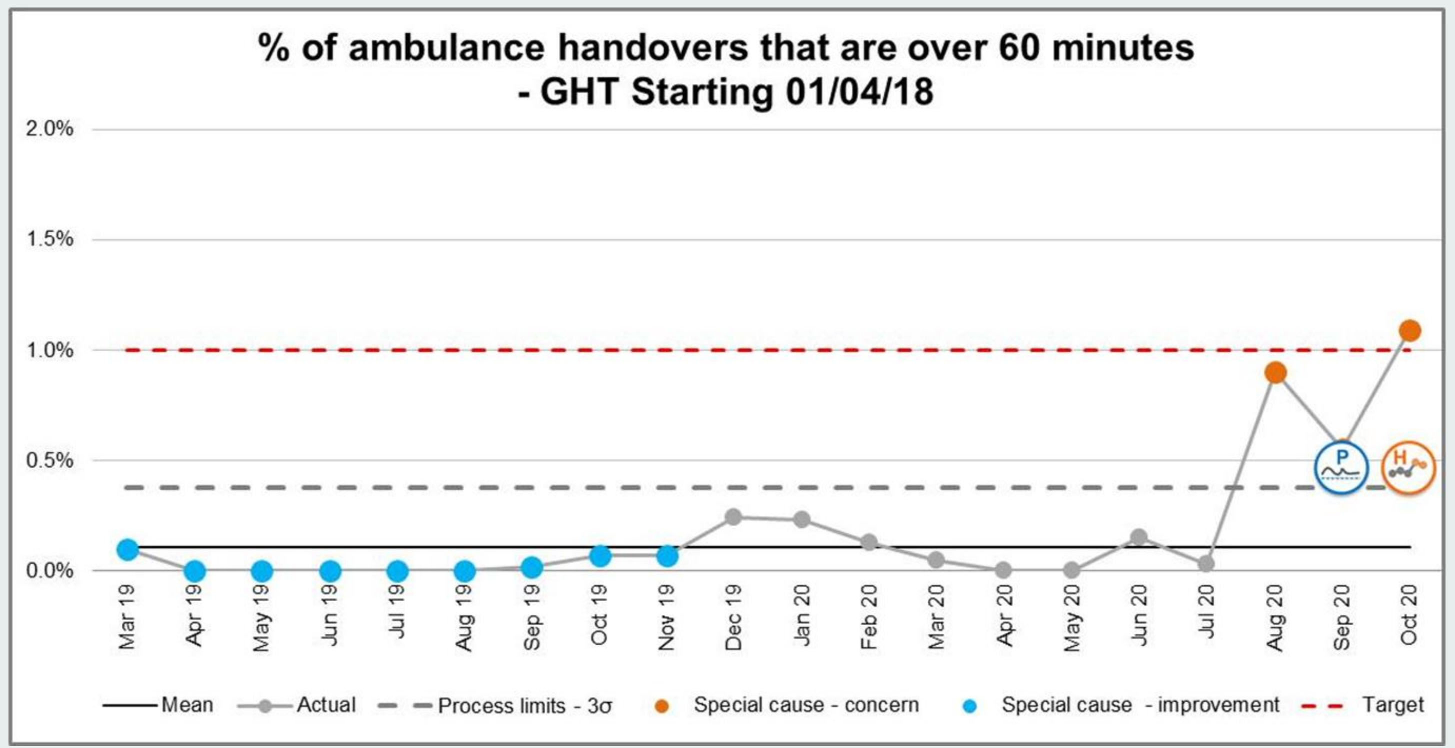

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Commentary

Ambulance handover delays increased in October. It is worth noting that ambulance handover delays are expressed as an absolute number. When reported as a percentage of ambulances arriving, it compares more favourably. Adhering to the new ambulance handover SOP and huddle protocol is enabling ambulance off loads.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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% of bed days lost due to delays - GHT Starting 01/04/19

6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
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, Sep 20, Oct 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
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

Commentary

DTOC has now stopped, so the improvement being shown is not accurate as related to data not captured anymore.

- Director of Unscheduled Care and Deputy Chief Operating Officer

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Length of stay for general and acute non-elective (occupied bed days) spells - GHT Starting 01/04/18

7.0
6.0
5.0
4.0
3.0
2.0
1.0
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 Sep 20 Oct 20

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

Commentary

LOS under review but also subject to changes in ward configuration to support surge 2.

- 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.
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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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, Sep 20, Oct 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 and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Commentary

GIRFT and Model Hospital under review. Need to account for phase 3 recovery and work undertaken in IS and in Community theatres. DC rates activity wise have improved in activity terms.

- Deputy Chief Operating Officer

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Urgent cancelled operations - GHT Starting 01/04/19

10
8
6
4
2
0

Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20

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

Commentary

Cancellations due to on the day emergency patients.

- Director of Operations - Surgery

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

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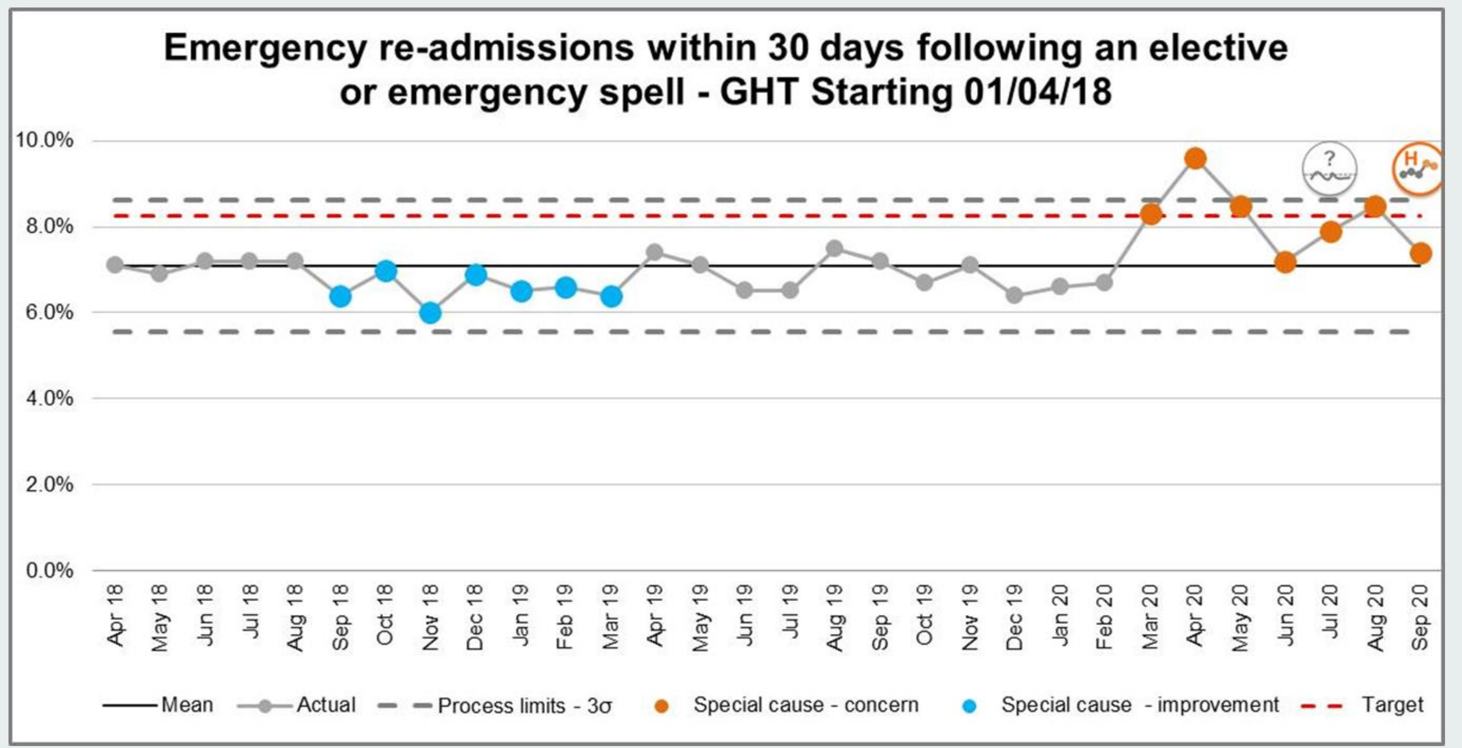

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
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 UPL this is a warning that the process may be changing

Commentary

The rate increased in March 2020 and was red in April 2020. This would be expected as the number of hospital admissions without COVID – 19 reduced dramatically. The elective workload has the lowest rate of emergency readmissions and this activity remains below pre-COVID time period so the arte would be expected to be higher. It is reasonable to expect the rate to fall as elective activity increases.

- Deputy Medical Director

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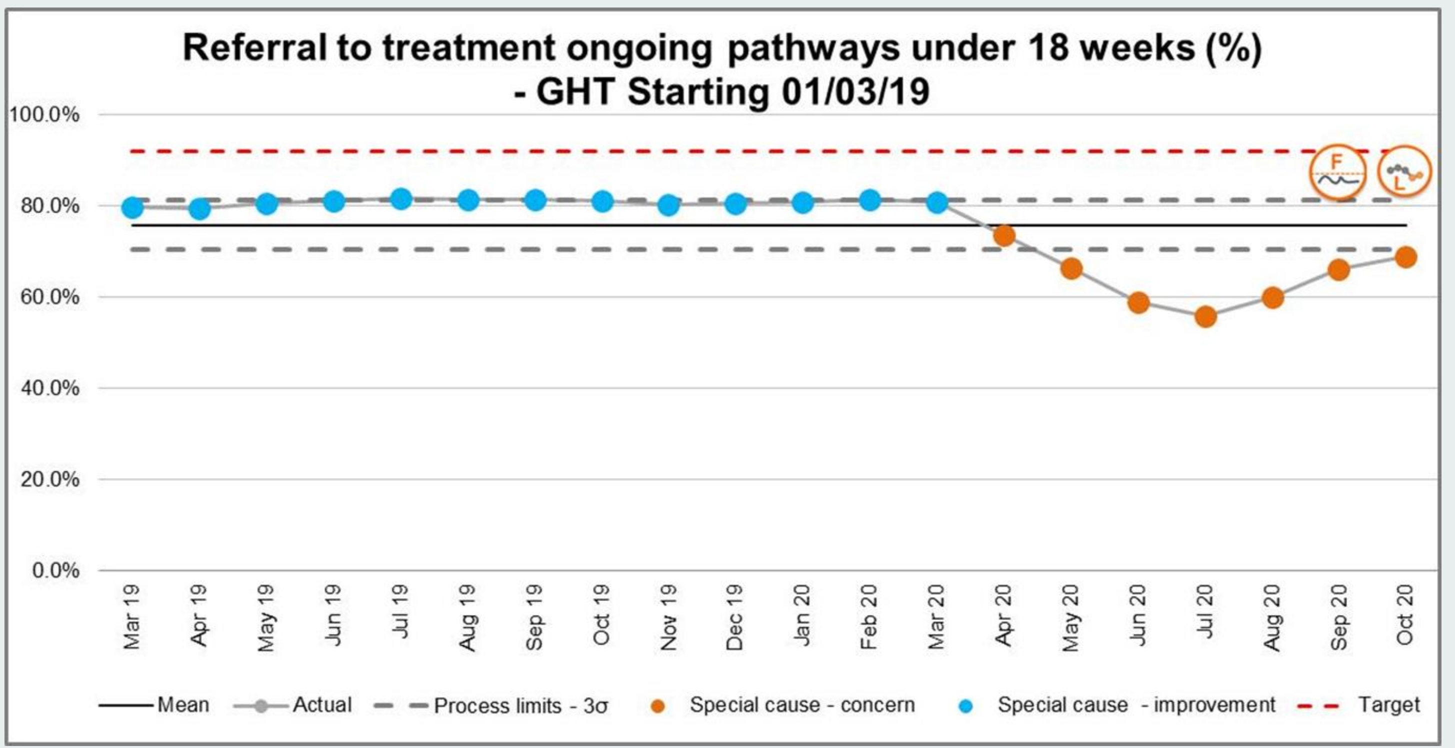

Commentary

See Planned Care Exception report for full details. The restoration and recovery phase continues and since the low of 55.8% in July, performance continues to creep up, with 60.1% in August, 66.3% for September and an unconfirmed position of 69.1% in October. As indicated in other metrics the long waiting cohort of patients has risen in recent months.

- 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 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 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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SPC – Special Cause Variation

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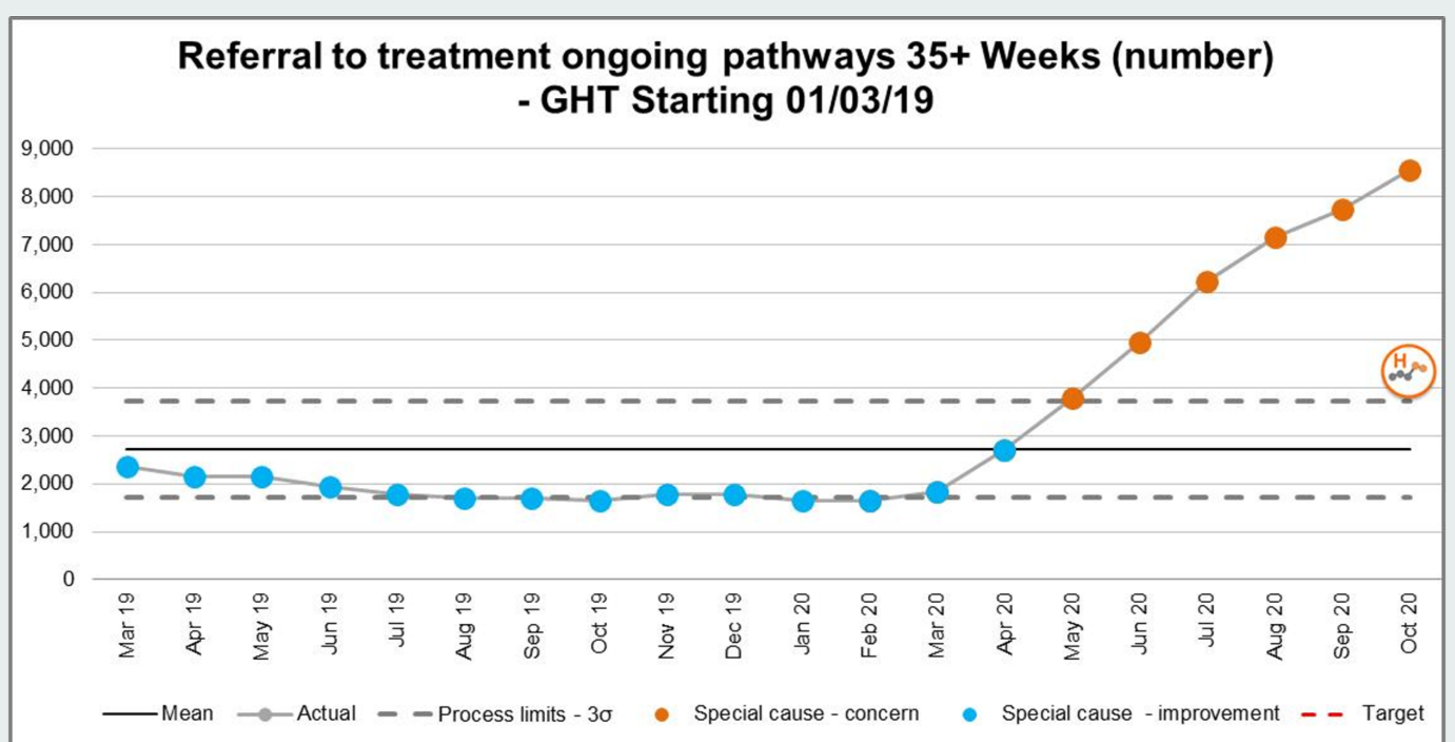

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 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 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

Recovery and restoration continues, prioritising in accordance with clinical urgency followed by chronology. Consequently cohort of long waiting patients increased, with approx 8,512 for October, compared to 7,748 for September and 7,155 for August.

- Deputy Chief Operating Officer

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Referral to treatment ongoing pathways 40+ 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, Sep 20, Oct 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 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 points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Recovery and restoration continues, prioritising in accordance with clinical urgency followed by chronology. Consequently cohort of long waiting patients has increased. QPR to be modified to capture >45 weeks (as opposed to 40) and >70 weeks.

- Deputy Chief Operating Officer

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SPC – Special Cause Variation

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

1,400
1,200
1,000
800
600
400
200
0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20

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

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 2 data point(s) below the line
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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 full details. The restoration and recovery phase continues, noting that our long waiting patients have increased over recent months, but potentially have stabilised subject to Surge 2. Octobers validated position is 1,290, compared to a 1,279 in September.
Clinical validation is ongoing with treatment of our most urgent patients being prioritised. Additional paid sessions are being provided to address long waiting patients in addition to those urgent patients.

- Deputy Chief Operating Officer

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Quality Dashboard

This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance			Variation		
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	
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Sep-20	79.0%
Dementia Screening	% of patients who have scored positively on dementia screening tool that then received a dementia diagnostic	>=90%	Mar-20	0.00%
Dementia Screening	% of patients who have received a dementia diagnostic assessment with positive or inconclusive results that were	>=90%	Dec-19	0.00%
Friends & Family Test	Inpatients % positive	>=96%	Oct-20	86.4%
Friends & Family Test	ED % positive	>=84%	Oct-20	74.7%
Friends & Family Test	Maternity % positive	>=97%	Oct-20	88.9%
Friends & Family Test	Outpatients % positive	>=94%	Oct-20	94.0%
Friends & Family Test	Total % positive	>=93%	Oct-20	91.5%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Oct-20	0
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Oct-20	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2019/20: 114	Oct-20	8
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Oct-20	7
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Oct-20	1
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Oct-20	29.2
Infection Control	Number of MSSA bacteraemia cases	<=8	Oct-20	1
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Oct-20	3.6
Infection Control	Number of ecoli cases	No target	Oct-20	6
Infection Control	Number of pseudomona cases	No target	Oct-20	0
Infection Control	Number of klebsiella cases	No target	Oct-20	0
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Oct-20	5

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	TBC	Oct-20	48
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	TBC	Oct-20	3
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	TBC	Oct-20	0
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	TBC	Oct-20	0
Inpatient Questions	How much information about your condition or treatment or care has been given to you?	>=90%	Mar-20	78%
Inpatient Questions	Are you involved as much as you want to be in decisions about your care and treatment?	>=90%	Mar-20	92%
Inpatient Questions	Do you feel that you are treated with respect and dignity?	>=90%	Mar-20	100%
Inpatient Questions	Do you feel well looked after by staff treating or caring for you?	>=90%	Mar-20	99%
Inpatient Questions	Do you get enough help from staff to eat your meals?	>=90%	Mar-20	67%
Inpatient Questions	In your opinion, how clean is your room or the area that you receive treatment in?	>=90%	Mar-20	100%
Inpatient Questions	Do you get enough help from staff to wash or keep yourself clean?	>=90%	Mar-20	86%
Maternity	% C-section rate (planned and emergency)	<=27%	Oct-20	32.91%
Maternity	% emergency C-section rate	No target	Oct-20	19.5%
Maternity	% of women smoking at delivery	<=14.5%	Oct-20	12.58%
Maternity	% of women that have an induced labour	<=30%	Oct-20	28.7%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Oct-20	0.83%
Maternity	% of women on a Continuity of Carer pathway	No target	Oct-20	0.0%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Jun-20	1.1
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Jul-20	104.6
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Jul-20	110.8
Mortality	Number of inpatient deaths	No target	Oct-20	139

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Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Mortality	Number of deaths of patients with a learning disability	No target	Oct-20	1
MSA	Number of breaches of mixed sex accommodation	<=10	Oct-20	0
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Oct-20	0
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Oct-20	6.9
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Oct-20	6
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Oct-20	5
Patient Safety Incidents	Medication error resulting in severe harm	No target	Oct-20	0
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Oct-20	1
Patient Safety Incidents	Medication error resulting in low harm	No target	Oct-20	9
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Oct-20	23
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Oct-20	5
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Oct-20	0
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Oct-20	7
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Oct-20	12
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Jun-20	68%
RIDDOR	Number of RIDDOR	SPC	Oct-20	1
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%
Serious Incidents	Number of never events reported	Zero	Oct-20	0
Serious Incidents	Number of serious incidents reported	No target	Oct-20	3
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Oct-20	100.0%
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Oct-20	100%
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Oct-20	89.8%

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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 Sep 20 Oct 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 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 score of 86.4% is a combined score of inpatients (82.77) and daycase (96.07) FFT. This has remained stable since a decline in August, and will continue to be monitored through QDG. The Patient Experience Improvement team are looking at adding in more questions to the FFT as a pilot on some wards, which patients can answer while in the hospital. This will give more insight about experience on wards vs discharge, and the opportunity to ask questions on more specific areas of experience that will be informed by trends emerging from comments.

- Deputy Director of Quality

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Quality:
SPC – Special Cause Variation

ED % 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, Sep 20, Oct 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 which is above the line. There is 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 this is a warning that the process may be changing

Commentary

The Unscheduled Care FFT scores have shown a slight increase (1.7%) from September, with 624 responses. The Divisional and specialty teams are working with colleagues to triangulate data sources and develop a patient experience improvement plan, which will be monitored in division and at QDG. This includes setting up a patient experience network for medical matrons.

- Deputy Director of Quality

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Quality:
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MRSA bacteraemia – infection rate per 100,000 bed days - GHT Starting 01/04/19

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

Not an exception. Reported as such in error.

- 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

14
12
10
8
6
4
2
0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20

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

Commentary

Not an exception. Reported as such in error.

- 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 6 data points which are above the line.
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Quality:
SPC – Special Cause Variation

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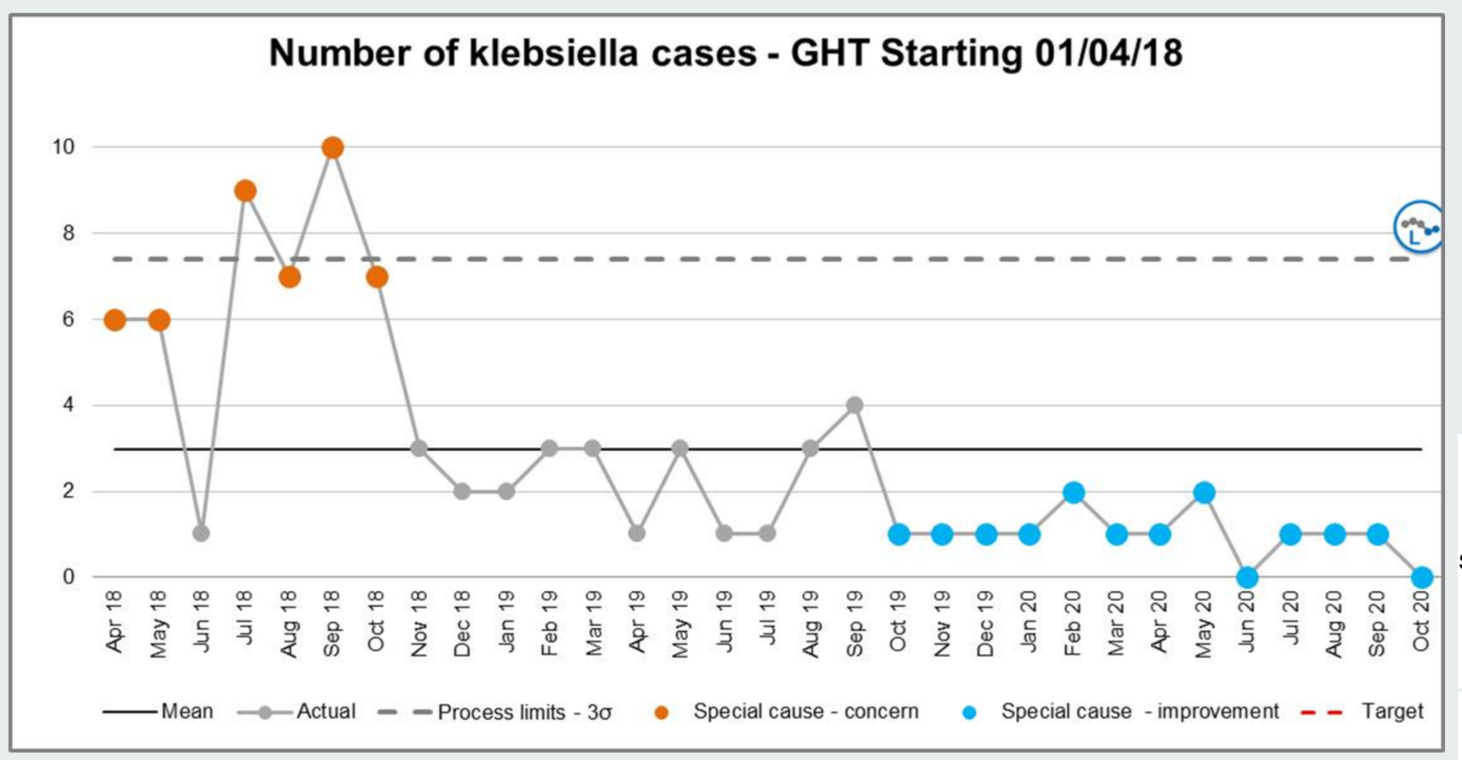

Data Observations

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2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Commentary

Not an exception. Reported as such in error.

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

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Quality:
SPC – Special Cause Variation

Number of bed days lost due to infection control outbreaks - GHT Starting 01/04/18

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Commentary

Bed days lost due to COVID exposures.

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

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Quality:
SPC – Special Cause Variation

Summary hospital mortality indicator (SHMI) – national data - GHT Starting 01/12/18

1.2
1.0
0.8
0.6
0.4
0.2
0.0

Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20

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

Commentary

As per HSMR although these figures are produced less frequently so they take longer to come through. The latest figure covers the period up to May 2020 and is in the expected range a decrease from the previous published figure.

- 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 is 1 data point(s) below the line
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

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Quality:
SPC – Special Cause Variation

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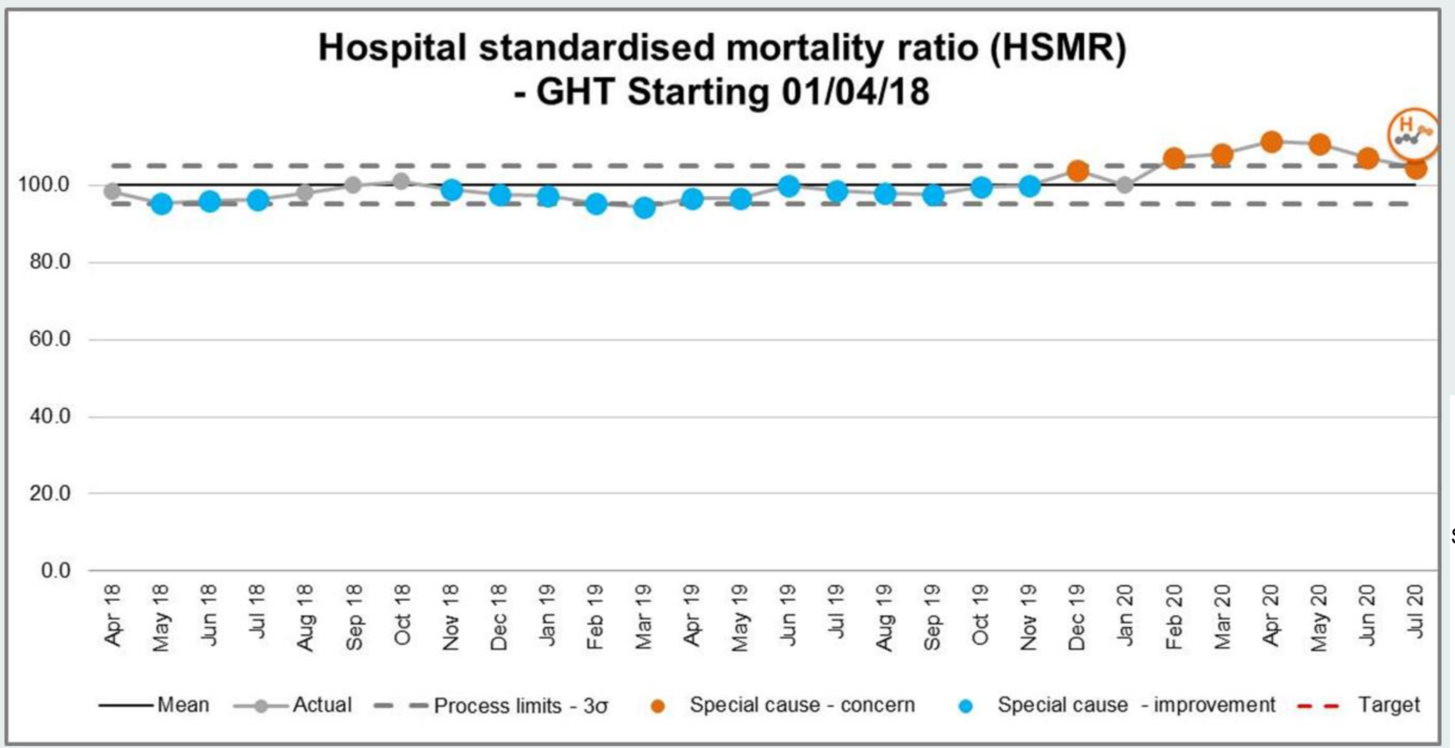

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 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

Commentary

These figures are showing as higher than expected when taking into the account of the COVID period, the months following the first wave show a reduction. The issue relates to similar or higher number of deaths but a greatly reduced number of episodes of care during that time, ie the rate increased. However this does not suggest any degree of complacency as these are monitored at HMG, and four specific areas are having a deep dive.

- Medical Division Audit and M&M Lead

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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, Jun 20, Jul 20

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

Commentary

These figures are showing as higher than expected when taking into the account of the COVID period, the months following the first wave show a reduction. The issue relates to similar or higher number of deaths but a greatly reduced number of episodes of care during that time, ie the rate increased. However this does not suggest any degree of complacency as these are monitored at HMG, and four specific areas are having a deep dive.

- 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 7 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

Number of patient safety alerts outstanding - GHT Starting 01/04/19

Y-axis: 0, 1, 2, 3, 4, 5

X-axis: Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 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 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

Commentary

The system continues to work effectively.

- Director of Safety

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Quality:
SPC – Special Cause Variation

Number of category 2 pressure ulcers acquired as in-patient - GHT Starting 01/04/19

45
40
35
30
25
20
15
10
5
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, Sep 20, Oct 20

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

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

Commentary

Improvement - expected performance.

- 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, Sep 20, Oct 20

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

Commentary

The system continues to work effectively.

- 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(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.

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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 & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	N/A
Finance	NHSI Financial Risk Rating		Sep-20	N/A
Finance	Capital service		Sep-20	N/A
Finance	Liquidity		Sep-20	N/A
Finance	Agency – Performance Against NHSI Set Agency Ceiling		Sep-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%		Oct-20	83.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Oct-20	93%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Oct-20	96.3%	
Safe Nurse Staffing	% registered nurse day	>=90%		Oct-20	95.5%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Oct-20	101.4%	
Safe Nurse Staffing	% registered nurse night	>=90%		Oct-20	97.8%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		Oct-20	113.4%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Oct-20	5.2	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Oct-20	3.4	
Safe nurse staffing	Care hours per patient day total	>=8		Oct-20	8.6	
Vacancy and WTE	Staff in post FTE	No target		Oct-20	6587.72	
Vacancy and WTE	Vacancy FTE	No target		Oct-20	371.63	
Vacancy and WTE	Starters FTE	No target		Oct-20	57.53	
Vacancy and WTE	Leavers FTE	No target		Oct-20	57.48	
Vacancy and WTE	% total vacancy rate	<=11.5%		Oct-20	5.34%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Oct-20	1.07%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Oct-20	7.76%	
Workforce Expenditure	% turnover	<=12.6%		Oct-20	9.6%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Oct-20	9.4%	
Workforce Expenditure	% sickness rate	<=4.05%		Oct-20	3.7%	

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People & OD:
SPC – Special Cause Variation

Trust total % overall appraisal completion - GHT Starting 01/06/18

Commentary

The Medical Division and Women and Children's Division have seen improvement in Appraisal compliance rates with the Medical Division now at 87%. Diagnostics and Specialities has seen a decline however recovery plans are in place.

Achieving the 90% compliance standard remains a focus for all Divisions.

- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 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.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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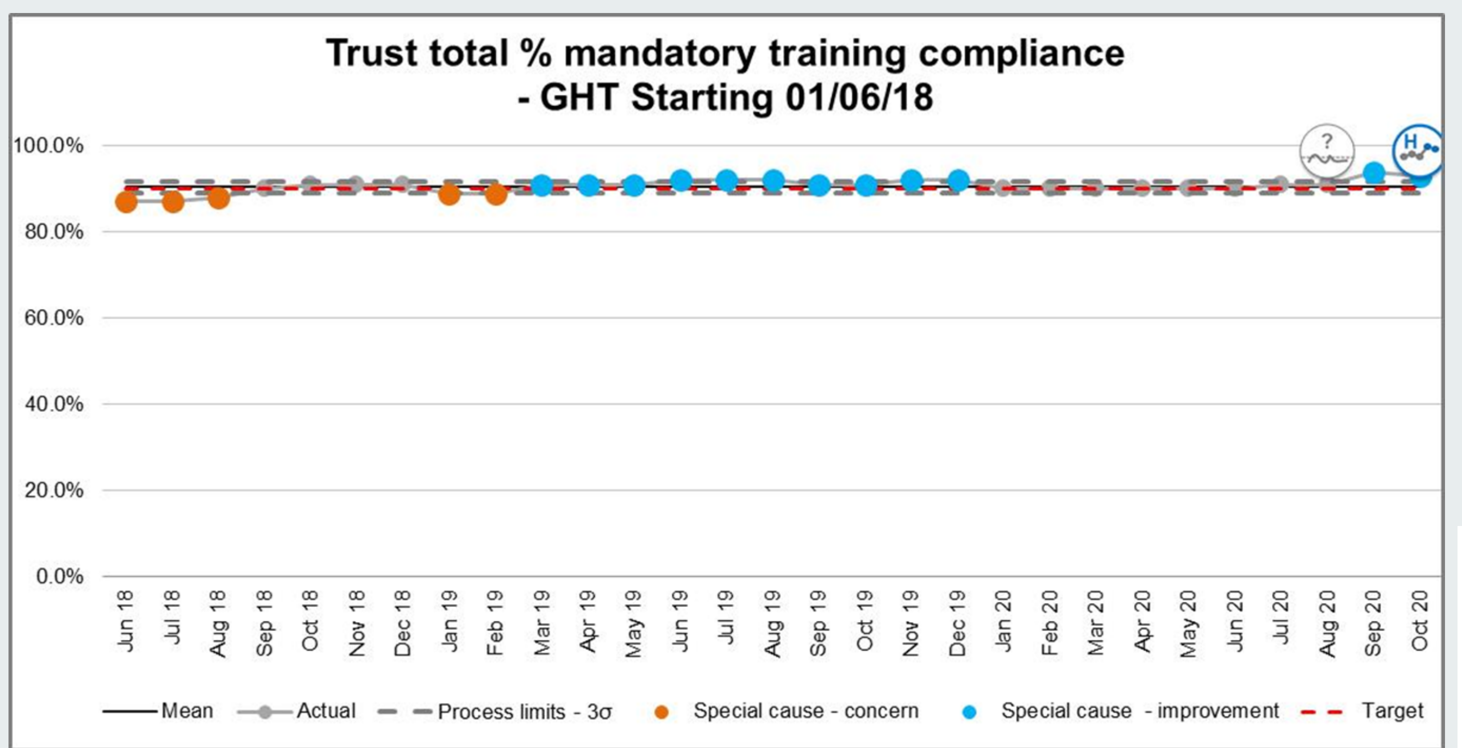
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Positive improvement noted regarding Mandatory Training compliance levels across all divisions by 1 or 2%, with all divisions exceeding the 90% target.

- **Director of Human Resources and Operational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 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.
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TRUST PUBLIC BOARD - DECEMBER 2020
Microsoft Teams, Commencing at 12:30

Report Title
Complaint Annual Report
Sponsor and Author(s)
Author: Jo Mason-Higgins, Head of Complaints, Claims and Patient Safety Investigations Sponsor: Steve Hams, Director of Quality and Chief Nurse
Executive Summary

Purpose

To provide assurance of meeting the national (NHS Complaints Regulations 2009) and local standards for investigation and learning in respect of complaints brought against the Trust.

Key Points to Note:

- 781 complaints were received by the Trust during 2019/2020 giving an average of 75 complaints per month. This number compares to 898 during 2018/19; a decrease of 13.02%.
- 96% of the time, acknowledgements were sent within the national target of 3 days. 100% was not achieved due to administrative pressures within the complaints team. A generic automatic email response is in place.
- 68% of responses were sent within the 35 or 65 standard; this is an increase of 16% on the previous year (52%). The Complaints Department set a local target of 80% response rate by April 2020, following their amalgamation into the Patient Investigation and Learning Team in January 2019. This target was met within Q4 and has remained consistent through the first quarter of 2020/2021.
- During 2019/2020 the Trust had 15 complaints referred to the Parliamentary and Health Service Ombudsman (13 in 2018/19). During 2019/20 a decision was received for 9 cases. Two cases were upheld, two cases partly upheld and five were not upheld.
- The amalgamation of the Complaints Department with the Claims and Patient Safety Investigation Department has provided a solid foundation for developing a team of specialist investigators who are both empowered and supported in undertaking patient centred and objective investigations into clinical concerns and incidents reported to the Trust. This principle is one underpinning both the awaited National Patient Safety Strategy and the Complaints Standard Framework.
- Divisions have signed up to ensuring that actions (one or more) are identified for every upheld and partially upheld complaint. The Complaints Department are recording each of those actions (and responsible lead) on the action module of Datix. The use of this module will enable Divisional Governance Teams to run reports providing oversight and the ability to monitor and assure those actions.

This Annual Complaints report will be published on the Trust website as required to meet our quality reporting requirements for the Quality Account.

Conclusions

2019/2020 has seen a further decrease in the number of complaints received by the Trust. Re-organisation of the Complaint Department, the same name now forming part of the Patient Investigation and Learning Team together with increased resource (in January 2019) has enabled the team to improve response times, the quality of investigation and opportunities for action and learning.

Implications and Future Action Required

Continued monitoring of progress.

Recommendations

To note the report

Impact Upon Strategic Objectives

Effective investigation and implementation of learning will impact on:
Outstanding Care & Quality Improvement
Quality Improvement
Involved People

Impact Upon Corporate Risks

Dependent on the incident or concern

Regulatory and/or Legal Implications

Investigations are carried out in parallel with other processes such as serious and moderate harm incidents, claims and Inquests

Equality & Patient Impact

Access to care is considered in relevant cases including mental health\consent concerns. LD patient investigations link with the LD team and LeDeR reviews. Relevant experts provide advice as required.

Resource Implications

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

Action/Decision Required

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

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

Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
							QDG 13th October 2020

Outcome of discussion when presented to previous Committees/TLT

QDG – Report accepted – requested further information and analysis of reduction in complaints when compared with increase in PALs concerns.

Annual Complaints Report 2019/2020

Author/Presenter:
Jo Mason-Higgins,
Head of Claims, Complaints & Patient Safety Investigations

Quality & Performance Committee
October 2020

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Executive summary

In accordance with the NHS Complaints Regulations (2009) this report sets out a detailed analysis of the number and nature of complaints received by Gloucestershire Hospitals NHS Foundation Trust during the 2019/2020 year.

In summary:

- 781 complaints were received by the Trust during 2019/2020 giving an average of 75 complaints per month. This number compares to 898 during 2018/19; a decrease of 13.02%.

- 96% of the time, acknowledgements were sent within the national target of 3 days. 100% was not achieved due to administrative pressures within the complaints team. A generic automatic email responseis in place. .

- 68% of responses were sent within the 35 or 65 standard; this is an increase of 16% on the previous year (52%). The Complaints Department set a local target of 80% response rate by April 2020, following their amalgamation into the Patient Investigation and Learning Team in January 2019. This target was met within Q4 and has remained consistent through the first quarter of 2020/2021.

- During 2019/2020 the Trust had 15 complaints referred to the Parliamentary and Health Service Ombudsman (13 in 2018/19). During 2019/20 a decision was received for 9 cases. Two cases were upheld, two cases partly upheld and five were not upheld.

- The amalgamation of the Complaints Department with the Claims and Patient Safety Investigation Department has provided a solid foundation for developing a team of specialist investigators who are both empowered and supported in undertaking patient centred and objective investigations into clinical concerns and incidents reported to the Trust. This principle is one underpinning both the awaited National Patient Safety Strategy and the Complaints Standard Framework.

- Divisions have signed up to ensuring that actions (one or more) are identified for every upheld and partially upheld complaint. The Complaints Department are recording each of those actions (and responsible lead) on the action module of Datix. The use of this module will enable Divisional Governance Teams to run reports providing oversight and the ability to monitor and assure those actions.

- This Annual Complaints report will be published on the Trust website as required to meet our quality reporting requirements for the Quality Account.

1. Accountability for complaints management

The Board of Directors has corporate responsibility for the quality of care and the management and monitoring of complaints received by our Trust. The Chief Executive has delegated the responsibility for the management of complaints to the Director of Quality & Chief Nurse.

In January 2019, the Complaints Department amalgamated with the Claims and Patient Safety Investigation Team to form the Patient Investigation and Learning Team. This team is managed by the Head of Claims, Complaints and Patient Safety Investigations, reporting to the Quality Improvement and Safety Director.

The Head of Claims, Complaints and Patient Safety Investigations is responsible for ensuring that:

- All complaints are fully investigated appropriate to the complaint
- All complaints receive a comprehensive written response from the Chief Executive or their nominated deputy in their absence
- Complaints are responded to within local standard response times of 35 or 65 days
- Where the timescale cannot be met, an explanation is provided and an extension agreed
- When a complaint is referred to the PHSO, all enquiries are responded to promptly and openly

As at April 2019, the complaints team consisted of 3.8 WTE band 6 complaints managers; responsible for the coordination of staff investigating and the final response to the complainant, supported by 1WTE band 4 and 1WTE band 3 administrators. The administrative function is further supported by the Band 7, Family Liaison and Investigation Co-ordinator.

In April 2020, following the departure of a WTE Band 6 Complaint Manager, one of the remaining Band 6 Complaint Managers moved into a Band 7 Patient Safety Investigation Manager (Complaint) position. A Band 5 WTE Assistant Complaint Manager has been recently appointed.

The aim of this reconfiguration is to align the investigation of serious complaints with serious incidents. The development of specialist investigators is a key theme of the (awaited) National Patient Safety Strategy and the new Complaints Standard Framework. Further professional development will be possible once the Ombudsman releases a national training package for complaint managers.

The appointment of a B5 Assistant Complaint Manager provides for more appropriate allocation of administrative work. In addition, this appointment will enable the existing B6 Complaint Managers to develop their investigative skills and increase their capacity for direct and personal contact with service users who have had cause to complain.

2. Complaints reporting

In 2019/2020, the Quality Improvement and Safety Director reported the following information to the Quality and Performance Committee monthly:

- Number of written complaints received per 1000 episodes of care and broken down by division
- Number of PHSO cases received during the quarter and the resolution during that quarter of any existing cases

Divisional Quality Leads received a weekly report from the Patient Investigation and Learning Team comprising; new complaints, complaints overdue, new Letters of Claim, moderate and serious incidents.

The Annual Complaints Report will be received by the Quality and Performance Committee and this report will be published in the public domain via the Trust website.

The Safety and Experience Review Group will continue to monitor action plans arising from serious complaints and those reported to the PHSO on a monthly basis. Action plans are developed with the Division\Specialty and form most of the change and learning required within the departments.

As part of the Quality Strategy programme key quality information is being standardised and provided including complaints data to every specialty governance meeting. This data provided includes both performance management information on the quality system and links to outcomes and learning. This enhances the specialties ability to visualise the full spectrum of quality rather than just specific system (complaints\incidents) learning and performance.

3. Total complaints received in 2019/20

During 2019/20 the Trust received a total number of 781 complaints which equates to an average of approximately 15 complaints received per week. This is a decrease of approximately 13.02% against the number of complaints received during 2018/2019 (891).

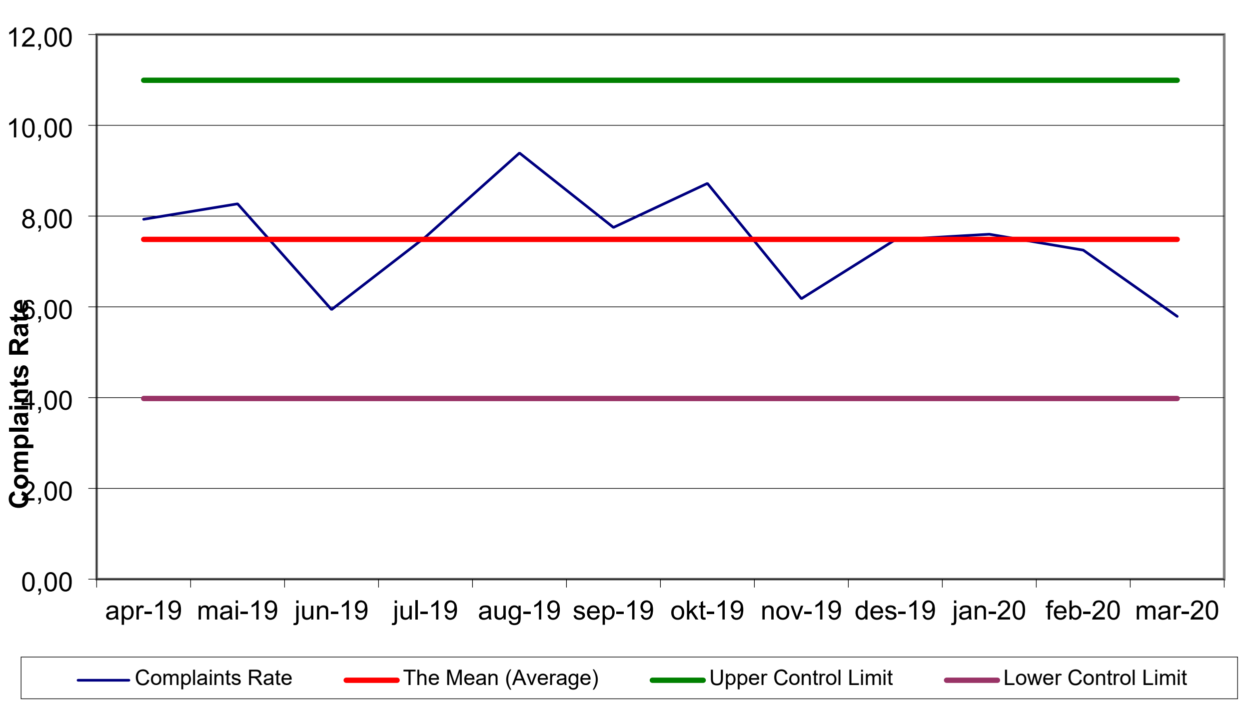


Figure 1 demonstrates the number of complaints received in each quarter during 2019/20 compared to the previous two fiscal years.

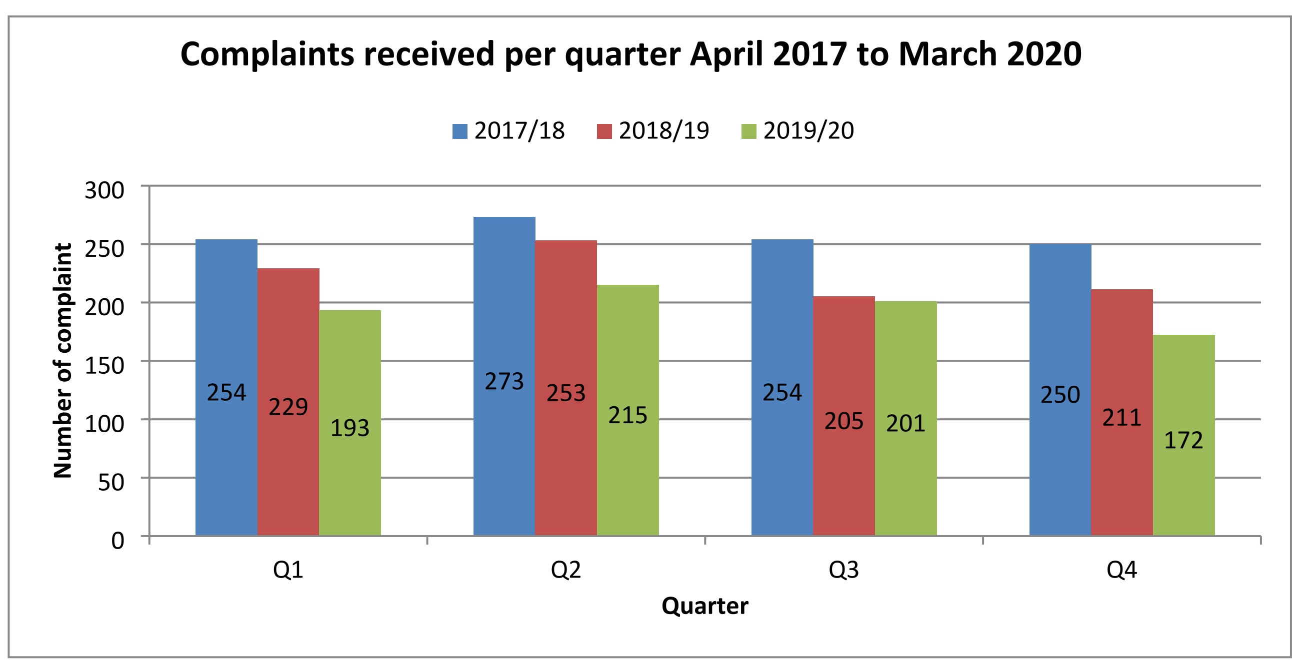
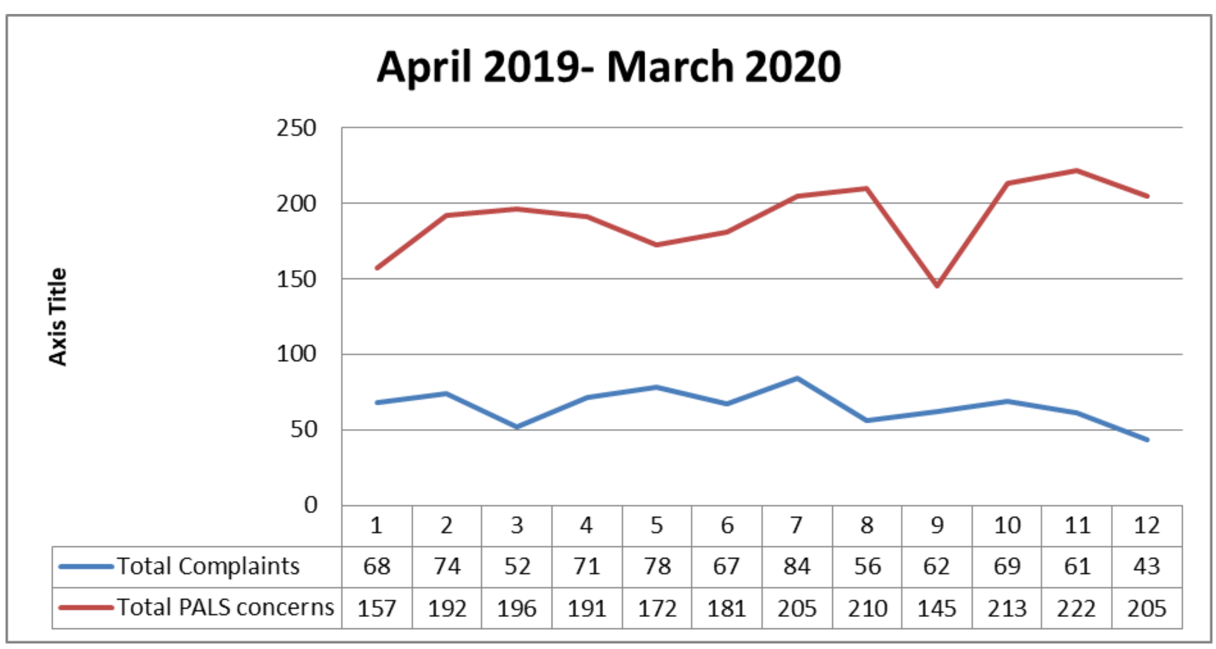


Figure 1

The following graph compares the number of complaints with the number of contacts through the Patient Advice and Liaison Service. The relative increase in PALs contacts and reduction in Complaints received evidences that the Trust are resolving an increased number of concerns within 24 hours, without recourse to a formal complaint investigation.



	1	2	3	4	5	6	7	8	9	10	11	12
Total Complaints	68	74	52	71	78	67	84	56	62	69	61	43
Total PALS concerns	157	192	196	191	172	181	205	210	145	213	222	205

3.1 Complaints by Division

Table 2 shows the number of complaints received by each of the Trust's divisions compared with the previous year. Directional arrows indicate change compared to the previous fiscal year.

Division	Complaints 2019/20	Complaints 2018/2019
Corporate	52 ↑	36
Diagnostics & Specialties	76 ↓	128
Estates & Facilities	9 ↓	19
Medicine	306 ↓	318
Surgery	249 ↓	299
Women & Children	89 ↓	98
TOTAL	**781**	**898**

Table 1

As the data demonstrates, with the exception of the corporate division there has been an overall decrease in complaints. The increase in complaints in the corporate division is primarily due to the central booking office having moved from the Diagnostics and Specialties Division to the Corporate Division.

In order to support the processes in place for medical staff and junior doctors our complaints are broken down by staff group. The three groups receiving the majority of complaints during 2019/20 are Medical (605), Nursing (523) and Clinical Support (261). These figures represent the number of issues, rather than number of complaints so totals are higher than total complaints received.

Complaints involving senior medical staff are recorded and doctors must submit this information for review and discussion at their appraisal. All complaints involving junior doctors are highlighted to the Deanery for further consideration with the doctor's educational supervisor.

4. Outcomes

Table 2 demonstrates the breakdown, by quarter, of complaint outcomes during 2019/2020.

Outcome	Q1	Q2	Q3	Q4	2019/2020 Total
Upheld	54	68	49	41	**212**
Partially	87	92	88	67	**334**
Not Upheld	52	55	64	54	**225**
Not Closed	0	0	0	10	**10**
Total	193	215	201	172	**781**

Table 2

The outcome is determined by the division and/or CEO indicating if the complaint is considered to be:

Upheld: If a complaint is received which relates to one specific issue, and substantive evidence is found to support the complaint, then the complaint should be recorded as upheld.

Not upheld: Where there is no evidence to support any aspects of a complaint made, the complaint should be recorded as not upheld.

Partially upheld: Where a complaint is made about several issues, if one or more of these, (but not all), are upheld then the complaint should be recorded as partially upheld.

27% of closed complaints were upheld in 2019/2020. This represents a 3% decrease in the percentage number of upheld complaints in 2018/2019. 42% of complaints were considered to have been partially upheld in 2019/20120, representing a similar percentage of partially upheld complaints in 2018/019. 28% of complaints were considered not upheld in 2019/2020. When compared with the percentage number of complaints not upheld in 2018/2019, an increase of 1% is noted.

5. Complaint Themes

The Trust follows the issue categories as stipulated by the Department of Health. Each complaint may involve more than one issue depending on the nature and complexity of the complaint. By coding our complaints it allows us to identify whether any trends are developing. Table 3 below identifies the themes and trends from our complaints; the top 5 themes are highlighted along with a directional arrow to denote the change on the previous year. Please note complaints can involve multiple themes, hence the disparity between issues and numbers of complaints.

Complaint Theme	Total complaints 2019/2020	Total complaints 2018/2019	Total complaints 2017/2018
Clinical Treatment (Medical)	↓**314**	530 ↑	523
Access to Treatment or drugs	↓**17**	20 ↓	33
Admissions, Discharge and Transfers	↑**113**	108 ↓	168
Appointments	↓**115**	265 ↑	247
Commissioning	0 ↔	0 ↓	1
Communications	↓**390**	458 ↑	453
Consent to treatment	↑**10**	6 ↓	8
End of Life care	↓**3**	15 ↓	21
Facilities	↓**48**	61 ↓	81
Integrated care	↓**0**	2 ↑	1
Patient Care (including nutrition and hydration)	↓**181**	230 ↓	287
Mortuary	0 ↔	0 ↓	3
Prescribing errors	↓**25**	43 ↓	51
Privacy, Dignity and Wellbeing	↓**15**	53 ↑	51
Restraint	↑**2**	1 ↑	0
Staffing Numbers	↓**3**	19 ↑	16
Transport	↓**0**	4 ↓	6
Trust Administration	↓**38**	53 ↓	69
Values and Behaviour	↓**177**	220 ↓	294
Waiting Times	↓26	46 ↓	77
Other	↓**12**	15 ↓	28

Table 3

Top Five Themes

During 2019/2020, the top five themes remain consistent with the top five themes in 2018/2019:

- Appointments
- Clinical Treatment (medical)
- Communications
- Patient Care (including nutrition and hydration)
- Values and Behaviour

However, each of these top five themes saw a significant reduction in 2019/2020 when compared with 2018/2019:

- Appointments – 57% decrease
- Clinical Treatment (medical) – 41% decrease
- Communications – 14% decrease
- Patient Care (including nutrition and hydration) – 22% decrease
- Values and Behaviour – 20% decrease

The most significant decrease in the top five themes, relates to appointments. The appointment category relates predominantly to the administration of appointment letters, including not being sent/ received or not sent in a timely way. The Trust saw a significant increase in this category in 2017/2018 (24%) and slight increase (6.7%) in 2018/2019. These increases were due in part to the immense pressure seen within our booking office following the implementation of our new patient administration system; TrakCare. The Trust has undertaken and continues to undertake a significant amount of improvement work to both the usability of TrakCare and also the support within our booking office. Whilst demand continues to outweigh supply in many areas across the Trust, a significant improvement is evident.

Clinical treatment (medical) also saw a significant 41% decrease in numbers of complaints received. The clinical treatment category relates to service user concern with diagnosis, access to and timeliness of treatment and complications following surgery. This is a noteworthy decrease given that in 2017/2018, the Trust saw a 35% increase in this theme and in 2018/2019 a 3% increase.

Complaints relating to communication generally relate to communication between staff and patients or staff and relatives/ carers/ visitors. This can include a lack of communication, incorrect method of communication, and timeliness of communications. Our Trust launched increased visiting hours to help improve this in 2018/2019 and the 14% decrease in complaints can in part be attributed to this.

During 2019/20 our Trust saw a 22% decrease in the theme of Patient Care which also included any complaints relating to nutrition and hydration. This theme covers much of the general nursing care, including providing help to eat meals if needed, answering the call bell, responding to the needs of the patient, providing help with washing and personal hygiene. It is worthy of note that the Trust had also seen a 19% decrease in the theme of Patient Care in 2018/2019.

In 2017/2018, there was a reported 9% increase in complaints relating to values and behaviour. 2018/2019 demonstrated a 25% decrease in this category of complaint and this decrease has continued through to 2019/2020 with a reported 20% decrease.

Other Themes

The decrease in 2018/19 on the previous year, in respect of access to treatment or drugs and waiting times of 40% has continued, with further reported decreases in 2019/2020. The Trust's continued focus on its Emergency Department performance and commitment to provide elective surgery during the very busy winter months continues to have a positive impact on the frequency of these themes in complaints. Waiting times in particular has seen a 55% decrease in frequency.

2019/2020 saw a significant (72%) reduction in complaints related to privacy, dignity and wellbeing. This significant reduction should be compared with a relative increase in this complaint category in 2018/2019. Similarly the reported increase in complaints relating to staffing numbers in 2018/2019 has seen a decrease of a considerable 85% in 2019/2020.

The decrease in complaints relating to commissioning, end of life care, facilities, mortuary, prescribing errors, transport and Trust administration in 2018/2019 has continued through 2019/2020.

There were increases in the number of complaints relating to restraint, consent to treatment and admissions, discharge and transfers.

Analysis of complaints relating to consent to treatment has identified a common theme in respect of end of life decision planning. The Trust have committed to adopting ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) at our hospitals from 10 October 2019. This national patient-held document, completed following an Advance Care Planning conversation between a patient and a healthcare professional, will be used across all care settings in Gloucestershire and will address many of the issues raised by service users within the complaint process.

The increase in the category of "Admissions, discharge and transport" relate to concerns over discharge from hospital. Patients/their relatives have raised concerns in respect of their inability to cope at home following discharge resulting in re-admission to hospital within a short period of time and delayed/lack of transport following discharge from hospital. A new programme of improvement looking at positive risk taking with discharge is being developed with some resource from the CCG. Part of this programme would be to change the expectation of families so that they prepare for early discharge as it is safer for the patient compared to the risks to health of a longer hospital stay. In addition the Deputy Divisional Director for Quality and Nursing (Medicine) has been investigating the impact of teams such as Onward Care and Bed Management on the discharge process

The increase in the category of restraint is a marginal increase from one complaint in 2018/2019 to two complaints, from the same patient, in 2019/2020.

6. Performance in responding to complaints

In addition to monitoring the number of complaints received by our Trust we also monitor our performance against nationally and locally set timescales (3 working days for an acknowledgement – nationally set and 35 or 65 working days for a response – locally set).

Guidance from the Parliamentary and Health Service Ombudsman recommends that a Trust must investigate a complaint 'in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed'. Therefore when a response is not going to be completed in the set timeframe then an explanation must be given, by the Trust, to the complainant and a new timeframe agreed.

Table 4 below shows the breakdown of response rate within 35 working days by division and demonstrated by quarter through the 2019/2020 year.

	Q1	Q2	Q3	Q4	YTD Rate
Corporate	75%	77%	83%	82%	79%
D&S	62%	83%	52%	100%	74%
E&F	100%	67%	50%	100%	78%
Medicine	49%	64%	55%	82%	62%
Surgery	71%	77%	76%	69%	73%
W&C	47%	53%	56%	93%	60%
Total	60%	69%	63%	81%	68%

Table 4

Upon amalgamating the Complaints Department with the Claims and Patient Safety Investigation Teams, to form the Patient Investigation and Learning Team, the Head of the Patient Investigation and Learning Team set a team objective of responding to 80% of complaints within agreed timescales by April 2020.

Table 4 above demonstrates that this target was met across the Trust through Q4. Analysis of response rate by Division confirms the 80% target to have been met in all Divisions in Q4, except Surgery. However Surgery's overall yearly response rate is improved at 73%.

Reasons for not meeting the target are explained by the categories in Table 5, below:

	Q1	Q2	Q3	Q4	YTD Rate
Annual Leave	0%	0%	0%	0%	0%
Complaints Department	1%	7%	2%	7%	4%
Clearing process	10%	4%	10%	18%	9%
Receipt of Consent	0%	0%	0%	0%	0%
Health Records availability	3%	1%	0%	0%	1%
Division	79%	83%	78%	75%	79%
Other Division	3%	3%	4%	0%	3%
Other Organisation	5%	1%	5%	0%	3%
Executive Team	0%	0%	0%	0%	0%
Legal Dept.	0%	0%	1%	0%	0%
Sick Leave	0%	0%	0%	0%	0%
No value	0%	0%	0%	0%	0%

Table 5

Following the Complaints Department joining the Patient Investigation and Learning Team, we implemented:

- Weekly Reports to the Director of Quality/Chief Nurse and Divisional Chief Nurses highlighting delays
- An improved escalation process for clearing with the Divisional Chief Nurses and thereafter after the Director of Quality/Chief Nurse and CEO

- Improved turnaround time for sign off from the Claims Department (as now one team)
- A maximum 65 day response rate for serious complaints (in conjunction with/ agreement with the patient/carer/NOK)

In order to further improve the Trust's overall response rate by April 2021, the following is being undertaken:

- The most commonly cited reason for staff delaying responses to complaints is the inability to access patient health records. The implementation of EPR will help long term with this. In the meantime, discussions continue with our Datix Lead and the Information Governance Department so as to design an IG compliant use of Datix for scanning and uploading patient records that can be accessed by staff. Datix is the system used by the Trust for recording concerns, compliments, complaints and incidents.
- The Head of Claims, Complaints and Patient Safety Investigations has agreed with the Medical Division an improved investigation and escalation process for complaints. This process provides specialty leads with greater responsibility in the investigation and sign off process and clearly defines the escalation process through the Divisional Quality Team and Chief Executive. This new process was implemented in August 2020 and is working well. It has beena agreed that this new process will also be adopted by other Divisions, following a period of staff engagement, in November 2020.

7. Complainant satisfaction with complaint response

Our Trust currently uses three measures to assess the satisfaction of the complainant with their final response, these are:

- Comebacks: where a complainant submits further questions or correspondence requiring further investigation and response. There were 82 comebacks received during the year (10% of all complaints received). This is a slight increase from 9% the previous year.
- Meetings: where a complainant requests to meet with staff to ask additional questions, or discuss the content of their response. There were 23 meetings held with complainants (2.94% of all complaints received). This is a slight increase on the previous year (20). The complaints team are offering meetings more proactively, particularly in complex complaints, as this can be very helpful for bereaved and distressed complainants. This increase is therefore not necessarily an indication that complainants are not satisfied with the initial written response.
- Parliamentary and Health Service Ombudsman (PHSO): where a complainant refers the matter to the PHSO for independent review. There were 15 cases referred by complainants to the PHSO during the year (1.9% of all complaints received). This is an increase on the previous year (13).

8. Parliamentary and Health Service Ombudsman (PHSO)

15 cases were referred to the PHSO during 2019/20. A decision has been received during the year on 9 cases (decisions may relate to cases referred in the previous year). 2 were upheld, 2 were partially upheld and 5 were not upheld. The PHSO do not inform us of complaint referrals that do not meet their threshold and are, therefore, not formally investigated through the second stage resolution process.

All cases referred to the PHSO are monitored by the Safety and Experience Review Group (SERG). This group has responsibility for signing off actions plans for partially upheld and upheld cases before they are returned to the PHSO. All action plans are developed by the relevant division. SERG is used as a mechanism to cascade any learning to other areas.

The Head of Complaints, Claims and Patient Safety Investigations has reviewed the slight increase in comeback complaints, meetings and referral to the Parliamentary Health Service Ombudsman and is working with the Complaints Department to:

- Improve personal contact between the service user and complaint manager (telephone and meeting) in order to better understand the rationale for the complaint upon receipt of it
- Ensure that complex (serious) complaints are identified early on and agreement reached to undertake a 65 working day investigation. A complaint's complexity will not always relate to the perceived or alleged adverse effect on the patient. The complexity for example may be in the number of specialties involved in the patient's treatment pathway and may require multiple staff to investigate and respond to the patient's concerns.
- Provide Complaints Managers protected time to review complaints referred to the PHSO so as to ensure that the PHSO are informed, early on, of the Trust's position and findings within our local investigation.
- Encourage Complaints Managers to develop relationships with PHSO case handlers where complaints referred to them are complex and/or vexatious.

9. Learning from Complaints

The Patient Investigation and Learning Team continue to contribute to the Trust's Quality Strategy and Quality Framework, particularly in relation to learning from complaints, claims and Patient Safety Incidents (SI and Moderate Harm).

In terms of action currently taken;

1. An investigation report style (similar to that of moderate harm and Serious Incident reports) with recommendations for learning is completed for relevant serious complaints. A report is not used where a formal report structure may be unhelpful to the complainant. Where the issues are significant, the Complaint Investigation Report is referred to the Safety Experience and Review Group who review the recommendations/actions and decide whether the same require monitoring and assurance through SERG or can be passed back to the Division to be monitored/assured by their local governance structure.
2. Divisions have signed up to ensuring that actions (one or more) are identified for every upheld and partially upheld complaint.
3. The Complaints Department are recording each of those actions (and responsible lead) on the action module of Datix. The use of this module will enable Divisional Governance Teams to run reports providing oversight and the ability to monitor and assure those actions.
4. The Complaints Department are notifying Divisional Risk Managers and Quality Leads of themes/trends as they arise and therefore in real time. A Datix is being raised so that the theme can be reviewed and where possible, action taken to address it.

10. Looking Forward

Gloucestershire Hospitals NHS Foundation Trust continues to be proactive in its management of its complaints process despite challenging times. The Complaints Department have reviewed the conclusions and recommendations of Healthwatch in their “Shifting the Mindset” Publication of January 2020 and are preparing for the launch of the Complaints Standard Framework.

The amalgamation of the Complaints Department with the Claims and Patient Safety Investigation Department has provided a solid foundation for developing a team of specialist investigators who are both empowered and supported in undertaking patient centred and objective investigations into clinical concerns and incidents reported to the Trust. This principle is one underpinning both the awaited National Patient Safety Strategy and the Complaints Standard Framework.

It is proposed that the following will be considered/undertaken through 2020/2021:

- Update our complaints policy ensuring it reflects current guidance, the improved process for management of complaints within the Trust.

- To continue to contribute to the quality and frequency of reports (data/themes/trends) to Divisional Quality Teams, through the Quality Strategy.
- To continue with support and training in the use of Datix, thereby enabling specialty leads and general managers to easily access key information relating to complaints.
- Improve communication of our complaints processes to the public. Whilst improvements have been made in respect of accessing the Trust's Patient Advice and Liaison service, (as evidenced by the increase in concerns with the PALs service) review of Trustwide communication in respect of making a formal complaint is indicated. . Complaint leaflets and the complaints section of the public website, require updating. In the meantime, signposting to the Complaints Department via the Patient Advice and Liaison service, is both appropriate and effective. Review of communication in respect of the formal complaint process is a priority for the Complaints Department.
- Consider (through consultation with the Quality Improvement Academy and Divisional Quality Teams) the publication of upheld/partially upheld complaints on the Trust website. This could be achieved through anonymous case reports and/or a "you said, we did" page on the Trust website that sets out changes made recently and the Trust's overall approach to improvement.
- By 2024 to be rated as Outstanding by CQC **("R.4:** People who use the service and others are involved in regular reviews of how the service manages and responds to complaints. The service can demonstrate where improvements have been made as a result of learning from reviews and that learning is shared with other services. Investigations are comprehensive and the service uses innovative ways of looking into concerns, including using external people and professionals to make sure there is an independent and objective")
- Make use of professional training for complaints managers when available via the Ombudsman as part of the Complaints Standard Framework.
- In line with the Complaints Standard Framework identity how all staff Trust wide can be trained to support patients who are unhappy with their care and may wish to raise a concern.

REPORT TO TRUST BOARD – December 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 25 November 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
Quality and Performance	**Quality** Suite of metrics presented noting FFT and subsequent deep dive, falls, HSMR, nosocomial transmissions, increase in PALS activity and pressure to cope	Last meeting reported a scoping up of PALS service to cope with increased demand, what has changed this month? Understanding the context of PALS issues important, is it single issue? Did the QDG ask for more assurance with ligature action plans as noted in paper? How responsive is QDG able to be when a pressing issue? What is the difference in unclassified deep tissue injury and grade 4 pressure ulcers?	Plan in place but affected by operational issues so more work ongoing to review ability of the service to manage demand Confirmed similar issues to previous reporting of delayed appointments and waiting, more volume due to delays through COVID Confirmed and good evidence of QDG acting in assurance capacity Key issues dealt with in real time and through executive review process Focus of piece of work currently to ensure common definitions and reporting	Suggestion to make QDG assurance role more explicit in report to QPC

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		Stroke continues to be an area of concern and consistent red rating, what is our aim to improve? GP discharge information not improving and monitored at 24 hours, do we know if they ever get there?	Both stroke and GP discharge information areas of concern and ongoing work by the Medical Director Responsibility for completing GP discharge information being reviewed	Agreement to return to committee in January with deep dive on stroke and plans to sustainably achieve standards.
	Cancer Green rating and achievement of several standards, positive external benchmarking. Some impact on patients awaiting specialist care at centres outside of Glos due to COVID.	What are the harm reviews telling us?	Assurance received on work in place to sustainably achieve standards. Detail of harm review process and outputs included as part of paper. One low harm incident noted in this reporting period.	
	Planned care Continued improvement in RTT performance with over 52 week waits relatively static. Audiology performance improving month on month, clearance of backlog largely unchanged. MRI/CT at 100% of pre COVID levels in this	Is there any change in reaction from patients to the mass communications sent to those waiting? Is there a risk	Increase in PALS contacts, a feature of second wave is that people are not cancelling their appointments to the same degree as in wave 1. Continued use of independent sector vital to supporting performance Same harm review	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	reporting period. Note any impact of wave 2 COVID will be in subsequent reporting. Endoscopy remains a concern. **Unscheduled care** Extremely challenged operational position noted, deterioration in 4 hour standard and increase in medically stable for discharge patients. Significant focus on trying to ensure patient safety within the pathway. Trust presentation to CQC on Patient FIRST included in report.	assessment attached to the delay in endoscopy, do we know the harm impact of slowdown? Are system partners capable of improving of patients flow from the hospital, to a level which makes it sustainable? Would be useful to see hourly breakdown of patients stay in ED over 4 hours. With the 5 top reported themes of incidents, what priority has there been to addressing them?	process in place, low harm profile to start with as 2week wait system in place for urgent referrals. British Society of Gastroenterologists provided updated guidance pre COVID for increased surveillance periods for specific patient groups. System has been able to pre-empt issues in the last few weeks, significant effort to get there, still feels a reliance on 'push' from the hospital rather than 'pull externally, System wide focus continues on improving patient pathways which has traction and is encouraging but needs pace. There is a focus and doing all that is possible whilst supporting staff through the changes. It remains challenging and will take	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		How assured are you that focus on key priority areas continues with local leadership?	time to embed changes.	For consideration in future reporting to committee.
		Noting violence and aggression statistics, is there anything we can do with GMS and partners? How can we influence system funding for mental health support? Are we using a risk based approach for providing support within the Trust?	Excellent and very positive working with GHC colleagues in emergency care setting. Joint proposal being worked up to continue the work. Confirmed a risk based approach in place Assurance received of significant work and effort to improve patient experience, outcomes and safety through the unscheduled care pathway in a very challenging environment.	
	Maternity ATAIN performance (focused on reducing harm leading to avoidable admissions into neonatal units for babies born at or after 37 weeks Performance noted to be within expected ranges		Assurance received. Agreement to have substantial maternity service item at January committee to include HSIB action plans, Key performance indicators and newly received maternity patient survey results.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Serious Incident Report	Nil Never Events within this reporting period. Three serious incidents noted, no action plans closed	How do we know that the actions which are noted to be implemented are embedded and sustained? Would more volunteers on wards assist with reducing falls?	Need to consider how to evidence this, suggestion of using specific action plan recommendations through clinical audit programme in a themed way, to be considered outside committee. Assurance received of immediate actions taken at 72 hour review stage. Known that visiting reduces falls, staffing always considered, volunteers not viable at night. Role of the Admiral Nurse to assess those with cognitive impairment. Will review non clinical ward moves as part of falls review.	
Corporate Risk Register	Changes to the corporate risk register noted. Re fractured neck of femur, briefing report due as requested at previous committee meeting	Is there a correlation in time to theatre and mortality? Based on previous discussion, does the risk regarding stroke services need reviewing?	Medical Director will review both of these questions as part of respective briefings to committee	
Board Assurance Framework	Principle risks within the framework presented	Question regarding strategic objective 1.1 and reduced risk rating and deterioration in	Need to include narrative to support any movement for future iterations	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		rating from green to amber Are the objectives still valid with COVID?	Objectives agreed at Board, intention to undertake a formal review after COVID surge	
Getting it Right First Time (GIRFT)	Planned briefing deferred from last month due to committee timing. Reminder of GIRFT process and Trust wide activity with executive oversight and deep dive speciality reviews. Recommendation that GIRFT becomes explicit part of the Quality Improvement process. Links to strategic objectives clearly set out. National deep dive visits planned.	Following a J2O visit to pathology, do the reviews capture every aspect of the service which needs to be involved, is the structure right? Is there an ability to learn in a more timely way from other organisations, benchmark and see how they are progressing without needing to go through national team?	GIRFT has a national dataset from which it works. In the case of pathology, a national dashboard being developed which can come to committee for assurance Current Trust review process includes presentation to executive tri. Will consider for next report how more 'horizontal' learning between organisations can be achieved.	
Quarterly Patient Experience Report	Comprehensive report outlining quarterly data. FFT performance noted and with lack of real time feedback through existing process, series of local surveys designed to understand experience better in real time		Good report highlighting detailed data and significant work in various areas.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Increased volunteer presence noted. Full hearing audit planned and report through to QPC			
COVID	Verbal update on current position, hospitals extremely busy, inpatient numbers exceeding wave 1. Different context as all other services trying to be maintained at the same time. Nosocomial infections rising.	What have we learnt from wave 2 which may be useful if a wave 3 occurs? When will the twice weekly testing for staff start and was there any resistance from staff?	Nothing new internally, continued focus on same actions and delivery. A quick response from system partners will have more impact. External national recognition noted for innovative approaches e.g. yellow respiratory lanyards. Assurance received of executive leadership and detail of position, challenges and opportunities. Kits expected by the end of the week and no issues raised by staff at this point.	

Alison Moon
Chair of Quality and Performance Committee
30th November 2020