Gloucestershire Hospitals
NHS Foundation Trust

# PUBLIC BOARD AGENDA

Meeting: **Trust Board meeting**

Date/Time: Thursday 13 May 2021 at 12:30

Location: Microsoft Teams

| | Agenda Item | Lead | Purpose | Time | Paper |
|---|---|---|---|---|---|
| | Welcome and apologies | Chair | | 12:30 | |
| **1.** | Declarations of interest | Chair | | | |
| **2** | Staff story | Mark Hutchinson | Information | | |
| **3.** | Minutes of the previous meeting | Chair | Approval | 13:00 | YES |
| **4.** | Matters arising | Chair | Approval | | |
| **5.** | Chief Executive Officer's report | Deborah Lee | Information | 13:05 | YES |
| **6.** | Trust risk register | Emma Wood | Approval | 13:20 | YES |
| | **FINANCE AND DIGITAL** | | | | |
| **7.** | Digital report | Mark Hutchinson | Assurance | 13:40 | YES |
| **8.** | Finance report | Karen Johnson | Assurance | 13:50 | YES |
| **9.** | Assurance report of the Chair of the Finance and Digital Committee | Rob Graves | Assurance | 14:00 | YES |
| | **BREAK** | | | 14:10 | |
| | **PEOPLE AND ORGANISATIONAL DEVELOPMENT** | | | | |
| **10.** | People and Organisational Development Report | Emma Wood | | 14:20 | |
| **11.** | Assurance Report of the Chair of the People and Organisational Development Committee | Alison Moon | | 14:30 | |
| | **QUALITY AND PERFORMANCE** | | | | |
| **12.** | Guardian for Safe Working Quarterly Report | Mark Pietroni | | 14:40 | YES |

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|---|---|---|---|---|---|
| **13.** | Quality and Performance report | Steve Hams / Rachael de Caux / Mark Pietroni | Assurance | 14:50 | YES |
| **14.** | Assurance report of the Chair of the Quality and Performance Committee | Alison Moon | Assurance | 15:00 | YES |
| | **STANDING ITEMS** | | | | |
| **15.** | Council of Governor minutes | Chair | Information | 15:15 | YES |
| **16.** | Governor questions and comments | Chair | | 15:20 | YES |
| **17.** | New risks identified | Chair | | | |
| **18.** | Any other business | Chair | | | |
| **CLOSE** | | | | 15:30 | |

**Date of the next meeting:** Thursday June 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<br>Rob Graves<br>Marie-Annick Gournet<br>Balvinder Heran<br>Alison Moon<br>Mike Napier<br>Elaine Warwicker | Deborah Lee, Chief Executive Officer<br>Emma Wood, Director of People and Deputy Chief Executive<br>Rachael de Caux, Chief Operating Officer<br>Steve Hams, Director of Quality and Chief Nurse<br>Mark Hutchinson, Chief Digital and Information Officer<br>Karen Johnson, Director of Finance<br>Simon Lanceley, Director of Strategy & Transformation<br>Mark Pietroni, Director of Safety and Medical Director |
| **Associate Non-Executive Directors** | |
| Rebecca Pritchard<br>Roy Shubhabrata | |

Gloucestershire Hospitals
NHS Foundation Trust

# DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MICROSOFT TEAMS THURSDAY 08 APRIL 2021 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 |
| Balvinder Heran | BH | Non-Executive Director |
| Marie-Annick Gournet | MAG | Non-Executive Director |
| Rob Graves | RG | Non-Executive Director and Deputy Chair |
| Steve Hams | SH | Joint Director of Quality and Chief Nurse |
| Karen Johnson | KJ | Director of Finance |
| Simon Lanceley | SL | Director of Strategy and Transformation |
| Alison Moon | AM | Non-Executive Director |
| Mike Napier | MN | Non-Executive Director |
| Mark Pietroni | MP | Director of Safety and Medical Director & Deputy Chief Executive Officer |
| Elaine Warwicker | EWa | Non-Executive Director |
| Carole Webster | CW | Joint Director of Quality and Chief Nurse |
| Emma Wood | EW | Director of People and Organisational Development & Deputy Chief Executive Officer |
| **IN ATTENDANCE:** | | |
| Molly Bradbury | MB | F1 Doctor – For Patient story 057/21 |
| James Brown | JB | Director of Engagement, Involvement & Communications |
| Sim Foreman | SF | Trust Secretary |
| Pete Bull | PB | Patient – For Patient story 057/21 |
| Pippa Medcalf | PM | Consultant – Acute Medical Unit (AMU) – For Patient story 057/21 |
| Rebecca Pritchard | RP | Associate Non-Executive Director |
| Roy Shubhabrata | RS | Associate Non-Executive Director |
| **APOLOGIES:** | | |
| Mark Hutchinson | MH | Chief Digital and Information Officer |
| **MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:** | | |
| There were six Governors, three members of the public and two member staff present. | | |

The Chair explained, for the benefit on attendees, that there had been a board development session earlier in the day focused on compassionate culture, equality, diversity and inclusion and this may be reflected in some of the comments made by colleagues today.

**ACTION**

## 057/21 PATIENT'S STORY

PM and MB introduced themselves and stated their interest in health inequalities and people who use drugs. They also introduced PB, a patient and former drug user who had been clean for eight months. PB shared his story which described a lack of support for drug users in hospital especially when compared to support available to homeless patients and those with alcoholism, for example.

As a recovering addict, PB advised he had felt rejected when being cared for and staff had lacked empathy. This had led to him self-discharging and the Board heard this was also common amongst people who use drugs (PWUD).

MB delivered a presentation on PWUD highlighting inpatient withdrawal issues and the Gloucestershire perspective from Public Health England data. The Board heard that the statistics were underrepresented as PWUD were at increased risk from cancer and other conditions related to drug use, and it was these conditions that were captured as their primary condition. It was reported that whilst the Trust's policy formation was well developed, there was more that could be done to improve the patient experience for PWUD. MB highlighted areas where there were shortcomings, such as staff not knowing how to care for PWUD, junior doctors having little to no experience of opiate prescribing, and patients finding it difficult to engage with staff because of previous negative experiences. It was felt that a specialist liaison clinician in the Trust would improve these issues as it had done when such roles had been introduced to support other vulnerable people.

The Chair thanked PB for sharing his story and was joined by other board members in apologising for his treatment and care over the years that was not as empathetic as it should have been.

MP asked if PM had been in contact with the Director of Public Health for Gloucestershire, Sarah Scott, and shared his experience of commissioning a drugs interface service to connect ED and community services. Through this, MP had found that staff training had been transformative in changing behaviours and improving care. PM confirmed she was in contact with Sarah Scott regarding this.

DL also thanked PB for his story and honesty and advised Dame Gill Morgan, Chair of the Gloucestershire Integrated Care System (ICS) was observing and this was a topic where the ICS could all work together through the health inequalities group. DL agreed to connect PM and MB to relevant colleagues in the team. DL felt that improving the treatment of PWUD was not about a "person" but more about 24/7 access to skills and therefore any appointee should have a role which included the education and upskilling of all staff caring for PWUD. MB advised the research had supported this view with most issues being identified out of hours. **DL**

PM reported that there had only been 20 COVID cases amongst the homeless population of thousands, as a result of getting people into accommodation. SH commended the amazing homelessness nurses and the safeguarding team for the work on the "vulnerability framework" that showed interdependencies in their widest sense. SH add that he hoped MB and PM would publish their research findings.

DL advised it was important not to shy away from what was being asked of the Trust and the models showed a need to win hearts and minds in making changes. It was confirmed the Executive team would consider how it might be possible to progress this work. **DL**

**ACTION**

## 058/21 DECLARATIONS OF INTEREST

There were NO declarations of interest.

## 059/21 MINUTES OF THE PREVIOUS MEETING

**RESOLVED:** The Board APPROVED the minutes of the meeting held on Thursday 11 March 2021.

## 060/21 MATTERS ARISING

**RESOLVED:** The Board NOTED the matters arising update and AGREED to close 050/21 as delayed discharges would be reported in the Quality and Performance report from September 2021.

## 061/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL stated that the patient story was a powerful frame for the rest of the meeting and reminded the Board that if the Trust consistently delivered "best care" for the most vulnerable patients, then they would get it right for everyone.

DL referenced the steps being taken nationally and locally to move out of lockdown and recognised the importance of the new emphasis on social contact outdoors. The Board were updated on the progress of the COVID vaccine programme and the complex risks and benefits from this related to individuals. Although there had been over 30 cases of blood clots linked to the AstraZeneca vaccine, this must be set in the context of over 20 million people being vaccinated and the number of lives saved as a result, so the advice remained to access the vaccine when offered. The Trust was about to commence a week of commemoration and celebration of the work of staff during the pandemic, which would include the official opening of the memorial garden on 21 April 2021. DL thanked EW for keeping the Board informed and updated on excellent progress being made. The dandelion pin badges and postcards sent to staff had been well received and some great memories and reflections were coming through.

The Care Quality Commission (CQC) had visited the Emergency Department (ED) at Gloucestershire Royal Hospital (GRH) as part of their targeted inspection programme. DL said that the visit had been triggered by the deteriorating position with respect to ambulance handover delays and the Trust was one of five in the South West who had received a targeted inspection. Feedback from the CQC reflected the efforts being made by the Trust and they felt patients were safe but stressed their expectations that patients should not be cared for in corridors or experience a delay in being handed over by ambulance crews. Formal feedback was expected later in the week, although the Trust had already identified further opportunities to improve care not least by utilising the additional temporary accommodation that had arrived on site in the last week.

The Trust had also received feedback from a second CQC inspection on

infection control and prevention which she said was exceptionally good, with the report highlighting leadership, multi-disciplinary team working and a highly engaged workforce. DL asked for the Board's formal thanks to Craig Bradley, Director of Infection Prevention and Control to be recorded.

DL updated that the number of patients waiting for treatment was no greater than the number waiting at the start of the pandemic, but these patients were now waiting longer. The Board also heard that not as many patients had presented for care during the pandemic which could result in an unseen demand in the future i.e. there were 40 fewer new lung cancer patients than would normally be expected at this time of year. The Trust was building a recovery plan for the future and DL was heartened by the scale of enthusiasm and eagerness of colleagues to address the backlogs and to do so in a way that reflected the inequalities inherent in the waiting list.

The Electronic Patient Record (EPR) had been implemented at Cheltenham General Hospital (CGH) Minor Injuries and Illness Unit (MIIU) and this would be a forerunner to the rollout at GRH ED. The rollout had gone well whilst also highlighting some learning and revisions to the system ahead of the GRH deployment.

RP asked about staff hesitancy to the vaccination programme, in particular from BAME staff. DL responded that the average take up for all staff was 76% with Asian staff not far behind this however take up amongst Black African and Black Caribbean colleagues was c20% lower, reflecting a similar picture in the community programme. SH outlined work taking place to improve this including a vaccine hesitancy webinar and the use of influential role models to dispel myths and encourage people to have their vaccine. SH advised another key concern related to hesitancy in women of child bearing age who were concerned about impacts of fertility and future new-born health.

AM congratulated staff for their commendation from the CQC on infection prevent and control. She asked in relation to the Emergency Department (ED) inspection; how staff were feeling and what the level of interest from ICS partners was? DL shared her disappointment that the CQC had not proceeded with their inspections based on "place" which looked at whole systems and not just providers especially given the conditions in A&E were a reflection of whole system working. She noted the importance of fully engaging the ambulance Trust in system working as they were sometimes peripheral to discussions although this was changing. She went on to say that the CQC had commended staff on their hard work and commitment to safe, high quality care despite the challenges but staff were undoubtedly disappointed that the CQC had expressed concerns about the quality of care.

MP advised that he had visited AMU and ED earlier in the day to ascertain how colleagues were feeling, after the changes made the previous evening (additional space from modular unit) and he reported they were surprisingly positive. It was acknowledged that there were still issues to work through but the commitment and positivity from the team to achieve this was there. RdC seconded the point about the South

West Ambulance Service being a key partner and being able to direct patients to the appropriate parts of the hospital being a key enabler. SH stated the additional demand from the inspection on clinical leaders should not be underestimated.

RS welcomed the good progress on elective recovery and asked if there had been feedback from patients waiting a long time. DL confirmed that there were over 40 thousand patients on our active waiting lists and communication would take place over several months but the priority was ensuring those that had waited the longest understood what was happening The theme from patient feedback to date was one of frustration on the uncertainty of treatment timelines which was unsurprisingly but unavoidable at this stage of recovery planning.

MN referenced the proposed legislation related to the establishment of the ICS as a statutory body and asked if the chair and CEO appointments taking place before the end of June 2021 would be subject to open and competitive recruitment. DL reported her understanding was that where the incumbent ICS chair had been appointed through a recent open, competitive process, as had happened with the appointment of Dame Gill Morgan in Gloucestershire, then they would be confirmed as the new chair without recourse to further process. Where this had not taken place or the incumbent was approaching the end of their tenure, competitive recruitment would take place. Executive appointments would be openly competed and it was not yet known if any "ring fence" would apply to existing CCG Executives who would be "at risk" with respect to ongoing employment.

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

**062/21 TRUST RISK REGISTER**

EW presented the Trust Risk Register (TRR) report which showed one additional risk, one change to scoring and one downgrade.

The datacentre risk (T3409) had been presented to the Finance and Digital Committee (FDC) in January 2021 and then to the Risk Management Group (RMG) who proposed its inclusion on the TRR.

The RMG had proposed a downgrade of risk (C3253PODCOVID) due to the consequence of harm to Black Asian Minority Ethnic (BAME) and clinically vulnerable staff from COVID being reduced as a result of the vaccination programme.

CF referenced the CQC inspection update in the previous item and asked if the Trust had adequately captured and mapped risks arising from the visit. EW confirmed that all of the issues raised were already reflected by risks on the register for departments and committees i.e. mortality, waiting times etc. The Board NOTED it would be for MP and RdC to amend existing risks or open new ones should they be subsequently identified. MP added that no formal report had been received but verbal feedback related to issues that the Trust was already aware and taking action to address. RdC confirmed the issues would be addressed through the ICS 30 day action plan and the Trust's own

internal plan.

**RESOLVED:** The Board NOTED the report and the changes to the Trust Risk Register.

**063/21 QUALITY AND PERFORMANCE REPORT**

SH confirmed there had been a reduction in the number of bed moves which in turn had reduced potential harm and it was planned to reenergise the champion approach to dementia.

It was known that having visitors reduced the number of falls and it was hoped this would still apply as the Trust lifted restrictions.

Clostridium Difficile (C.Diff) performance was disappointing with six community and five hospital cases in February after a year of no cases. Post-infection reviews would be carried out to understand causes and/or themes and followed up in QPC.

RdC noted sustained good performance for cancer and a favourable recovery of elective active when compared with 19/20 activity.

AM advised there had been considerable discussion on the importance of visiting at QPC and asked for confirmation of the current Trust approach. SH replied it was still being reviewed but provided his personal view that the Bristol approach of one visitor for one hour seemed sensible.

The Chair asked how the Trust would restore its bed base and the pace at which it might happen. RdC confirmed 80 beds were out of use; 50 for social distancing which would be subject to a staged, safe reintroduction and 30 removed to improve quality of care and provide a second area for the Systemic Anti-Cancer Therapy (SACT) unit to operate from whilst social distancing was still required.

SH added that establishing whether patients have received COVID vaccinations and/or have antibodies would also help to ensure patients were cared for in the right places.

MP stated that whilst the return of the beds was relevant, it was more important to understand the triggers of when to remove beds again if the numbers of cases start to increase as the learning from the second wave was to ensure this happened sooner than had been the case in wave two.

RG noted the level of patient discharge summary in 24 hours and asked why the Trust could not achieve the target. MP agreed it was disappointing but the reasons were multi-factorial and work was underway to look at ward level data rather than consultant level to enable more targeted action.

RdC followed up to confirm that all COVID escalation areas i.e. Aveta birth unit, orthopaedics and surgical areas had been stood down and restored to their normal usage.

**RESOLVED:** The Board RECEIVED the report as a source of assurance.

## 064/21 LEARNING FROM DEATHS REPORT

MP reported that indicators from Dr Foster were moving strongly in a downward direction having been close to, but not reaching, the upper limits of acceptability. COVID performance showed the Trust as one of the top groups and excess mortality was attributed to undiagnosed COVID in the early stages of the pandemic.

The Board heard that Structured Judgement Reviews (SJRs) had restarted and although there was a backlog to catch up on, the findings were coming through and being embedded into processes.

The Chair asked what had changed in relation to fractured neck of femur and MP explained the indicator had turned RED due to associated COVID mortality in this group but the review had also recognised that good practice implemented a few years ago had slipped. The review had been positive with the Trauma and Orthopaedics team owning the actions and responding quickly.

Discussion took place on COVID mortality attributed to obesity and MP explained this question had been raised at QPC but Dr Foster did not record on that specific statistic. However MP confirmed that obesity was a major factor in COVID mortality.

RdC advised the Trust had received a favourable GiRFT (Getting it Right First Time) visit to orthopaedics for services provided to geriatric inpatients over seven days.

RG commented on the level of detail presented and felt it would useful to remind the Board of the process and statistical significance of the data. The Chair advised this would happen through QPC, unless there was a specific request from the Board.

**RESOLVED:** The Board NOTED the Learning from Deaths Quarterly Report.

## 065/21 JOURNEY TO OUTSTANDING QUARTERLY REPORT

SH presented the report which was a summary of Journey to Outstanding (J2O) visits over the past few months with four virtual visits a month. The key highlights reported were COVID related and the actions were led by executive directors and divisional teams.

DL asked how the visits were prioritised and targeted, especially given discussions earlier in the day in the development session. SH replied that the staff survey results could be used to provide an insight on any "hot spots" and would discuss this with EW and Andrew Seaton, Director of Safety. **SH/EW**

Discussion took place on whether the "Board to ward" gap was bigger

than it should be and the Chair suggested a three month follow-up or senior line manager review might increase the consistency

MN felt virtual visits were working well and asked if NEDs could see reports from previous visits to aid their understanding. It was confirmed this should be the process. DL would discuss with the executive team to ensure that accountability and oversight of actions sat with them but reports were shared with NEDs for information and education.

**RESOLVED:** The Board RECEIVED the report as a source of assurance of leadership visibility and engagement with staff.

**066/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE**

AM updated on discussion on the evolution of the Quality and Performance report and confirmed a new, improved report would be introduced in September 2021.

The impact of COVID on urgent care had been reviewed with work in hand noted including the 30 day recovery plan.

Further detail on Clostridium Difficile, VTE (venous thromboembolism) and falls had been requested.

A review of patients waiting for care (both planned and urgent) was linked to the Serious Incident (SI) and patient experience report. Although there was a backlog at PALS, the Trust was still compliant with national standards.

In relation to CQC assessment, consideration had been given to appropriate mental health metrics. AM highlighted the Committee had not seen the Healthwatch report on this topic. DL added that the CQC had been very positive about our approach to mental health during their recent inspection of the Emergency Department and the Trust's approach to psychological health and wellbeing of staff in departments i.e. TRIM practitioners and Psychological Link Workers.

MP provided an update on stroke services outlining the good work on diagnostics and recovery planning. The importance of a specialist nurse at the front door was highlighted with the efficacy being tracked via executive review process. He added that investment for additional stroke nurses had been secured via the annual planning round and positively the national SNAPP data showed us to have improved further to a 'B' rating.

COVID restrictions had meant the Trust was unable to get feedback from relatives to feed in to the learning from deaths process.

The presentation on the safer staffing review from SH had shown some achievements from last time and new recommendations but there had been a clear impact on this work due to COVID.

RP asked what the current Trust position was regarding aiming for 60:40

ratios between registered nurses and healthcare support workers (HCSW). EW confirmed that over 70 HCSWs had been recruited to fill known vacancies. SH advised that like all other trusts during COVID there was a need to dilute ratios and it was recognised this had not worked as well as it should and there was need to restore 60:40 and invest in the registered nurse element. These ratios would be reported in the Safer Staffing Report which goes to QPC.

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

**067/21 ASSURANCE REPORT OF THE CHAIR OF THE ESTATES AND FACILITIES COMMITTEE**

MN was pleased to report that more timely data on the performance of Gloucestershire Managed Services (GMS) was being seen by the Committee and also highlighted the estimated £25k cost of works on drains blocked by wet wipes. DL confirmed this was the focus of the "wipes in the pipes" campaign.

The Contract Management Group (CMG) had reported GMS were meeting or exceeding all key performance indicators (KPIs) except for urgent portering in January and this was attributed to the high demand from COVID.

An independent national review of hospital food had identified some recommendations for the Trust. These were being followed up with patients and the dietetics team.

The GMS business plan was also presented and although largely based on ongoing activities, MN advised that it may change in future as greater certainty on planning emerged. The plan would also be reviewed by the FDC as required by the Reserved Matters.

A deep dive on risks associated with estates and facilities identified 27 risks for the Committee and 62 across the Trust, with more work to take place on addressing longstanding risks.

The Six Facet survey output report was expected at the May 2021 meeting and would provide a view on the estate technical infrastructure and scale and nature of backlog maintenance. The last survey took place in 2013.

DL asked if the GMS business plan reflected the Trust's ambition for GMS; if it was more transformative than previous versions and had the need to further improve the culture within GMS featured. MN advised it did not come through as strongly as described, but there were proposals within it, subject to future business cases, that did reflected a stronger level of ambition and the work on leadership within GMS. DL asked how the request and desire for more transformation could be reflected back to the GMS Board and RdC confirmed the Trust Leadership Team would have an opportunity to feedback. The Estates and Facilities Committee feedback had already picked up that GMS could access resources

related to compassionate leadership. DL suggested that the EFC give thought to how they get assurance from GMS with respect to staff experience.

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

**068/21 ASSURANCE REPORT OF THE CHAIR OF THE AUDIT AND ASSURANCE COMMITTEE**

CF reported that the Committee had received a report following a deep dive on the risk register to ensure all risks were appropriate and the document had not stagnated. The Committee were assured by the movement, actions and when reviews were taking place.

Both the external and internal auditors had presented at the meeting. The external audit work was making good progress with early work completed and formal and informal relationships were working well. The internal audit plan had been reviewed and the Executive team were going to do some more work to ensure resource and efforts were targeted at the issues which would deliver best value and benefit.

CF shared the reflections and challenges from governor observers and how these added value. The Board also heard that CF had attended the Clinical Commissioning Group (CCG) Audit Committee as part of an arrangement with ICS partners. Audit chairs were attending each other's audit and assurance committees to get a sense of each other's approach and key issues.

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

**069/21 FINANCE REPORT**

KJ presented the report and reminded the Board of a previous discussion about potential support for the system to breakeven. This was received during Month 11 (M11) into the ICS and subsequently the Trust, which would address, amongst other things, the GenMed pressure. The forecast position had shifted from £11m deficit in M10 to £4m deficit in M11. The £4m was related to a nationally prescribed accrual for annual leave, although this was subject to discussion and the outcome would not be known until after the first draft of the accounts. KJ assured the Trust was not an outlier on this.

KJ reported that capital expenditure was on course to be spent and deliver (and possibly exceed) the plan which was a tremendous achievement by all involved.

KJ summarised that the year-end capital position would hopefully show a breakeven position and all (or more) capital funding spent. The Chair congratulated KJ and her full team for their work. KJ acknowledged they had all worked hard and she was encouraging them to take annual leave

at the end of May.

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

*MAG left the meeting at 14:34.*

**070/21 DIGITAL REPORT**

DL referred to the update on EPR within her Chief Executive Officer's report and there were no further questions or comments.

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

**071/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE**

RG advised the digital assurance had focused on the infrastructure and smaller systems that were supported. A RAG report on all active projects was provided and MH had advised his team were still in a good place with regards to energy and motivation, but recognised there would be a need for decompression period over the summer when the ongoing major projects in ED and pathology were delivered.

RG flagged a major shift to new Microsoft programmes was planned as part of an NHS-wide initiative and there was a need to be aware of the impact of this on less digitally competent staff.

A cross system workshop of health and local authority partners had been delivered by MH and his team and attended by RG, MN and BH. Discussion focused on future collaboration and challenges. RG had also attended an NHS Providers session on digital strategy which had also assured him that our levels of collaboration in the system came over well, especially compared to other trusts.

The finance elements were as described by KJ with the Committee looking at actual and planned finances and being assured by the quality and content of the materials provided by the Finance team.

RG highlighted the perverse incentive of a stronger financial position as a result of reduced activity levels, but commended the capital spending work.

DL updated on an exciting digital work stream focused on discharges which would hopefully drive significant improvements and support the ICS 30 day recovery plan and particularly the goal of discharging patients sooner in the day.

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

**ACTION**

**072/21 TRUST CONSTITUTION UPDATE**

SF presented the proposed amendments to the Trust Constitution as outlined and summarised in the paper. SF thanked the Governance and Nominations Committee, and in particular, Alan Thomas (AT), Public Governor for Cheltenham and Lead Governor, for their input and support to refresh the document.

**RESOLVED:** The Board APPROVED the proposed amendments to the Trust Constitution ahead of it being presented to the Council of Governors.

**073/21 GOVERNOR QUESTIONS AND COMMENTS**

AT thanked SF for his work on the Constitution update and provided comments on the meeting as follows:

The patient story was as powerful as ever but highlighted a disassociation in the treatment of drug and alcohol addiction from the work of both trusts in the county. AT felt this was a prime example of where ICS working could improve care.

The capital spending update was welcomed and AT praised the great work for all involved.

The importance of the return of visitors potentially reducing the number of incidents related to falls and dementia was noted and welcomed.

AT noted from the J2O visits that it appeared there was a sense of feeling left out amongst staff at Cirencester and asked what was being done about this? SH acknowledged that staff who were not on either of the main sites described this and the Trust had learned from the experience of staff at Stroud, ensuring that they were always included in any events such as days to celebrate staff. The Divisional Tri and speciality leadership team were ensuring Cirencester staff were included and that they were visible on site. The Chief of Service held clinical sessions there too. DL explained that these staff had gone through a few changes of employer in recent years (from Independent Sector Treatment Centre to GHC) which had not been easy. AM advised she had conducted the visit with MH and said 16 loyal staff provided great service but did provide examples where they felt left out.

AT asked about the bereavement service and when the normal feedback process would resume. MP confirmed that all families were spoken to on the telephone, with video calls encouraged wherever possible. Face to face conversations would resume again as soon as permitted.

AT asked if there would be any public involvement in the ICS Chair and CEO appointments. DL referred back to her previous update on the ICS chair appointment and the process that would be applied. DL added that it would then be for the ICS Chair to work within the national framework for the CEO appointment while recognising that Gloucestershire's practice was to engage and include as many stakeholders as possible

**ACTION**

including lay involvement.

**074/21 NEW RISKS IDENTIFIED**

There were NO new risks identified.

**075/21 ANY OTHER BUSINESS**

The Board heard that CW was due to retire the following day. The Chair thanked CW, on behalf of the Board, for her service and contribution, particularly her focus on mental health, to the Trust and the wider NHS. AT added thanks from the governors.

There were NO other items of any other business.

**DATE AND TIME OF THE NEXT MEETING**

The next Trust Board meeting will take place at 12:30 on Thursday 13 May 2021 via Microsoft Teams



*[Meeting closed at 15:02]*

Signed as a true and accurate record:

**Chair**
**13 May 2021**

Gloucestershire Hospitals
NHS Foundation Trust

## Public Trust Board – Matters arising – May 2021

| Minute | Action | Owner | Target Date | Update | Status |
|---|---|---|---|---|---|
| **APRIL 2020** | | | | | |
| **057/21** | **PATIENT STORY** | | | | |
| *057/21a* | DL agreed to connect PM and MB to relevant colleagues in the team to support improvements in care across the Integrated Care System (ICS) for people who use drugs (PWUD). | DL | May 2021 | Meetings have taken place and new model of care agreed. Funding secured for development of a dedicated worker to support people who use drugs and those who care for them, with aim of developing a business case to secure recurrent funding. | **CLOSED** |
| *057/21b* | Executive team would consider how it might be possible to progress this work on vulnerability framework. | DL | May 2021 | SH confirmed that the work is in hand with estimated completion of Autumn 2021. | **CLOSED** |
| **065/21** | **JOURNEY TO OUTSTANDING QUARTERLY REPORT** | | | | |
| | Discuss how staff survey results could be used to provide an insight on any “hot spots” with Andrew Seaton, Director of Safety. | SH/EW | May 2021 | EW provided a list of those areas with poorer performance across five themes linked to staff engagement as measured in the staff survey so they can be prioritised when planning J2O visits. AS confirmed that visits have started to be booked based on these reports and the pattern of visits will start to be reflected in future J2O reports. | **CLOSED** |

Gloucestershire Hospitals
NHS Foundation Trust

**PUBLIC BOARD – MAY 2021**

**CHIEF EXECUTIVE OFFICER'S REPORT**

## 1 Operational Context

1.1 Since my last report, we have taken our second tentative steps out of lockdown and, positively, with no discernible detrimental impact on community transmission rates or COVID-19 related hospitalisations. Many commentators consider the further easing of restrictions on the 17 May, which include the reintroduction of mixing indoors and the spectre of non-essential international travel, to represent the greatest risk; the latter specifically in relation to the importing of variants of concern. However, very positively the vaccination programme continues to be world leading with coverage rates in the UK amongst the best globally and community cases at 9.9 per 100,000 are the lowest when compared to our statistical and geographical neighbours.

1.2 In Gloucestershire we have now vaccinated 66% of the adult population with their first dose and second dose take up remains high; a total of 528,711 vaccinations to date with 57,541 delivered by the hospital hub. 91% of those in the initial priority groups 1-9 have now been vaccinated. Our aim to vaccinate all eligible staff is progressing with an excellent uptake of second doses although we continue to fall short in respect of overall coverage. We have established a partnership with Royal Berkshire NHS Foundation Trust who is leading the way nationally, with over 93% of their staff now vaccinated.

1.3 Positively, these tentative steps have enabled the Trust to open up some visiting on the way to fully restoring open visiting in due course. This step has been very well received by staff as well as patients and their families. Equally, the easing of restrictions in residential and nursing home settings has been equally welcomed.

1.4 COVID-19 cases in our hospitals are now minimal with no more than one patient in our care during the last few weeks. There has been some easing of Infection Prevention and Control (IPC) measures in "green" settings which has been appreciated by staff although we continue to ensure high compliance in "amber" and "red" areas with regard to mask wearing, eye protection and social distancing. Guidance on what the proposed end of lockdown on the 21 June means for IPC requirements in hospital settings is still awaited.

1.5 Operationally we remain very busy with our Emergency Departments (EDs), and notably Gloucestershire Royal Hospital (GRH), being especially challenged. As a result, waiting times are much longer than we would wish despite the considerable efforts of all to make improvements but we continue in our endeavours to ensure that every patient's experience is a positive one. Very positively, significant improvements have been made with respect to ambulance handover delays and we have eliminated corridor care, alongside significant improvements in the timeliness of initial triage and assessment. The Trust has been commended by our regulator NHS Improvement for such significant improvements in these areas however, significant challenges remain with respect to improved four hour waiting time performance, caused by ongoing vacancies in medical staffing. Recent consultant recruitment and ongoing recruitment efforts for non-medical advanced practitioners will hopefully address these workforce gaps in due course. The system *30 Day Recovery Plan* continues to drive the focus of efforts to improve flow, care quality and urgent care performance and is now considering other mitigations to manage the workforce shortfalls.

1.6 On a more positive operational note, we continue to increase the amount of routine surgery we are undertaking. In respect of regional benchmarks, the Trust is top of the South West Region "leader board" in respect of activity undertaken compared to the baseline period in 2019/20. This is not only excellent for patients but will ensure that the Gloucestershire system is able to access the national *Elective Recovery Fund (ERF).* As reported previously, clinical priority and waiting time will determine who is invited for surgery but the Trust is increasingly focussing on how this approach can be further developed to ensure that those patients most at risk of health inequalities are appropriately prioritised. The Gloucestershire system was recently invited to present its approach to a national meeting of system leaders; huge credit to our Director of Planned Care and Deputy Chief Operating Officer, Felicity Taylor-Drewe, for her work in this area.

1.7 Planning to restore aspects of the temporary service change is now underway including the re-opening of the Cheltenham General Hospital (CGH) ED as a consultant-led service from 8am to 8pm and a nurse-led service overnight. Our commitment to restoration of services, no later than 1 July, remains but we envisage the restoration of the consultant-led service ahead of this.

1.8 As signalled last month, the long awaited national planning guidance arrived and the system submitted its draft Operational Plan on the 6 May. The system has worked very well together, in short timescales, to submit an ambitious plan for the first six months if this year (H1) in the context of a plan that is also financially balanced; as always there are numerous risks articulated within this position and our wider plan but with mitigations wherever possible. The key risks include the unknown with respect to "bounce back" referral demand which is estimated to be anywhere from 20% to 50% by external observers, the future requirements relating to social distancing which will impact on our physical capacity and productivity and the risks to finance relating to assumptions about activity and the receipt of associated money from the national ERF.

1.9 Subsequent to last month's update confirming that the Care Quality Commission (CQC) had undertaken their targeted inspection of the Trust's approach to Infection, Prevention and Control, the final report has now been published and describes a very positive picture with the themes of strong leadership, high staff engagement and innovation characterising the Trust's approach. Media coverage was also very positive, which is very welcome and always a huge boost to staff when they see their hard work and dedication is heralded in this way.

## 2 Key Highlights

2.1 Since my last report, we welcomed Her Royal Highness (HRH), The Princess Royal to both GRH and CGH; HRH also made time to visit Gloucestershire Health and Care (GHC) staff at the Wotton Lawn site. The visit was a huge boost for all those involved and. as is typically the case, provided a morale boost to staff across both our hospitals. The commemoration of our two gardens was led by our Chaplains Reverend John Thompson and Muslim Chaplain Atique Miah at GFH and Reverend Katie McClure at CGH. The Princess Royal was experienced by all as being well informed, curious about the work of those she met and engaging.

2.2 On the back of our very positive CQC report, the team were out and about on the 5 May celebrating national *Hand Hygiene* day, alongside a very positive presence on social media. The team were not only sharing best practice and busting myths but running the odd competition or two! Their message for the day was "clean hands,

saves lives" and based on the engagement from everyone, their message was well received.

2.3 This month has also been characterised by celebrations of two key staff groups – our midwifery and nursing colleagues. On 5 May, I was delighted to share a platform with Chief Midwife, Vivien Mortimore and Chief Nurse, Professor Steve Hams to open our first (virtual) Midwifery Festival of Excellence as part of our local celebrations of *International Day of the Midwife*. It was a hugely successful event hearing colleagues describe the innovation, research and excellence which defines much of what they do. The implementation of our response to the national *continuity of carer* strategy was a personal highlight, not just because of the very clear benefits to women but equally because of the positive feedback from midwives about this new way of working, in light of some initial concerns and fears. On 12 May, we will be celebrating International Nursing Day and I look forward to providing the Board with a verbal update on activities, when we meet on 13 May.

2.4 With so many important issues to focus upon, week commencing 10 May, is national *Dying Matters* week and also national *Mental Health Awareness* week. I shall be "vlogging" with colleagues working in these two important areas and teams throughout the Trust will be making the most of the national spotlight on these issues. The focus for *Dying Matters* will be based around the importance of discussing death and planning for a good death; undoubtedly, the tragedies of the pandemic have brought the spectre of unexpected death closer to many of us and therefore, the importance of planning and discussing about our concerns and wishes. The focus for the Trust will be the roll out of the *Swan Model* which has been developed to focus on end of life care in acute hospital settings and builds upon the incredible innovation and motivation we saw throughout the pandemic to support patients to have a good death, despite the very many challenges at play – not least the inability of loved ones to be present as they typically would be. Our aim is that each ward will have a *Swan Ambassador* and I was delighted to discover the breadth of staff involved in developing our approach including ward clerks, mortuary staff and colleagues from Gloucestershire Managed Services (GMS).

2.5 The Board has previously heard of our focus on improving care for those with mental illness whether they present in crisis in our EDs or when they are under our care for their physical health and the Mental Health Working Group continues to meet and make good progress. Following the last Board meeting and our powerful patient story, we have already made considerable progress on the issues described by Dr Pippa Medcalf and Dr Molly Bradbury with the aim of established a dedicated worker in the next month or so. We will making the most of *Mental Health Awareness Week* from 10 to 17 May to showcase what we are doing, the challenges we face, the progress we are making and the resources available to staff, patients and families. Our 2020 Hub will also be active in raising awareness of the support they offer to staff struggling with their mental health and psychological wellbeing.

2.6 The 2020 Hub has always been available to support physical, psychological and financial wellbeing and this last strand of support took a huge step forward this week with the launch of a range of support for staff who find themselves at risk of debt or other financial worries. The support ranges from trusted advice, debt management tools to loans and saving schemes; many of which can be directly linked to individual's salary. Its early days but it has been very well received since launch and very much in the "you said; we did" space.

2.7 On 13 May, the Board will spend the morning on "part 2" of our discussions in response to the **Big Conversation** led by partners DWC. The session aims to finalise

our ambition both with respect to scale, how we will judge our success and the key planks of our culture improvement activities. One key aspect of our response is a revised approach to recruitment to ensure we are as inclusive as we can be when seeking to attract, recruit and develop a diverse workforce; our aim is to launch our new recruitment policy and associated support tools at the beginning of June.

2.8 Finally, although Dr Rachael De Caux doesn't leave the organisation until the end of June, due to leave commitments this month will be her final Board meeting. Rachael has made a phenomenal contribution to the Trust in the two years she has been with us not only as part of our response to the pandemic but equally in addressing some seemingly intractable performance issues in cancer services and other specialities where long waits were typical. I would like to record by formal and heartfelt thanks to Rachael on behalf of the whole Board.

**Deborah Lee**
**Chief Executive Officer**

6 May 2021

Gloucestershire Hospitals
NHS Foundation Trust

**Public Trust Board – 13 May 2021**
**Microsoft Teams – Commencing at 12:30**

| **Report Title** |
|---|
| **TRUST RISK REGISTER (TRR)** |
| **Sponsor and Author(s)** |
| Author: Lee Troake, Corporate Risk, Health & Safety<br>Sponsor: Emma Wood, Deputy CEO and Director of People and OD |
| **Executive Summary** |
| **Purpose**<br>The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. At the Risk Management Group (RMG) Meeting on 31 March 2021 the following decisions were made.<br><br>**Key issues to note**<br><br>• NO new risks were added to the Trust Risk Register (TRR)<br><br>• Two scores were reduced for ONE risk already on the TRR, although the scores still meet the criteria to remain on the TRR:<br><br>**C3089COO-** Risk of failure to achieve the Trust's performance standard for domestic cleaning services due to performance standards not being met by service partner.<br><br>**Score:** Quality was C4 x L4 = 16 reduced to C4 xL3 = 12, Statutory was C4 x L4 = 16 reduced to C4 xL3<br><br>The risk had been discussed at the Infection Control Committee and the consensus was that quality and statutory scoring could be reduced as cleaning standards have improved since it was last scored. This was agreed by the Estates and Facilities Committee also and at RMG.<br><br>• There were no proposed closures of risks on the Trust Risk Register. |
| **Recommendations** |
| To note this report. |
| **Impact Upon Risk – known or new** |
| The RMG / TRR identifies the risks which may impact on the achievement of the strategic objectives |
| **Equality & Patient Impact** |
| Potential impact on patient care, as described under individual risks on the register. |

| **Resource Implications** | | | |
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| Finance | **x** | Information Management & Technology | |
| Human Resources | | Buildings | **x** |

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

| **Date the paper was presented to previous Committees** | | |
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| **Divisional Board** | **Trust Leadership Team** | **Other (Specify)** |
| | | Risk Management Group 31 March 2021 |

| **Outcome of discussion when presented to previous Committees** |
|---|
| Risk score reduction approved. |

| Ref | Inherent Risk | Controls in place | Action / Mitigation | Highest Scoring Domain | Score | Current | Approval status |
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| M2353Diab | The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision. | 1)E referral system in place which is triaged daily Monday to Friday.<br><br>2)Limited inpatients diabetes service available Monday - Friday provided by 0.80wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. | Business case draft 2 to be submitted<br>Business case to be submitted<br>Demand and Capacity model for diabetes<br>Liaise with Steve Hams to raise this diabetes risk onto TRR | Safety | 12 | 8 -12 High risk | Trust Risk Register |
| S2579Th | The Risk to patients safety and experience of being unable to safely complete procedures across multiple theatres resulting from mains power failure combined with generator failure | Generator back up system and generator checks<br><br>On site Estates team<br><br>x5 UPS units in the affected theatre areas across both sites. x3 in GRH and x2 in CGH. These units will successfully run a stacking system for 30 minutes in order for a surgeon to safely bring the procedure to a controlled stop or to assist until the generator/power has been restored. Potential for moving patient between theatres to ensur esafety<br><br>Theatre refurbishment programme - Theatres being equipped as per HBM as part of a refurbishment plan<br><br>Annual service contract for existing UPS and annual check at GRH | support Estates in delivery of the theatre refurbishment programme<br>Work with manufacturers to obtain UPS specifically designed for use on endoscopic stacks<br>Gather evidence of power failure incidents for theatres<br>identify national standards for requiring UPS<br>Creation of action plan to upgrade/replace UPS<br>Plan for theatre in the event of mains & UPS failure | Safety | 5 | 4 - 6 Moderate risk | 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. | Implement ward closure programe to provide access to undertake the works.<br>Ward 3B being assessed for ability to undertake works this Summer | Safety | 5 | 4 - 6 Moderate risk | 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);<br>2) Heras fencing has been put up to isolate persons from the areas of immediate concern;<br>3) Areas of concern being monitored (frequency TBC).<br>(All Controls to be reviewed and confirmed as active & appropriate). | Refurbish the roof outside and make safe<br>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<br>Planning permission for investigatory works | Safety | 5 | 4 - 6 Moderate risk | Trust Risk Register |
| | | | Discussion with Matrons on 2 ward to trial process | | | | |

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| C2669N | The risk of harm to patients as a result of falls | 1. Patient Falls Policy<br>2. Falls Care Plan<br>3. Post falls protocol<br>4. Equipment to support falls prevention and post falls management<br>5. Acute Specialist Falls Nurse in post<br>6.Falls link persons on wards<br>7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee<br>8. Falls management training package | Develop and implement falls training package for registered nurses<br>develop and implement training package for HCAs<br>#Litle things matter campaign<br>Discussion with matrons on 2 wards to trial process<br>Review 12 hr standard for completion of risk assessment<br>Alter falls policy to reflect use of hoverjack for retrieval from floor<br>review location and availability of hoverjacks<br>Set up register of ward training for falls<br>Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR<br>Discuss flow sheet for bed rails on EPR at documentation group | Safety | 12 | 8 -12 High risk | Trust Risk Register |
| C2984COOEFD | Risk of harm to patients, staff and visitor from hazardous floor conditions and damaged ceilings as a result of multiple and significant leaks in the roof of the Orchard Centre GRH, (E51), Wotton Lodge (E58), Chestnut House | •Wet floor signs are positioned in affected areas<br>•Existing controls/mitigating actions as referenced in 'Control in Place' including provision of additional domestic staff on wet days to keep floor clear of water (e.g. dry, signage, etc.)<br>•Some short term patch repairs are undertaken (reactive remedial action);<br>•Temporary use of water collection/diversion mechanism in event of water ingress<br>•Risk assessment completed in 2019 and again in 2020 – issue escalated to Executive team<br>•Options provided to TLT regarding building in June 2019 | Long term repairs to roofs needed GRH<br>To revise specification and quote for Orchard Centre roof repairs to include affected area. Urgently provide quote and whether can be done this financial year to KJ / Finance<br>Discuss at Infrastructure Delivery Group whether there is sufficient slippage in the Capital Programme for urgent repairs to the Orchard Centre Roof | Safety | 12 | 8 -12 High risk | Trust Risk Register |

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| 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<br>• Winter pressure plan in place<br>• RED ED flip / RED surge Plan<br>• Empty two green bays on 8a to create red capacity<br>• Paediatrics red area<br>• Following National Guidance across all domains / reviewing guidance and applying according to local circumstances<br>• Fit testing programme<br>• PPE training provision, training, information and PPE Safety Officers / social distancing guardians<br>• Action cards published for staff<br>• Pathways for trauma for COVID and non COVID for all specialties<br>• COVID testing on admission, testing on day 5<br>• Outbreak MDT meetings - clinical staff, ICP and Safety<br>• COVID Secure programme & working group<br>• Provision of social distancing materials / guidance and PPE<br>• All staff to wear masks if within 2m of others<br>• Patients to be required to wear mask if away from bed space (and can tolerate it)<br>• Paediatrics and Obstetrics – both have clear pathway for COVID or non COVID problem patients<br>• Gynaecology – early pregnancy and miscarriage is being managed through OP where possible<br>• Limited public access to hospital<br>• Telephone triage support to ED to reduce wait times e.g. OMF<br>• Prescriptions (FP10s) e-mailed direct to community Pharmacies<br>• Patient belongings and letters drop-off service<br>• Family and friends helpline | Establish IMT to manage response | Workforce | 16 | 15 - 25 Extreme risk | 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 interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings. | 1. Board approved, risk assessed capital plan including backlog maintenance items;<br>2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group;<br>3. Capital funding issue and maintenance backlog escalated to NHSI;<br>4. All opportunities to apply for capital made;<br>5. Finance and Digital Committee provide oversight for risk management/works prioritisation;<br>6. Trust Board provide oversight for risk management/works prioritisation; | 1. Prioritisation of capital managed through the intolerable risks process for 2019/20<br><br>escalation to NHSI and system | Environmental | 16 | 15 - 25 Extreme risk | Trust Risk Register |
| M1215Resp | The risk of compromised patient safety due to failure to meet national standards for advanced respiratory support. | - Daily escalation of acuity when Amber/red.<br>- Guidelines, checklists and prescriptions introduced for nasal high flow oxygen and acute non-invasive ventilation<br>- Training support for medical staff for acute NIV<br>- Increased training and education for nursing staff.<br>- Support for ward staff from ACRT nurses | working party to review the possibility of a NIV bay<br>business case re-submitted to divisional Tri<br>reconfiguration of bed base to support x10 high care beds<br><br>to link all datix with any adverse outcome to patients recieving NIV and any datix related to staff shortages for High care patients. | Workforce | 16 | 15 - 25 Extreme risk | Trust Risk Register |
| | | • RAG rating of patients in clinical priorisation & Clinical Harm Reviews | Incremental step up of elective activities, including through the independent sector | | | | |

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| C3224COOCOVID | Risks to safety and quality of care for patients with increased waiting in relation to the services that were suspended or which remain reduced | • RAG rating of patients in clinical prioritisation & Clinical Harm Reviews<br>• Movement of the acute take from CGH to GRH (see issues outlined in gaps below) ED dept at CGH will operate as a minor injuries unit, all emergency patients are managed through GRH. This will enable CGH to manage planned patients who have tested negative to COVID.<br>• All emergency surgery will move to GRH. Vascular emergency patients will move from CGH to GRH. 50% of benign Gynaecology elective day cases will transfer from GRH to CGH. Some Upper GI urgent activity may also move to CGH (Hot laparoscopic Cholecystectomy), if additional theatre capacity is required.• Use of BI models to underpin next phases in medicine – impact on AMU / ACUC• 9a will come in to Medicine and there will be clear pathways to move Elderly Care and Stroke to CGH• Respiratory bed base will be at GRH with a HOT Respiratory Consultant at CGH • Cardiology has an allocation of 17 beds at GRH due to acute specialty and all elective activity to go to CGH. • Hot PCI's will go directly to CGH and managed in side rooms pending swabs, supported by a Respiratory nurse to give full review of patients at CGH• Have assessed impact of move to GRH based on patient numbers and acuity in MIU at CGH overnight• Overnight staffing of MIU to be moved to GRH to increase GRH ED resilience • AEC presence 8am-8pm at CGH / triage via Cinapsis<br>• Red Oncology – after patients are triaged on the helpline they will go to GRH if suspect red. If confirmed COVID they will not have chemo and will stay under medical beds at GRH. If Haematology is the primary issue they will move to Knightsbridge.• limit emergency admissions through to CGH as predominantly NON COVID Site• Green ITU established at CGH<br>• Optimise elective activity whilst maintaining COVID beds and ready to take another surge• Optimise urgent and less urgent diagnostic and therapeutic activities across specialties whilst maintaining COVID beds and ready to take another surge• Pre-op testing and 7 days patient isolation for surgical pathways in place• Cancer & urgent work is put out to the Nuffield & Winfield | Continued review of clinical waiting lists | Safety | 12 | 8 -12 High risk | Trust Risk Register |
| C3431S&T | The risk is that planned reconfiguration of Nuclear medicine and Lung Function is considered to be 'substantial change' and therefore subject to formal public consultation. | Feasibility study underway to explore alternative locations for Nuclear Medicine and Lung Function.<br>Work underway to determine whether centralising Nuclear Medicine to CGH (preference of the service) and establishing a hub and spoke model for Lung Function meets the criteria for 'substantial service variation' | Develop case for change for Nuclear Medicine & Lung Function | Business | 15 | 15 - 25 Extreme risk | Trust Risk Register |
| M2613Card | The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment. | Modular lab in place from Feb 2021<br>Maintenance was extended until April 2021 to cover repairs<br>Service Line fully compliant with IRMER regulations as per CQC review Jan 20.<br>Regular Dosimeter checking and radiation reporting. | This has been worked up at part of STP replace bid.<br>Submission of cardiac cath lab case<br>Procure Mobile cath lab<br>Project manager to resolve concerns regarding other departments phasing of moves to enable works to start | Safety | 12 | 8 -12 High risk | 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)<br>Desktop and floor-standing fans used in some areas<br>Quality control procedures for lab analysis<br>Temperature monitoring systems<br>Temperature alarm for body store<br>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<br>Review service schedule<br>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<br>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. | Statutory | 16 | 15 - 25 Extreme risk | Trust Risk Register |
| | | | Develop Intensive Intervention programme<br>Escalation of risk to Mental Health County Partnership | | | | |

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| C1850NSafe | The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour whilst on the ward. the The risk of a prolonged inpatient stay whilst awaiting an Adolescent Mental Health (Tier 4) facility or foster care placement. | 1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols.<br>2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients.<br>3. CQC and commissioners have been made formally aware of the risk issues.<br>4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff after difficult incidents | Escaled to CCG | Safety | 12 | 8 -12 High risk | 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 | Safety | 5 | 4 - 6 Moderate risk | 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)<br>2. Speciality specific clinical review of patients (clinical validation)<br>3. Utilisation of existing capacity to support long waiting follow up patients<br>4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties<br>5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients.<br>6. Use of telephone follow up for patients - where clinically appropriate<br>7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19<br>8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties<br>9. Review of % over breach report with validated administratively and clinically the values<br>10. Each speciality to formulate plan and to self-determine trajectory.<br>11. Services supporting review where possible if clinical teams are working whilst self-isolating. | 1. Revise systems for reviewing patients waiting over time<br>2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan<br>3. Additional provision for capacity in key specialiities to support f/u clearance of backlog | Quality | 15 | 15 - 25 Extreme risk | Trust Risk Register |
| | | Ongoing education on NEWS2 to nursing, medical staff, AHPs etc | Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams | | | | |

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|---|---|---|---|---|---|---|---|
| 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 | o E-learning package<br>o Mandatory training<br>o Induction training<br>o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days<br>o Ward Based Simulation<br><br>o Acute Care Response Team Feedback to Ward teams<br>o Following up DCC discharges on wards<br>• Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients<br>• Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient<br>• ACRT are able to escalate to any department / specialist clinical team directly<br>• ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors<br>o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians | Development of an Improvement Programme | Safety | 12 | 8 -12 High risk | Trust Risk Register |
| S2424Th | The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes. | Annual Verification of theatre ventilation.<br>Maintenance programme - rolling programme of theatre closure to allow maintenance to take place<br>External contractors<br>Prioritisation of patients in the event of theatre closure<br>review of infection data at T&O theatres infection control meeting | Write risk assesment<br>Update busines case for Theatre refurb programme<br>Agree enhanced checking and verification of Theatre ventilation and engineering.<br>meet with Luke Harris to handover risk<br>implement quarterly theatre ventilation meetings with estates<br>gather finance data associated with loss of theatre activity to calculate financial risk<br>investigate business risks associated with closure of theatres to install new ventilation<br>review performance data against HTML standards with Estates and implications for safety and statutory risk<br>calculate finance as percente of budget<br>Creation of an age profile of theatres ventilation list<br>Action plan for replacement of all obsolete ventilation systems in theatres | Business | 16 | 15 - 25 Extreme risk | Trust Risk Register |
| IT3409 | The risk to data security and availability, including Sunrise EPR as a result of physical malicious attack or environmental damage to equipment housed in an ageing data centre. | Included in the GMS site security provision.<br>Business Continuity Plan - Second data Centre at different location if data centre were to become unusable.<br>Fire alarms in place within data centre to alert if there is a fire<br>Business case approved. | New / refurbished Data centre Plan | Environmental | 10 | 8 -12 High risk | Trust Risk Register |
| C3084P&OD | The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels. | Risk Managers monitoring the system daily<br>Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions<br>Risk Assessments, inspections and audits held by local departments<br>Risk Management Framework in place<br>Risk management policy in place<br>SharePoint used to manage policies and other documents | Prepare a business case for upgrade / replacement of DATIX<br><br>Arrange demonstration of DATIX and Ulysis | Quality | 15 | 15 - 25 Extreme risk | Trust Risk Register |

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|---|---|---|---|---|---|---|---|
| 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<br>Controls in place from an operational perspective are:<br>1.The daily review of existing patient tracking list<br>2. Additional resource to support central and divisional validation of the patient tracking list.<br>3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI.<br>4. A delivery plan for the delivery to standard across specialities is in place<br>5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting<br>6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to implement. Reporting through Theatre Collaborative and PCDG.<br>7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating | 1.RTT and TrakCare plans monitored through the delivery and assurance structures | Statutory | 16 | 15 - 25 Extreme risk | Trust Risk Register |
| C2786NSafe | The risk of insufficient workforce to plan and prepare new arrangement ahead of new statutory requirements as an authorising body for Liberty Protection Safeguards by 1st April 2022, as a result of not having staff trained and processes in place from autumn 2021. | Safeguarding Adults policy<br>DoLS checklist<br>Mental Capacity Act documentation<br>Daily updates between GHFT Safeguarding Adults team and DoLS office.<br>CQC updated with every DoLS outcome.<br>MCA included as a mandatory element in Safeguarding Adults training<br>MCA training has been provided live via MSTeams<br>All divisions have developed MCA improvement plans.<br>QDG are monitoring progress monthly | A Trust MCA/DoLS Delivery Group is being established. Clinical leads being recruited and Divisional leads. DoLS scoping in place. July DoLS awareness month. Support to teams in practice, IT enhancemenst to DoLS applicatiosn process.<br>Divisional improvment plans for MCA<br>MCA and DoLS training included in Safeguarding Adults training<br>Workforce planning | Statutory | 12 | 8 -12 High risk | 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<br>Hover-jack to aid evacuation of level 3 patient<br>Fire extinguisher training for staff | Fire extinguisher training<br>Simulation training to evaluate hoverjack and slide sheets<br>Discuss estates option for creating adequate fire escape facilities<br>Purchase of twenty sliding sheets<br>order oxygen cylinder holders<br>Evacuation practice<br>relocation of small O2 cylinders b end of unit | Safety | 5 | 4 - 6 Moderate risk | Trust Risk Register |
| | | RN identified for ambulance assessment corridor 24/7<br>Identified band 3 24 hours a day for third radiology corridor with identified accountable RN on every shift | Complete CQC action plan<br>Compliance with 90% recovery plan<br>Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. | | | | |

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| M2268Emer | The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor | Additional band 3 staffing in ambulance assessment corridor 24 hours a day - improvement in NEWS compliance and safety checklist<br><br>Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH)<br>8am - 12mn consultant cover 7/7 (GRH)<br>reviewed by fire officers<br>safety checklist;<br>Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor.<br>Silver QI project undertaken to attempt to improve quality of care delivered in corridor inc. fleeced single use blankets and introduction of patient leaflet to allow for patients to access PALS.<br>90% recovery plan May 2019.<br>adherence.<br>Pitstop process late shifts Mon - Fri to rapidly assess all patient arriving by ambulance - early recognition of increased acuity to prioritise into the department.<br>Establishment of GPAU to stream GP referrals direct into alternative assessment area reducing demand in corridor. | Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR | Safety | 12 | 8 -12 High risk | 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.<br>2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team.<br>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.<br>4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns.<br>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.<br>6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards.<br>7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure.<br>8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied.<br>9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked.<br>10. Regular Monitoring of Nursing Metrics to identify any areas of concern.<br>11, Acute Care Response Team in place to support deteriorating patients.<br>12, Implementation of eObs to provide better visibility of deteriorating patients.<br>13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes.<br>14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes. | To review and update relevant retention policies<br>Set up career guidance clinics for nursing staff<br>Review and update GHT job opportunities website<br>Support staff wellbing and staff engagment<br>Assist with implementing RePAIR priorities for GHFT and the wider ICS<br>Devise an action plan for NHSi Retention programme - cohort 5<br>Trustwide support and Implementation of BAME agenda<br><br>Devise a strategy for international recruitment | Safety | 15 | 15 - 25 Extreme risk | Trust Risk Register |
| | | 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;<br>2. Many windows have a protective film to prevent shards of glass fragmenting and causing harm; | 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 | | | | |

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| 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 | 3. Patient Risk Assessments are in place by the Trust for vulnerable patients to ensure that controls are in place locally to minimise and/or mitigating patient contact with windows/glass;<br>4. Window Restrictors are fitted to all windows which require them and are maintained on an annual PPM schedule by Gloucestershire Managed Services;<br>5. Window Restrictor Policy in place which is reviewed and updated on a three yearly basis or as required;<br>6. If a window is broken or damaged it is replaced with a window which has toughened glass and complies with all current legislative requirements (e.g. 6.4mm laminate safety glass tested to provide class 2 level of protection to BS EN 12600, manufactured to BS EN 14449 and/or BS EN ISO 12543-2);<br>7. Money is made available in the Capital budget for replacement of windows (Note for AM: Accuracy of control/mitigation action to be confirmed). | Review, assess and enact agreed future actions/controls | Environmental | 10 | 8 -12 High risk | Trust Risk Register |
| C3295COO | The risk of patients experiencing harm through extended wait times for both diagnosis and treatment | Booking systems/processes:<br>Two systems were implemented in response to the covid 19 pandemic.<br>(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.<br>(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 or discharged (with instructions required). Both systems were operational from end March. | No Further actions | Safety | 16 | 15 - 25 Extreme risk | 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;<br>ED escalation policy in place to ensure timely escalation internally;<br>Cubicle kept empty to allow patients to have ECG / investigations (GRH);<br>Pre-emptive transfer policy<br>Patient safety checklist up to 14 hours<br>Monitoring Privacy & Dignity by Senior nurses<br>Appointment of band 3 HCA's to maintain quality of care for patients in escalation areas.<br>Review of safety checklist to incorporate comfort measures and oxygen checks.<br>Introduction of pitstop trial to identify urgent patient needs including analgesia and comfort measures. | CQC action plan for ED<br>Development of and compliance with 90% recovery plan<br>Winter summit business case<br>Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR | Quality | 15 | 15 - 25 Extreme risk | Trust Risk Register |
| | | | Deliver the agreed action fractured neck of femur action plan<br>Develop quality improvement plan with GSIA<br>Review of reasons behind increase in patients with delirium<br>Development of parallel pathway for patients who fracture NOF in hospital<br>Pull together complaints and compliments to understand patient/care views<br>Pull together any complaints or compliments to understand patient/care views for #NOF patients<br>develop joint training and share learning to reduce issues and optimise care | | | | |

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| 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<br>Early pain relief<br>Admission proforma<br>Volumetric pump fluid administration<br>Anaesthetic standardisation<br>Post op care bundle – Haemocus in recovery and consideration for DCC<br>Return to ward care bundle<br>Supplemental Patient nutrition with nutrition assistant<br>medical cover at weekends<br>OG consultant review at weekends<br>therapy services at weekends<br>Theatre coordinator<br>Golden patients on theatre list<br>Discharge planning and onward referrals at point of admission | discuss admitting patients to 3a with site team<br>create SOP for prioritisation of #NOFs to 3rd floor with intention that other trauma should outlie first<br>restart TATU to help reduce length of stay and improve discharges<br>Identify potential capital works and funding for TATU<br>revisit possibility of Mayhill taking planned trauma<br>revisit community teams administering antibiotics<br>agree targeted approach for high volume conditions<br>engagement activities with staff on ideas for improving LOS<br>Prioritise 3rd floor for ward rounds to aid flow<br>creation of new inpatient clerking proforma<br>progress pre op protocols through documentation committee<br>launch pre op protocols<br>early escalation by trauma coordinators of any trauma backlog to prioritise hip fracture patients<br>review of escalation policy and relaunch if necessary<br>creation of snapshot report to aid escalation<br>re educate trainees that if femoral head if not out/guide wire not within 20 mins, requirement to request senior help<br>Need to emphasise with trainees that access available to JUYI/SCR to inform full list of patient medication<br>Feedback on ward care plan audit results and education of trauma coordinators and medical staff of importance<br>feedback on care bundle audit and feedback to nursing teams and junior Drs of importance<br>recruitment into vacant post for nutrition support practitioner<br>good practice re optimisation for nutrition and hydration to be shared outside 3a<br>Audit post op blood taking over weekends<br>investigate options to increase junior orthogeri cover<br>on call junior dr to be supported by 2nd registrar in MIU, freeing up on call Dr to see ward patients<br>explore issue relating to complex patients not being assessed by COTE team before theatre<br>process for escalation of DATIX to junir Dr and escaltion superviserd to aid learning<br>undertake time and motion study of juniors to understand pressures<br>work with HR to develop recruitment and retention plan for trauma nursing<br>review feeback from nursing education programme<br>engagement activities across T&O nursing<br>Explore issues around Gallery ward taking NOF patients with complex needs<br>review TOR for hip fracture mortality meetings<br>Identify staff to undertake silver QI course to develop QI skills<br>Review and update transfusion policy post surgery<br>Review post op transfusion policy for NOF patients<br>Learning disability passport to be included when appropriate fro NOF patients with learning disability<br>EPR trigger to be implemented from transfusion policy<br>Communicate with recovery staff the new transfusion guidance from the updated policy. | Safety | 12 | 8 -12 High risk | Trust Risk Register |

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|---|---|---|---|---|---|---|---|
| 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<br>2. Annual programme of antimicrobial stewardship in place<br>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 | Safety | 12 | 8 -12 High risk | Trust Risk Register |
| S2537Th | The risk to patient safety & experience due to loss of main theatre lighting impacting on ability to safely complete surgical procedures | Maintenance by Estates and Fulbourn Medical. | Request funding for all obsolete lights<br>Put light risk on the risk register<br>Add Apollo Lights to the risk assessment and MEF request<br>Carry out surveys of the theatres requiring lights<br>Replacement programme<br>Work with estates to produce a list of outstanding lights<br>Identify access to additional lighting in case of failure<br>Action plan for lights replacement<br>To produce risk assessment for light failure | Safety | 12 | 8 -12 High risk | 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.<br>Quality control procedures for lab analysis<br>Temperature monitoring systems<br>Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times). | Develop draft business case for additional cooling<br>Submit business case for additional cooling based on survey conducted by Capita<br>Rent portable A/C units for laboratory | Quality | 16 | 15 - 25 Extreme risk | Trust Risk Register |
| S3316 | The risk of not discharging our statutory duty as a result of the service's inability to see and treat patients within 18 weeks (Non-Cancer) due to a lack of capacity within the GI Physiology Service. | purchase of anopress machine for use by lower GI surgeons to reduce the numbers requiring GI phys<br>Escalation of patients> 52 weeks to Head of GI physiology to review prioritisation<br>Referral outside of Trust | to discuss alternative treatment options with upper GI surgeons<br>review cost implications and resources for treatment option of bravo capsule<br>Further individual being trained in GI Physiology by Bev Gray. Individual will work 35.5 hours per week total, not all will be GI Physiology, hours TBC. Will increase GI Physiology capacity by >100%<br>Capital application form completed, Candice Tyers presenting to MEF<br>VCPs have been submitted / await outcome of approval | Statutory | 16 | 15 - 25 Extreme risk | Trust Risk Register |
| C3223COVID | The risk to safety from nosocomial infection, acute respiratory illness (COVID-19) and prolonged hospitalisation in patients, or transmission of COVID-19 to / from staff and patients causing an outbreak. | •2m distancing implemented between beds where this is viable<br>•Perspex screens placed between beds<br>•Clear procedures in place in relation to infection control<br>•COVID-19 actions card / training and support<br>•Planning in relation to increasing green bed capacity to improve patient flow rate<br>•Transmission based precautions in place<br>•NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control<br>•H&S team COVID Secure inspections<br>•Hand hygiene and PPE in place<br>•LFD testing – twice a week<br>•72 hour testing following outbreak<br>•Regular screening of patients | CAFF inspections to be progressed | Safety | 8 | 8 -12 High risk | Trust Risk Register |
| | | | 1. To create a rolling action plan to reduce pressure ulcers<br>2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions | | | | |

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| 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.<br>2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training.<br>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.<br>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.<br>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.<br>4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing<br>Discuss DoC letter with Head of patient investigations<br>Advise purchase of mirrors within Division to aid visibility of pressure ulcers<br>update TVN link nurse list and clarify roles and responsibilities<br>implement rolling programme of lunchtime teaching sessions on core topics<br>TVN team to audit and validate waterlow scores on Prescott ward<br>purchase of dynamic cushions<br>share microteaches and workbooks to support react 2 red<br>cascade learning around cheers for ears campaign<br>Education and supprt to staff on 5b for pressure ulcer dressings<br>Review pressure ulcer care for patients attending dilysis on ward 7a | Safety | 12 | 8 -12 High risk | Trust Risk Register |

Gloucestershire Hospitals
NHS Foundation Trust

**TRUST PUBLIC BOARD – 13 May 2021**
**Microsoft Teams – Commencing at 12:30**

| **Report Title** |
|---|
| **Digital & EPR Programme Report** |
| **Sponsor and Author(s)** |
| Author: Anna Wibberley, Digital Programme Director<br>Nicola Davies, Digital Engagement & Change Lead<br><br>Sponsor: Mark Hutchinson, Executive Chief Digital & Information Officer |
| **Executive Summary** |


Purpose
This paper provides updates and assurance on the delivery of digital work streams and projects within GHFT, as well as business as usual functions. The progression of this agenda is in line with our ambition to become a digital leader.

Key Issues to Note
MIIU at Cheltenham went live with full EPR functionality (clinical documents, order comms and e-observations) on 24th March. A two-week programme of support was put in place, with ongoing support from digital teams as required.

- A new pharmacy stock control system (EMIS) went live on Wednesday 7th April.
- The latest Sunrise patch release is needed to fix existing issues with EPR tracking boards. This will require additional testing resource.
- Our EPR partner, Allscripts, is recommending an upgrade of Sunrise EPR to version 20 to enable full and effective implementation of electronic prescribing and medicines administration (EPMA). This could delay the implementation of EPMA by 4 to 6 months.
- The Business Intelligence team have been selected to work with NHSX AI Skunkworks Project to develop algorithms that could identify patients at risk of a long hospital stay.

Conclusions
The importance of improving GHFT's digital maturity in line with our strategy has been significantly highlighted throughout the COVID-19 pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, but needs to continue at pace.

Implications and Future Action Required
As services continue to move on-line 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 | | | | Information Management & Technology | | **X** | |
| Human Resources | | | | Buildings | | | |
| | | | | | | | |
| **Action/Decision Required** | | | | | | | |
| For Decision | | For Assurance | **X** | For Approval | | For Information | **X** |

**FINANCE & DIGITAL COMMITTEE**

**APRIL 2021**

# DIGITAL & EPR PROGRAMME UPDATE

## 1. Purpose of Report

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.

## 2. Sunrise EPR Programme Update

This section provides status updates on Sunrise EPR workstreams and interdependent digital projects, in particular the latest position on EPR in MIIU at CGH. Detailed information on each workstream, including RAG status, is provided below.

Key issues to note:

- MIIU at Cheltenham went live with full EPR functionality (clinical documents, order comms and e-observations) on 24th March. A two-week programme of support was put in place, with ongoing support from digital teams as required.
- A new Pharmacy stock control system (EMIS) went live on Wednesday 7th April.
- The latest Sunrise patch release is needed to fix existing issues with EPR Tracking Boards. This will require additional testing resource.
- Our EPR partner, Allscripts, is recommending an upgrade of Sunrise EPR to version 20 to enable full and effective implementation of electronic prescribing and medicines administration (EPMA). This could delay the implementation of EPMA by 4 to 6 months.
- The Business Intelligence team have been selected to work with NHSX AI Skunkworks Project to develop algorithms that could identify patients at risk of a long hospital stay.

## 2.1 EPR High Level Programme Plan

The programme plan below details the EPR functionality being delivered this year. The launch of order comms in theatres and outpatients has been rescheduled following delays because of COVID service changes.

| 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 (other inpatient areas) | February 2021 | February 2021 |
| Cheltenham MIIU (all functionality) | March 2021 | 24th March 2021 |
| Pharmacy Stock Control new system (EMIS) | April 7th 2021 | April 7th 2021 |
| Order Communications (theatres) | May 2021 | |
| HDS (ward handover list) | May 2021 | |
| Sepsis/deteriorating patients | May 2021 | |
| Order Communications (outpatients using phlebotomy services) | June 2021 | |
| TCLE – replacement lab system (replacing IPS) | June 2021 | |
| Gloucester Emergency Department (all functionality) | Summer 2021 | |
| Electronic Prescribing (known as EPMA) | Originally planned for winter 2021. Upgrade to Sunrise EPR v20 required may impact this. | |

### 2.2 Sunrise EPR live in Cheltenham MIIU

Full EPR functionality went live in Cheltenham MIIU on Wednesday 24th March. With wraparound support from clinical and EPR leads, the staff began documenting the majority of their clinical information on EPR; including triage, clinical assessments, safety lists, observations, requests and results and bed requesting. The department is also the first to use *Follow me Desktop* which allows staff to quickly and securely tap in and out of machines within the MIIU, without losing their work.

More than 75% of clinical staff working shifts in MIIU completed online or face to face training ahead of go live, and training teams have been on hand (at elbow) to support staff using the system in the first week. Staff engagement has been excellent, with support from senior clinical and operational colleagues on the ground and attendance at go-live monitoring calls being held three times a day. GPs are now receiving discharge summaries and notice of attendances electronically, and we are working with primary care partners to communicate the changes and monitor its success.

It is planned that Cheltenham will provide detailed learning and information ahead of Gloucester ED go live in the Summer – providing an opportunity for us to identify system and process issues, as well as important lessons around culture change and working practices. Our aim is for as many staff as possible to rotate through the department before we go live in GRH.

Delivery of Sunrise in Cheltenham MIIU has been a whole team effort, with TrakCare and EPR teams working closely together with data quality, coding and operational staff to ensure the quality and integrity of the clinical information we are capturing. A huge thank you to Dr Rob Stacey and Dr Tom Mitchell for their clinical leadership of this project. A more detailed review will be submitted to next month's DCDG.

Staff ceremoniously cleared the unit of paper forms (keeping some for business continuity purposes).

### 2.3 Critical EPR issue requiring urgent fix

Since going live in Cheltenham MIIU, we have identified an issue with EPR Tracking Board updates across the hospital and we are recommending an urgent fix is applied, to prevent the issue escalating further.

The issue relates to the queue in the system that stores the list of patient moves and pushes them out to the Tracking Boards. This provides vital live data for clinical and operational staff. What began as occasional errors or delays in patients not appearing on the boards, or appearing in the wrong location – has now escalated into becoming a regular occurrence needing ongoing support from our EPR team. It also presents a significant clinical risk.

#### 2.3.1 Solution

Our Sunrise EPR supplier, Allscripts, has recommended that we take the latest patch release as soon as possible to fix this issue. This patch involves 69 other updates that will likely bring additional improvements and resolve minor system issues. The alternative would be to change the way EPR is configured to allow users to move patients manually. However, this is not a recommended way forward as it would require additional training, add additional risk and affect our data integrity.

We would take the patch release as soon as possible and this would then need to be properly tested by our internal teams, with full Allscripts support. This means that resource from across the digital team will be taken off other projects over the next six weeks – possibly impacting our ability to deliver other EPR projects during May and June. The work involves staff from EPR configuration and training team, integration, business intelligence, TrakCare and clinical apps.

### 2.3.2 Recommended way forward

DCDG has approved the recommendation that we take the latest patch release to fix the critical tracking board issue. DOAG should also understand that this will impact the delivery of other EPR programmes and optimisations. A redefined project plan will be presented to EPR Programme Delivery Group, DOAG and shared with the organisation.

## 2.4 EPR Project Summaries and status updates

The following tables provide updates on the status of major EPR projects planned for 2021. There are two key issues to note:

- EMIS (pharmacy stock control) successfully went live on 7th April.
- EPMA is currently planned for November 2021. However discussions are underway with our EPR partner Allscripts to upgrade to Sunrise EPR version 20 ahead of electronic prescribing and medicines administration implementation. This would mean a delay to the planned go live date. More detail is included in the update below.

## 2.5 Sunrise EPR upgrade to enable full functionality EPMA

A key benefit of bringing electronic prescribing and medicines administration to the organisation is medicines reconciliation. The latest version (V20) of Sunrise EPR has enhanced medicines reconciliation capabilities, bringing improvements to the Order Reconciliation Manager. This brings with it significant safety and clinical benefits; providing an up to date, accurate medication history; the current prescribed position; and simplified management of changes to medication across a patient's stay. This includes documenting the documentation as discharge.

Version 20 of Sunrise EPR enables all of these features and provides the latest release position, with numerous issue fixes, including a prescribing-specific fix for issues with the display of prescribed medications changes since admission.

Benefits of upgrading to Version 20 before launching EPMA:

- In response to real world usage the new version has been enhanced to more clearly identify alterations to medications, significantly improving clinical safety when discharging our patients back to GPs.
- Discharge medication is a key priority for the Trust and one of the most important benefits of EPMA – as guided by our ICS strategy.
- Clinicians in primary and secondary care, and in community pharmacies would support the improved information the enhanced functionality of the upgrade will provide.
- Safely conveying the correct medications down to GP colleagues is one of the most important benefits of implementing EPMA and the upgraded version will make reconciliation safer and more effective.

Risks/challenges of upgrading to Version 20:

- The localisation flexibility of Allscripts Sunrise EPR means increased upgrade effort and subsequent validation of the upgrade, requiring significant trust resource input and is not as simple as 'putting a new CD in'. It must be properly timed, planned and resourced.
- The upgrade will require significant testing of the whole system to ensure that nothing has been broken or changed in the upgrade. Although Allscripts will provide additional support, this will delay the implementation of EPMA by 4 to 6 months and will not allow us to deliver as planned in November 2021.

Discussions are ongoing with our partner Allscripts and a further report will be brought back to DOAG.

### 2.6 Hospital Discharge Service

This project is being led by Acting Deputy Chief Nurse, Eve Olivant and Chief of Service (D&S) Kate Hellier. The aim is use EPR to improve the way we track, manage and report on patient discharges. The digitisation of this workflow will help reduce length of stay for patients and ensure appropriate and timely discharging. This involves input from operational, digital and clinical colleagues. This will digitise the capture of relevant discharge information to feed into national ECIST reporting requirements; as well as providing a workflow to help medical staff manage their ward/board rounds.

- Ward based engagement has taken place to assess the current state and how Doctors use EPR to make clinical notes.
- Using this information, the EPR team have created a ward handover document for further testing and development
- Two engagements sessions have been held with doctors (and juniors) from across specialities to demonstrate the ward handover document and get feedback and input
- A dedicated Team has been set up (using MS Teams) to continue the engagement and enable further testing and development with clinicians.
- The proposed go live is mid-May 2021.

### 2.7 EPR project summaries and status updates

The following tables provide updates on the status of major EPR projects planned for 2021.

| Title: | Order Communications –Theatres and Outpatients | |
|---|---|---|
| Current Project RAG Status: | A | Scope: |
| AG Status against Programme: | G | • All Theatre locations at GRH, CGH and SMH<br>• All Outpatient locations that use phlebotomy services at CGH and GRH<br>• All other Outpatient locations – in a separate go live at a later date. |

| RAG Status | Workstream | Update |
|---|---|---|
| G | Benefits | An initial review meeting has been held with weekly follow-on meetings scheduled to enable comparison work. |
| R | Config | Theatres – A meeting to review the updated Theatres Project has been held and a review of the future state for Histopathology, Radiology Requesting & applying labels in Theatres is scheduled for 09/04/2021.<br><br>Outpatients – The Discharge Policy set up requires validation.<br>A revised Future State Process scenario for the Takeaway Form is required and a review of the process is pending.<br>Completion of the Phlebotomy Takeaway Form is underway. |
| G | Testing | A Testing Manager is now in place ensuring robust testing strategy is being worked to for all interdependent projects. |
| G | Training | Theatres – Histology training will be prepared once workflows are confirmed.<br><br>Outpatients - Load to the E-learning environment has commenced, with staff to be identified and verified.<br>A review of training for Outpatient Phlebotomists is pending. |

| | | |
|---|---|---|
| G | Site Readiness | Theatres – There are 4 PCs and 20 printers being deployed. 2 PCs and 1 printer will be deployed to all theatres (17) that have less than 2 PCs.<br><br>Outpatients – 8 laptops & printers are to be deployed to Phlebotomy and 2 PCs in Oncology at CGH if 3.3 only. |
| G | Integration | Theatres – Testing of temporary locations is outstanding.<br><br>Outpatients – Testing of clinics from TrakCare is outstanding. |
| G | Reporting | Theatres – Testing of BCP reports is outstanding. Phase 4/5 Histology labels will be used.<br><br>Outpatients – Testing of BCP reports is outstanding. |
| G | Cutover | Women and Children's have gone live. New go lives are being agreed. |
| **Overall Status:** | | |
| The overall status is Amber due to an issue with the Histopathology order form | | |

| | | | |
|---|---|---|---|
| **Title:** | **Order Communications – TCLE Implementation** | | |
| **Current Project RAG Status:** | | **R** | **Scope:** |
| **RAG Status against Programme:** | | **A** | • **Implement TCLE and Retire IPS within all GFHT labs** |
| **RAG Status** | **Workstream** | **Update** | |
| G | Benefits | New benefits lead has commenced. | |
| R | Config | MSoft development has been deployed to UAT.<br>The Blood Transfusion functionality required from InterSystems is included in CCN19 and a mocked up web services has been received.<br>The gap analysis of SCM 'non TCLE' configuration has been completed and a list of build requirements identified. | |

| | | |
|---|---|---|
| **R** | Testing | End 2 End Validation cycle 2 is overrunning due to the volume of tests and the number of issues identified, with 4375 of 6181 tests completed.<br>There are 47 open issues of which 14 are now ready for retest – 6 x Critical, 23 x High, 18 x Medium and 0 x Low.<br>Histo End 2 End Validation is being held up by interface issues, with remedial work required within the TIE.<br>A testing bridge with all relevant stakeholders has been established to speed up end to end testing. |
| **R** | Training | Training plans have been received from the Labs (with the exception of Transfusion) and work is progressing to ensure a consistent format across all disciplines.<br>There are 143 SOPs required for Go Live – 5 have been completed with 88 outstanding (38% complete). |
| **G** | Site Readiness | The installation of equipment at both GRH and CGH is complete. PC, printer and IP details have been provided to ISC and loaded into the CUPs server, with work to define printer rules due to complete this week. |
| **R** | Integration | Histology continues to have interface issues and has not started formal testing yet.<br>Downstream systems integration works are complete with the exception of ICNet. Development for this is not due to be delivered until 14/05. |
| **A** | Reporting | The BI Team have produced local schema documentation and this has been distributed to InterSystems for sign off, with revised delivery timescales pending. |
| **A** | Cutover | Cutover Planning documentation has been provided by InterSystems and distributed to the Labs for review. Feedback is being collated and co-ordinated to finalise all relevant cutover documentation. |
| **Overall Status:** | | |
| While this project is progressing for delivery there are a number of key concerns. End 2 End testing in Histopathology is delayed owing to necessary remedial work in the TIE and End 2 End Validation Cycle 2 is overrunning due to the volume of open issues that require resolution. The Labs have raised concern regarding the pending MHRA audit scheduled for 13 April and the impact this may have on the resource required to deliver TCLE. | | |

| Title: | EPR in GRH ED | | |
|---|---|---|---|
| Current Project RAG Status: | | A | Scope: |
| RAG status against programme: | | G | • Implement Follow Me Desktop in ED locations<br>• Implement EPR in ED in GRH |

| RAG Status | Workstream | Update |
|---|---|---|
| G | Benefits | Benefits assumptions have been baselined as part of CGH Go Live. |
| G | Config | Critical Optimisation list has been added to milestones and a meeting has been scheduled for 1st April to discuss the scope requirements of GRH ED.<br>Discussions of the scope of Discharge Summary optimisation and the timescales for the mode of arrival and bed details to be visible in EPR are pending. |
| G | Testing | A detailed plan will be developed as planning progresses. |
| G | Training | Training materials will be reviewed following the CGH go live, with training numbers being updated based on those completing CGH go live. The scope for visiting Doctors in under review. |
| A | Site Readiness | A confirmation of equipment requirements has been established, with sign off pending prior to orders being placed and Estates work has been requested (with lead times awaited). Igels have been dispatched. |
| G | Integration | The location of Igels within ED still needs to be determined. A list of consultants and locums is under review to determine follow-me desktop requirements and licensing availability.<br>There are currently 13 open issues under review. |
| G | Reporting | The plan has been updated to include Data Warehouse optimisation elements and timescales (with milestones for optimisation work pending). |
| G | Cutover | A detailed plan will be developed as planning progresses. |

| Overall Status: |
|---|
| Site Readiness is a key area of concern and focus at the moment with the lead time for the delivery of equipment pending. All other workstreams are progressing well without major issues. |

| Title: | Pharmacy Stock Control – EMIS<br>*Update ahead of go live on 7th April* | |
|---|---|---|
| **Current Project RAG Status:** | **A** | **Scope:** |
| **RAG Status against Programme:** | **A** | • **Replace current Pharmacy Stock Control system with EMIS** |

| RAG Status | Workstream | Update |
|---|---|---|
| G | Benefits | EMIS – Initial benefits have been identified, with work continuing to complete. Baseline data has been collected but needs to be reformatted. |
| A | Config | EMIS – Environment refresh has been completed, following a configuration review. |
| G | Testing | EMIS - Reporting testing has been completed and signed off. |
| G | Training | EMIS – 24 SOPs had been identified as requiring reviewing and updating by Pharmacy, with 50% having now been completed. QRGs completed. FAQs are being collated as part of the feedback from training sessions. Majority of staff have been trained |
| G | Site Readiness | EMIS – CGH PCs have been deployed. GRH PC network installations. Printer configuration work has been completed at both CGH and GRH. |
| A | Integration | EMIS – Finance Interface (AP) specification has been approved by EMIS and confirmation received that the interface will be delivered on the 6th April. |
| A | Reporting | EMIS – The 32 report requirements identified have been fully tested and signed off. The EMIS Finance reporting sign off has been scheduled |

| | | |
|---|---|---|
| A | Cutover | EMIS – The detailed cutover plan has been completed with input from key stakeholders and the OIA approved by senior leads. DCAB has approved subject to submission of Communications Plan. Go live briefing sessions held with staff in CGH and GRH. |

**Overall Status:**

EMIS is progressing well and on schedule for the 6th April go live. There are concerns that the AP finance interface will be delivered by EMIS until 6/04 (although already successfully tested) and Medecator mapping will not be completed until 06/04.

| **Title:** | **EPMA** | | |
|---|---|---|---|
| **Current Project RAG Status:** | | **A** | **Scope:** |
| **RAG Status against Programme:** | | **A** | • **Implement EPMA in Adult Inpatient areas**<br>• **Implement EPMA in other areas** |

| RAG Status | Workstream | Update |
|---|---|---|
| **G** | Benefits | Benefits outlined and data collection being planned |
| **A** | Config | EPMA – Core class types have been agreed. A Tracking Board workshop review is in progress with a view to develop a detailed design specification.<br>The Order Entry Form requirement specification has been completed. |
| **G** | Testing | EPMA – Testing activities are not planned to commence for several months. |
| **G** | Training | EPMA – Training is not planned to commence for several months. |
| **A** | Site Readiness | EPMA – Work is required to review equipment needs vs future states. |
| **A** | Integration | EPMA – The design specification for integration is currently being reviewed. |
| **A** | Reporting | EPMA – This will be monitored as an ongoing activity. Discussions are ongoing between Pharmacy and BI to define the requirements. |

| | | |
|---|---|---|
| **A** | Cutover | EPMA – Cutover activities are not planned for several months. |
| **Overall Status:** | | |
| EPMA – a re-planning exercise is in progress with draft plan to be reviewed with senior leads. | | |

### 2.8 Activity planned for next period

MIIU at CGH will move into business as usual and all lessons learned built into the Gloucester ED project. EMIS, TCLE, Theatres and Outpatient go lives will be planned and go live execution started.

### 2.9 Risks

Current risks to the project timeline and success include:

- COVID response work, particularly where locations need to be amended back to their pre-COVID configurations could impact the delivery team.
- Blood Transfusion – the MHRA inspection could pull significant blood transfusion resources away from projects to assist with their enquiries.
- Patch to fix known Tracking Board issue needs additional resource from across the team and will impact other projects.
- An upgrade to version 20 of Sunrise EPR is needed to implement EPMA which in turn will have a knock on effect to EPMA implementation timeline.

### 2.10 Conclusion

Sunrise EPR remains the key to a much safer approach to the way we manage patient care. Workstreams are continuing to deliver at pace, with clinician-led improvements and optimisations ongoing.

## 3. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). Seven projects are either in closure or have been closed during the last period.

Key issues to note:

- The REDCap Database System, New Text Messaging for GHT, VNA PACS Imaging Archive Solution, Transpara Research Expansion and Single Domain/Windows 10 projects have been closed.
- The decommissioning of legacy telephony equipment to complete the Next Generation Telephony project has slipped owing to a delay in ceasing the legacy telephone circuits.
- The SBS Data Lake Migration project is in initiation. This will migrate the NHS Digital Secure Boundary Service managing the Trust outbound internet traffic to a new hosted location and enable the retention of staff internet history (mandated by NHS Digital).
- The Tableau project is in initiation. This will provide a design for and implement the Tableau Visualisation and Reporting platform.

## 3.1 Areas of Concern & Mitigating Actions

**SQL Migration & Windows 2003 Upgrade**
A number of problematic servers and issues with engagement have prevented progress. The required engagement has been escalated and an Exception Report has been prepared to detail the issues and outline the approach required to successfully deliver the last, problematic, elements of the project.

**BI Data Warehouse Migration**
Progress to completion has slowed owing to resource being focused on impending TCLE and ECDS implementations. The outstanding work is under review to determine how and when this can be addressed. There is also concern at the crossover between this project and the delivery of the Tableau project, which both deliver reporting solutions. Discussion is therefore underway to determine how reporting should proceed.

**GHT N365 Transition and Change**
A number of issues have arisen during the investigation phase of this project. These are focused on each phase of data migration and the use of software that will no longer be available after the transition. Work is underway to identify and provide a clear and achievable solution for each.

## 4. AI Skunkworks Project NHSX

The GHT BI Team have been successful with their bid to become part of the NHSX Artificial Intelligence Skunkworks project this spring.

The BI Team, joined by Mark Hutchinson and Kate Hellier, presented the concept of a Long Stay Risk Score algorithm to a Dragons Den of NHSX AI experts and their colleagues, and were one of only three pitches to be successful, from a field of more than 30 applications.

The project involves bringing together the skills of GHT BI analysts with the AI expertise of NHSX and their partners to create a risk score for every admitted patient, which will indicate the likelihood of that patient becoming a “long stayer”. Data shows that more than a third of GHT’s beds are occupied by patients whose admission lasts for 21 days or more, and published evidence shows that this generally does not lead to a positive outcome for the patient and steps can be taken to prevent this. This collaborative project between GHT and NHSX aims to use learning from 7 years’ of historic data to flag these patients at the earliest opportunity, allowing clinicians to work with them differently, possibly on a bespoke care pathway, to try to reduce their length of stay.

If successful, this project aims to help deliver:

- Decreased length of stays
- Decreased patient deterioration during admission
- Decreased mortality during admission and immediately after
- Reduced readmission rates
- Increased patient independency
- Improved patient flows
- Reduced occupancy
- Savings & improvements across health and social care

If the models proves to be accurate and effective, NHSX have plans to scale it up to implement at a national level.

## 5. Countywide IT Service (CITS) monthly report

The CITS team continue to experience increasing demand to support more remote working, increased used of clinical systems and supporting hospital-wide operational changes.

One of the KPI measurements against which CITS is monitored is calls answered within 60 seconds. To date, the average is between 60% and 80% and February shows a continued trend in improvement.

Focus continues to be placed on reducing the number of open incidents within CITS and to reduce the number of breached calls for all organisations.

We are working to reduce calls to desktop team (100 a month on average) by directing repeat incidents to problem management.

There has been an increase in open incidents with the Network/Telephony Team - a weekly review with all team leads is carried out to monitor queues and identify any on-going issues or themes, which in turn feed into problem reviews. There has been an increase in February and March because of office/service moves and change requests.

There has been an increase in open incidents with the Server Team; the same weekly monitoring process is in place. During February and March we saw increases due to software deployment issues with MS Teams via SCCM.

However, we have reduced the number of open deployment incidents; as deployment of equipment is organised and managed in much quicker timescales.

## 6. Information Governance

This section provides updates and assurance on the Information Governance Framework in operation within the trust to ensure the senior team is regularly briefed on Information Governance issues and the broader Information Governance agenda.

Following submission of the baseline position in February for the 2020/21 DSPT and completion of the information gathering stage of the NHS Digital commissioned toolkit audit undertaken during February by PricewaterhouseCoopers LLP (PwC) work is ongoing to achieve compliance by 30 June 2021.

We achieved the mandatory requirement of 95% of staff completing annual Information Governance refresher training during the current 12 month reporting period. This remains an ongoing requirement of DSP toolkit compliance and is an important method of ensuring staff is aware of their personal responsibilities in regards to data security and protection. As such, compliance continues to be closely monitored and reported through the divisions and via this report. The Medical and Dental staff group continues to be most challenging in recording training levels around the compliant 95%.

### 6.1 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.

- Ten incidents have been reported to the ICO during the 2020/21 reporting period to date.
- 33 Confidentiality incidents have been reported on the Trust internal Datix incident reporting system during January 2021, including two that were external to GHT.

### 6.2 Information Asset Register (IAR)

The IG team are now working on a new version of the IAR Flowz, following a successful system upgrade. Some revisions to the data protection Impact assessment (DPIA) template and process will follow to ensure processes are aligned. Validation of the list of Information assets and the corresponding information asset owners continues across clinical and corporate divisions. Included in this work is an expectation that the N365 project will uncover previously under reported Information assets in the form of specialty specific access database. Following validation of the information assets the second phase of the Flowz IAR implementation is planned, which is to record the key external data flows for each.

## 7. Cyber Security

This section highlights cyber security activity for February 2021 and details the controls in place to protect Gloucestershire Healthcare Community's information assets. CITS Cyber function is working with GHC to agree cyber SLA requirements in order to support a standardised cyber approach across Gloucestershire ICS.

Key issues to note:

- One open High CareCERT Advisory, to be closed in March.
- One open CareCERT Threat Notification, under investigation by GHC IT.
- ATP categorised Sendgrid.net detections as 'Suspicious Activity'. Associated IP address and organisation is deemed clean buy multiple threat detection sources. Additional investigation to be carried out.

**Authors:** Nicola Davies, Digital Engagement & Change Lead
**Presenter:** Mark Hutchinson, Executive Chief Digital & Information Officer

Gloucestershire Hospitals
NHS Foundation Trust

**PUBLIC TRUST BOARD – 13 May 2021**
**Microsoft Teams – Commencing at 12:30**

| **Report Title** |
|---|
| **Financial Performance Report**<br>**Month Ended 31 March 2021** |
| **Sponsor and Author(s)** |
| Author: Johanna Bogle, Associate Director of Financial Management<br>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 12 to the Trust Board.

System Position as at Month 12

Systems were instructed to break even at Month 12, with the expectation that their annual leave provision would be funded up to a maximum of 5 days.

We achieved this, and had no movement from our Month 11 expected annual leave cost of £4.01m. This meant we reported a small £22k surplus for the full year.

Month 12 overview

Month 12 reports a £0.04m surplus in month, compared to £4.42m expected deficit = £4.46m better than forecast in month.

Activity was up 21% month on month, and we delivered 20% more activity than we had planned for in March.

Next Year

We are progressing with system discussions around funding allocations. Systems are expected to breakeven within their allocations, while maximising recovery activity.

Conclusions

The Trust is reporting a full year surplus of £0.02m, £14.69m better than the planned £14.67m deficit.

The Gloucestershire system is reporting breakeven.

Implications and Future Action Required

To continue the report the financial position monthly.

| **Recommendations** |
|---|
| The Committee 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)** |
| | 29/04/2021 | | | | | | |

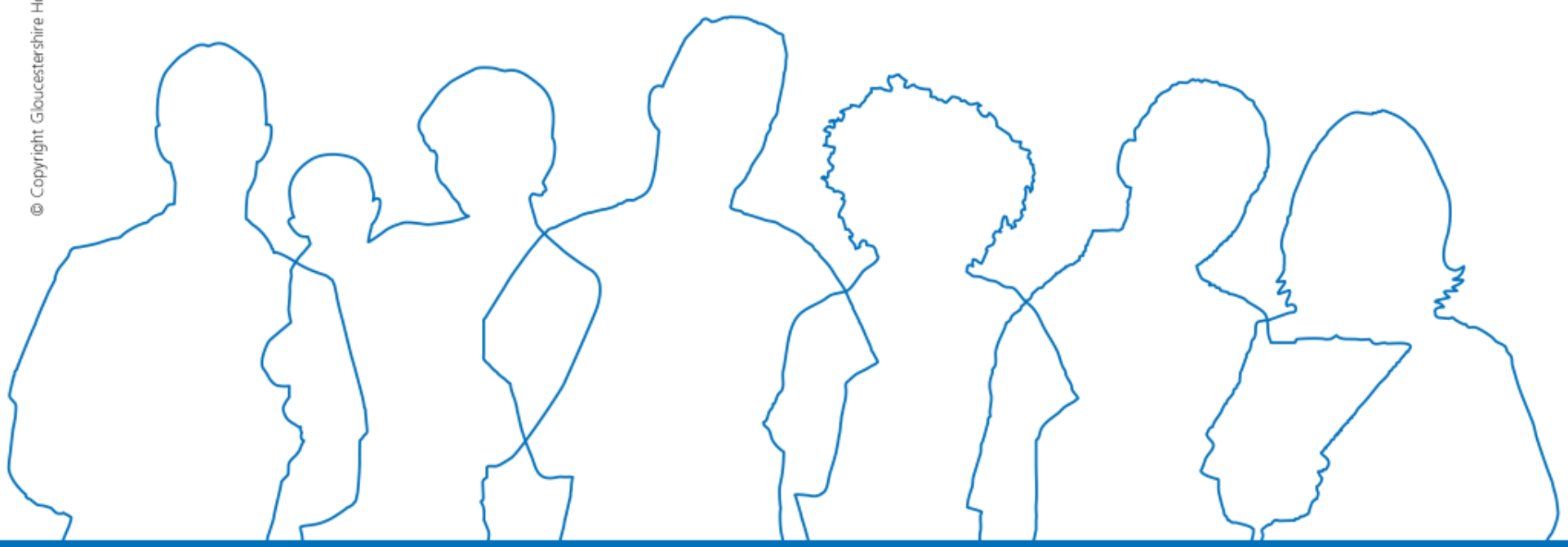
| **Outcome of discussion when presented to previous Committees/TLT** |
|---|
| |

Gloucestershire Hospitals
NHS Foundation Trust

# Report to the Trust Board

## Financial Performance Report
## Month Ended 31st March 2021





Gloucestershire Hospitals
NHS Foundation Trust

**System Position as at Month 12**

The Gloucestershire System ended the year with a surplus below the £100k requirement. The Trust's position was in line with the month 11 forecast so ended the year with a provision £22k surplus.

**Month 12 overview**

Month 12 reports a £0.04m surplus in month, compared to £4.42m expected deficit = £4.46m better than forecast in month.

Activity was up 21% month on month, and we delivered 20% more activity than we had planned for in March.

## Month 12 headlines

Gloucestershire Hospitals NHS Foundation Trust

| Headline | Better or Worse Compared to plan | Narrative | Change from last month |
|---|---|---|---|
| I&E Position full year is £0.02m surplus |  | Overall YTD financial performance is £0.02m surplus. This is £14.69m better than plan. The improvement is due to most of our original deficit forecast being funded through extra income from NHSEI. |  |
| Income is better than plan at £685.0m full year . |  | YTD £47.39m better than plan, due to new system funding allocations since the plan was submitted, as well as Covid (outside envelope) funding, better-than-expected private patient, overseas, road traffic accident and pass-through drugs income. |  |
| Pay costs are higher than plan at £434.66m full year . |  | YTD this is £19.3m higher than plan. This is due the national pension contributions funded centrally at M12, plus an annual leave provision to cover staff time that will need to be covered at premium cost in 2021/22. |  |
| Non-Pay expenditure is more than plan at £241.36m full year. |  | YTD this is £13.88m higher than plan. This is partly due to activity with related income (eg Covid outside envelope and pass-through drugs), but also a review of our I&E and balance sheet to ensure we have sufficient prudence in the position to reflect current costs. |  |
| CIP schemes are 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 is ongoing, and is identifying CIP for 2021/22 (£5.2m as at M12). |  |
| The cash balance is £77.92m |  | Cash is £71.5m ahead of plan. Alongside more income than plan, cash spend has been less than plan, while our balance sheet and I&E review has been largely accruals-based to ensure prudence. |  |

## YTD True-Up Funding agreed by NHSE

Gloucestershire Hospitals NHS Foundation Trust

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 and other overspends of £2.5m compared to the nationally-calculated block funding.

In Month 12, NHSE paid us for the £4.2m Gen Med true-up from Month 5. If we were to win in our appeal against HMRC, this value would need to be repaid to NHSEI, and we would release our provision.

| 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 Paid | 4,200 |
| True-Up M06 Paid | 5,145 |
| ***Grand Total (Revised) True-Up YTD - all paid*** | **21,881** |

## Month by Month Trend

Gloucestershire Hospitals NHS Foundation Trust

Month 12 has seen an in-month movement for all categories, compared to previous months. This is due to national allocations of additional funding to cover our adjusted forecast outturn, as well as a national adjustment for pension contributions that are paid for and funded centrally.

Covid costs have dropped £0.2m month-on-month to £1.5m, with outside-funding envelope elements remaining at approximately £0.5m per month. The £2.6m full year outside envelope income for Covid relates to the SIREN study £0.1m, the regional testing centre £1.6m and the mass vaccination centres £0.9m

Non-operating costs and the impact of donated assets have shown benefits in month. This is due to the work done to ensure the balance sheet is up to date for our annual accounts.

| Consolidated Run Rate Actuals | 20/21 £'000 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M01 | M02 | M03 | M04 | M05 | M06 | M07 | M08 | M09 | M10 | M11 | M12 | Full Year Actuals |
| Pay | 31,315 | 32,229 | 32,550 | 31,839 | 33,432 | 34,174 | 33,654 | 33,549 | 33,955 | 33,536 | 33,434 | 58,159 | 421,827 |
| Non Pay | 16,407 | 13,855 | 15,843 | 17,418 | 21,004 | 17,569 | 23,324 | 18,709 | 18,766 | 19,614 | 19,101 | 28,985 | 230,594 |
| Covid Costs (in envelope) | 2,114 | 3,757 | 2,835 | 2,334 | 1,119 | 1,614 | 691 | 693 | 1,129 | 1,447 | 1,727 | 1,504 | 20,964 |
| Covid Costs (outside envelope) | | | | | | | 192 | 87 | 458 | 820 | 553 | 531 | 2,641 |
| Non-operating Costs | 855 | 991 | 1,072 | 946 | 1,004 | 129 | 745 | 767 | 338 | 750 | 743 | (148) | 8,192 |
| Remove impact of Donated Asset Depreciation / impairments | (37) | (37) | (37) | (38) | (37) | (37) | (37) | (37) | (37) | (37) | (37) | 1,158 | 750 |
| Total Cost | 50,654 | 50,796 | 52,263 | 52,499 | 56,522 | 53,449 | 58,569 | 53,767 | 54,609 | 56,130 | 55,521 | 90,189 | 684,968 |
| Run Rate Funding / Billable Income | (48,897) | (49,027) | (48,452) | (48,872) | (50,748) | (48,304) | (54,113) | (54,678) | (53,767) | (55,078) | (58,828) | (89,702) | (660,466) |
| Covid Income (outside envelope) | | | | | | | (40) | (10) | (677) | (816) | (568) | (530) | (2,641) |
| **Total (Surplus) / Deficit** | **1,757** | **1,769** | **3,811** | **3,627** | **5,774** | **5,145** | **4,416** | **(921)** | **165** | **236** | **(3,875)** | **(43)** | **21,861** |
| True-up Funding | (1,757) | (1,769) | (3,811) | (3,627) | (5,774) | (5,145) | 0 | 0 | 0 | | | | (21,883) |
| **Grand Total (Surplus) / Deficit** | **0** | **0** | **0** | **0** | **(0)** | **0** | **4,416** | **(921)** | **165** | **236** | **(3,875)** | **(43)** | **(22)** |

## M12 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS Foundation Trust

| Month 12 Financial Position | M12 Plan £000s | M12 Actuals £000s | M12 Variance £000s | M12 Cumulative Plan £000s | M12 Cumulative Actuals £000s | M12 Cumulative Variance £000s |
|---|---|---|---|---|---|---|
| SLA & Commissioning Income | 49,664 | 71,318 | 21,654 | 550,783 | 566,615 | 15,832 |
| PP, Overseas and RTA Income | 206 | 346 | 140 | 2,624 | 3,475 | 851 |
| Other Income from Patient Activities | 55 | 60 | 5 | 441 | 814 | 373 |
| Operating Income | 3,654 | 18,508 | 14,854 | 83,752 | 114,086 | 30,334 |
| **Total Income** | **53,579** | **90,232** | **36,653** | **637,600** | **684,990** | **47,390** |
| **Pay** | | | | | | |
| Substantive | 33,964 | 47,909 | 13,945 | 371,531 | 387,951 | 16,421 |
| Bank | 2,445 | 9,508 | 7,063 | 25,083 | 29,931 | 4,848 |
| Agency | 1,914 | 1,886 | (28) | 18,742 | 16,783 | (1,959) |
| **Total Pay** | **38,323** | **59,303** | **20,980** | **415,356** | **434,666** | **19,310** |
| **Non Pay** | | | | | | |
| Drugs | 6,216 | 7,360 | 1,144 | 72,674 | 74,312 | 1,638 |
| Clinical Supplies | 7,313 | 15,889 | 8,576 | 78,032 | 89,197 | 11,165 |
| Other Non-Pay | 5,353 | 6,547 | 1,194 | 76,779 | 77,771 | 992 |
| **Total Non Pay** | **18,882** | **29,796** | **10,914** | **227,485** | **241,280** | **13,795** |
| **Total Expenditure** | **57,205** | **89,099** | **31,894** | **642,841** | **675,946** | **33,105** |
| **EBITDA** | **(3,626)** | **1,133** | **4,759** | **(5,241)** | **9,044** | **(14,285)** |
| **EBITDA %age** | **(6.8%)** | **1.3%** | **(8.0%)** | **(0.8%)** | **1.3%** | **(2.1%)** |
| Non-Operating Costs | 833 | (68) | (901) | 9,869 | 8,272 | (1,597) |
| **(Surplus)/Deficit** | **4,459** | **(1,201)** | **(5,660)** | **15,110** | **(772)** | **(15,882)** |
| Fixed Asset Impairments | 0 | 433 | 433 | 0 | 433 | 433 |
| **(Surplus)/Deficit after Impairments** | **4,459** | **(1,634)** | **(6,093)** | **15,110** | **(1,205)** | **(16,315)** |
| Remove impact of donated assets and grants | (117) | 1,592 | 1,709 | (445) | 1,183 | 1,628 |
| **(Surplus)/Deficit** | **4,342** | **(42)** | **(4,384)** | **14,665** | **(22)** | **(14,687)** |

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

**PP / Overseas / RTA Income** – This was forecast on the basis of M1-6, but recovered more than expected in the second half of the year.

**Other Operating income** – This 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** – up against plan in month due to the national pension contribution and an annual leave accrual to cover the days staff were unable to take during Covid.

**Non-Pay** – above plan, mainly due to additional prudence accruals and provision reviews.

## Balance Sheet

| Trust Financial Position | Opening Balance 31st March 2020 £000 | GROUP Balance as at M12 £000 | B/S movements from 31st March 2020 £000 |
|---|---|---|---|
| **Non-Current Assests** | | | |
| Intangible Assets | 5,851 | 8,280 | 2,429 |
| Property, Plant and Equipment | 257,352 | 276,161 | 18,809 |
| Trade and Other Receivables | 5,889 | 5,761 | (128) |
| **Total Non-Current Assets** | **269,092** | **290,202** | **21,110** |
| **Current Assets** | | | |
| Inventories | 9,121 | 8,933 | (188) |
| Trade and Other Receivables | 31,268 | 18,443 | (12,825) |
| Cash and Cash Equivalents | 37,385 | 77,918 | 40,533 |
| **Total Current Assets** | **77,774** | **105,294** | **27,520** |
| **Current Liabilities** | | | |
| Trade and Other Payables | (79,872) | (104,060) | (24,188) |
| Other Liabilities | (3,401) | (8,540) | (5,139) |
| Borrowings | (132,582) | (3,860) | 128,722 |
| Provisions | (170) | (162) | 8 |
| **Total Current Liabilities** | **(216,025)** | **(116,622)** | **99,403** |
| **Net Current Assets** | **(138,251)** | **(11,328)** | **126,923** |
| **Non-Current Liabilities** | | | |
| Other Liabilities | (6,484) | (6,517) | (33) |
| Borrowings | (40,609) | (36,982) | 3,627 |
| Provisions | (2,850) | (2,889) | (39) |
| **Total Non-Current Liabilities** | **(49,943)** | **(46,388)** | **3,555** |
| **Total Assets Employed** | **80,898** | **232,486** | **151,588** |
| **Financed by Taxpayers Equity** | | | |
| Public Dividend Capital | 179,302 | 332,033 | 152,731 |
| Reserves | 29,891 | 27,976 | (1,915) |
| Retained Earnings | (128,295) | (127,523) | 772 |
| **Total Taxpayers' Equity** | **80,898** | **232,486** | **151,588** |

Gloucestershire Hospitals NHS Foundation Trust

The table shows the M12 balance sheet and movements from the 2019/20 closing balance sheet.

# Cash flow: March

Gloucestershire Hospitals NHS Foundation Trust

| Cashflow Analysis | Apr-20 £000s | May-20 £000s | Jun-20 £000s | Jul-20 £000s | Aug-20 £000s | Sep-20 £000s | Oct-20 £000s | Nov-20 £000s | Dec-20 £000s | Jan-21 £000s | Feb-21 £000s | Mar-21 £000 | Outturn £000s |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Surplus (Deficit) from Operations | 818 | 954 | 1,035 | 908 | 967 | 92 | (3,708) | 2,602 | (271) | (65) | 4,579 | 1,133 | 9,044 |
| Adjust for non-cash items: | | | | | | | | | | | | | 0 |
| Depreciation | 1,509 | 1,509 | 1,509 | 1,509 | 1,509 | 1,509 | 1,509 | 1,509 | 1,509 | 1,509 | 1,509 | 1,094 | 17,693 |
| Impairments within operating result | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 433 | 433 |
| Other operating non-cash | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,717 | 1,717 |
| Operating Cash flows before working capital | 2,327 | 2,463 | 2,544 | 2,417 | 2,476 | 1,601 | (2,199) | 4,111 | 1,238 | 1,444 | 6,088 | 4,377 | 28,887 |
| Working capital movements: | | | | | | | | | | | | | |
| (Inc.)/dec. in inventories | 221 | 232 | (57) | (152) | 116 | (429) | 157 | 41 | (215) | 510 | (105) | (131) | 188 |
| (Inc.)/dec. in trade and other receivables | (4,178) | 10,065 | (797) | (7,991) | 1,749 | (2,843) | (4,979) | 16,338 | 2,737 | (5,423) | 2,312 | 5,835 | 12,825 |
| Inc./(dec.) in current provisions | 0 | 0 | 0 | 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 | (4,927) | 1,119 | 4,722 | 7,255 | 13,561 | 24,188 |
| Inc./(dec.) in other financial liabilities | 7,099 | (4,559) | 41,320 | (1,168) | 2,140 | 1,665 | (4,988) | 7,417 | (1,687) | (4,299) | 2,212 | (40,013) | 5,139 |
| Net cash in/(out) from working capital | 38,294 | 509 | (3,572) | (2,201) | 6,508 | 1,420 | (5,877) | 18,869 | 1,954 | (4,490) | 11,674 | (20,748) | 42,340 |
| Capital investment: | | | | | | | | | | | | | |
| Capital expenditure | (1,667) | (1,667) | (1,729) | (882) | (1,737) | (2,149) | (1,417) | (4,584) | (807) | (1,021) | (5,345) | (17,182) | (40,187) |
| Capital receipts | 0 | 0 | 0 | 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) | (4,584) | (807) | (1,021) | (5,345) | (17,182) | (40,187) |
| Funding and debt: | | | | | | | | | | | | | |
| PDC Received | 0 | 0 | 0 | 353 | 0 | 127,860 | 0 | 6,258 | 0 | 0 | 0 | 18,260 | 152,731 |
| Interest Received | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| Interest Paid | 0 | 0 | 0 | 0 | (658) | (525) | 0 | 0 | 0 | 0 | 0 | (658) | (1,841) |
| DH loans - received | 0 | 0 | 0 | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DH loans - repaid | 0 | 0 | 0 | 0 | 0 | (129,180) | 0 | 0 | 0 | 0 | 0 | (865) | (130,045) |
| Finance lease capital | (95) | (95) | (95) | (488) | (488) | (488) | (488) | (488) | (488) | (488) | (488) | (488) | (4,677) |
| Interest element of Finance Leases | (17) | (17) | (17) | (12) | (12) | (12) | (13) | (13) | (13) | (13) | (13) | (13) | (165) |
| PFI capital element | (43) | (43) | (43) | (68) | (68) | (68) | (68) | (68) | (68) | (68) | (68) | (68) | (741) |
| Interest element of PFI | (182) | (182) | (182) | (38) | (38) | (38) | (38) | (38) | (38) | (38) | (38) | (38) | (888) |
| PDC Dividend paid | | | | | | 0 | | (1,040) | | | | (3,852) | (4,892) |
| Net cash in/(out) from financing | (326) | (337) | (337) | (253) | (1,264) | (2,451) | (607) | 4,611 | (607) | (607) | (607) | 12,278 | 9,493 |
| Net cash in/(out) | 38,628 | 968 | (3,094) | (919) | 5,983 | (1,579) | (10,100) | 23,007 | 1,778 | (4,674) | 11,810 | (21,275) | 40,533 |
| | | | | | | | | | | | | | |
| Cash at Bank - Opening | 37,385 | 76,013 | 76,981 | 73,887 | 72,968 | 78,951 | 77,372 | 67,272 | 90,279 | 92,057 | 87,383 | 99,193 | 37,385 |
| Closing | 76,013 | 76,981 | 73,887 | 72,968 | 78,951 | 77,372 | 67,272 | 90,279 | 92,057 | 87,383 | 99,193 | 77,918 | 77,918 |

**Cashflow Key movements:**

The Cash Position – reflects the Group position.

In month 12 we have received further PDC to fund specific capital projects.

We received non cash donations of capital equipment of £1,717. this was received from both the Gloucestershire Hospitals Charity and the DOH as part of its COVID response.

The receivables balance this year is lower than normal as the majority of our payments this year have been directly made rather than invoiced.

## Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a full year surplus of £0.02m, £14.69m better than the planned £14.67m deficit.
- Note that the Gloucestershire system is reporting breakeven

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

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

**Date:** **April 2021**

Gloucestershire Hospitals
NHS Foundation Trust

**REPORT TO TRUST BOARD – May 2021**

**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 29 April 2021, 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 |
|---|---|---|---|---|
| **Planning Update** | Briefing from Operations and Finance on the requirements, approach, process and status of the 21/22 plan which has to be submitted on May 7th. This was work in progress and covered multiple scenarios. | Detailed questions about the activity levels, financial consequences and the system wide view of their implications including the gap between what is deliverable and national expectations in each scenario. | At this point in the process the Trust has a c. £5million challenge to address but there remains significant work to be done to finalise the required inputs and close the gap.<br><br>The committee was assured of the thoroughness and robustness of the approach to date. | Further review meeting scheduled for May 6th to allow scrutiny and approval ahead of the submission date. |
| **Financial Performance Report** | 12th month and year-end financial results presented and explained. Key points being:<br>- A small surplus (c. £20k) in year i.e. meeting the national expectation to break even | What, if any, impact will the national pension adjustment (employers' contribution moves from 14% to 20.3%) have on the 21/22 budgets? | No local budgeting impact as this will continue to be handled as a nationally mandated adjustment. At some future date the change will be reflected in Trust level detailed budgets but funding will | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | - Explanations of reserves and exceptional entries e.g. annual leave provision<br>- Positive cash balance<br>- Month on month activity increase (20%)<br>- Improved payment performance | Have year-end balances been agreed with partner organisations? | flow to offset.<br>Yes. Some minor differences had been settled resolved as part of the first half true up process.<br>The Team was commended on achieving a break even position and thanked for their hard work in what has been a very turbulent year. | |
| **Capital Programme Report** | Summary of total 20/21year spend - as planned at £43.5 million including grants and charity funded d equipment.<br>21/22 planned expenditure analysed by projected with a current projected total of £57.5 million from all sources | Explanation requested of year to year accrual adjustment with a c. £1.8 million favourable impact | Correcting entry process applied and described including use of national guidance – committee assured<br><br>Overall the committee was assured of the robustness of capital control and monitoring that is now in place and looks forward to seeing this improved discipline providing a smoother spending pattern and more tightly controlled process in 21/22 | As previously described there will be a continuing focus on project management capability |
| **Update on GENMED VAT Challenge with HMRC** | Finance Director provided an update on the status of this ongoing challenge | | The Committee was assured that there is a clear understanding of the process and associated issues and acknowledged | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | | | the uncertainty around time to reach a conclusion | |
| **Overseas Patient Charging and Procedures** | Comprehensive presentation and supporting material to update the committee on the current processes and associated cash recovery position in respect of overseas patients and eligibility for NHS treatment.<br>Overall performance is among best in class when compared to NHSI defined peers<br>Strong link to specific write-off reports presented at Audit and Assurance | What procedural changes that are not in the control of the department would improve the process and outcome?<br><br>Is there an impact from Brexit?<br><br>Given the challenging nature of the conversations and associated communication does the team encounter unacceptable behaviour? | The key element is access to real time data with delayed entry making recovery more difficult. This is not unique to this system and comprehensive prompt data entry is an active Trust objective as the move to digital gathers pace<br>Current circumstance due to Covid have reduced activity and the European Health Insurance Cards are still accepted. Future impact will need monitoring<br>Some "disgruntled individuals" are encountered but the majority of staff are supportive of the role that the team has to fulfil. | |
| **Financial Sustainability** | Further update on the approach to driving financial sustainability with emphasis on transformation leading to quality improvement and efficiency in place of a narrow cost reduction focus. | | Committee understands and supports the direction of travel and acknowledges that Covid related demands have limited progress at this stage. | Monthly review will continue with evolving project detail focus in future months. |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | Summary of key projects. | | | |
| **Digital Programme Report** | Full project update report presented highlighting:<br>• The Minor Injury and Illness Unit at Cheltenham went live with full Electronic Patient Record (EPR) functionality (clinical documents, order comms and e-observations) on 24 March<br>• A new pharmacy stock control system (EMIS) went live on Wednesday 7 April<br>• The latest Sunrise patch release was needed to fix existing issues with EPR tracking boards which has resource implications<br>• The need to upgrade the version of EPR in use to enable full and effective implementation of electronic prescribing and medicines administration (EPMA) with resulting delays of four to 6 months in EPMA's implementation | Does EPR upgrade adversely impact the implementation of projects other than EPMA or have consequences for the Trust's Digital Aspirant funding award?<br><br>When should the committee see a further detailed update on cyber security? | No, while electronic prescribing will be delayed other projects will be advance in parallel confining the delay to EPMA<br><br>The Committee continues to be assured that sound project management and monitoring is in place | Date to be set for review |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | • The Business Intelligence team had been successful in being selected to work on an Artificial Intelligence project with the NHSX AI Skunkworks Project to develop algorithms that could identify patients at risk of a long hospital stay. | | | |

**Rob Graves**
**Chair of Finance and Digital Committee**
**6th May 2021**

Gloucestershire Hospitals NHS Foundation Trust

**Public Trust Board – 13 May 2021**
**Microsoft Teams – Commencing at 12:30**

| **Report Title** |
|---|
| **People and Organisational Development Report** |
| **Sponsor and Author(s)** |
| Authors: Alison Koeltgen, Operational Director of People and Organisational Development, Abigail Hopewell, Head of Leadership and OD, Coral Boston, EDI Lead, Lee Troake Corporate Risk and Health and Safety Manager and Emma Wood, Deputy CEO and Director of People and Organisational Development.<br><br>Sponsoring Director: Emma Wood, Deputy CEO and Director of People and Organisational Development |
| **Executive Summary** |

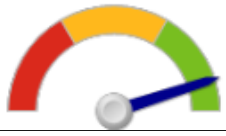
**Purpose**

This report provides the Board with an update on:

- Key performance metrics as measured through the performance dashboard;
- An overview of staff survey results and the impact these have had on our People and OD strategic objectives inclusive of an overview of some new approaches to bullying and harassment which seek to make substantial change in this theme;
- An overview of new governance arrangements and ambitions for reducing violence and aggression incidents (following a recent BDO audit and staff survey results).

**Performance Dashboard**

The Performance dashboard aligns to the strategic and operational measures identified within the People and Organisational Development Strategy. Key measures detailed within the overview at the end of this report and in Annex 1 are benchmarked (where appropriate) to Model Hospital Peer rates and University Hospital/ Teaching Peer rate. The indicators include:

| | |
|---|---|
| Retention, Turnover, Vacancy |  |
| Appraisal |  |
| Mandatory Training |  |
| Sickness Absence |  |

The dashboard indicates that performance across the Trust is Green against strategic measures in 3 themes and amber in 1. **A detail analysis of performance is at the end of this report** and SPC Charts and trend descriptors linked to all dashboard indicators are located in Annex 1

A Job plan completion report is included and detail provided as Annex 2. Previous outliers are showing some improvement (notably vascular has increased from 14% compliance to 57%). Current outliers are: Dermatology, Cardiology and Colorectal. Job planning has been impacted by the changes in service provision during the pandemic and improvements form part of the restoration and recovery plan. Divisions are held to account for job planning compliance in monthly executive reviews.

**Staff survey**

The full analysis of the report and actions planned to improve ratings is provided at Annex 3.

The key issues to note from the staff survey are as follows:

- Response rate 48%, which is 1% lower than 2019 although more 30 more colleagues completed the survey in 2020. This includes at 22% increase in the response rate from ethnic minority colleagues.
- Of the five themes identified in the People and OD strategy as priority areas, we remain below target across all of these. Two theme scores have improved (Health & Wellbeing; Morale); two have remained the same, and one has dropped (Equality Diversity and Inclusion). **A visual representation of progress is at the end of this report.**
- Statistically significant improvement in the Health & Wellbeing theme; improvements in two other themes (Morale; Violence)
- Scores dropped in two themes (not statistically significant): Equality Diversity and Inclusion; Team Working
- Significant improvements in the Staff Friends and Family test questions relating to recommending the Trust as a place to work, and being happy with standard of care of family/friend treated here.
- The report has increased focus on the Bullying and Harassment theme as an important indicator of culture and behaviours, which reflects our increased attention on developing a compassionate and inclusive culture.
- All staff groups present a mixed picture of performance, with above and below average scores against at least one theme. The exception to this is Additional Prof Scientific tech staff group which performs equal to, or above, the trust average for all themes.
- From a divisional perspective, Diagnostics and specialities, Surgery and Women's and Children present a mixed picture of performance. Corporate division performance is equal to or above average for all themes. Medicine division performance is below average for all themes.
- The report provides more detailed analysis of strengths and areas of concern for each division, including identification of departments/cost centres which overall have the most negative question responses across the staff survey. This is accompanied by high-level action plans/priorities which each division will focus on in the year ahead to address these areas.
- Our performance has been compared against acute Trusts with CQC Outstanding ratings and this will inform some of the actions and research we will undertake in the year ahead.
- The report highlights our performance against the experience indicators in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Overall the WRES statistics paint a concerning picture and underlines the importance of the work we have been doing to progress the EDI agenda, including forthcoming outcomes and recommendations identified in the Big Conversation/Widening Participation Review. The WDES indicators present more of a mixed picture with encouraging improvements in some areas.
- Further detailed analysis has been carried out against other protected characteristics, including ethnicity. Reviewing Ethnicity data in granular detail illustrates the stark contrast in experience between e.g. Asian and Black colleagues. We have also identified stark contrasts in experience between our older and younger workforce.
- We have described our intentions to develop a 'cultural barometer' which combines the staff survey data with other data sources (both hard and soft) which can provide an holistic picture of cultures within and across different departments, cost centres and staff groups. This is something we will progress in 21/22.

- The two-year staff survey action plan which was agreed last year has been updated to show what progress has been made against the four priorities in spite of the pressures of COVID-19, and lists specific actions we want to achieve in the year ahead. The four priorities are:
    - Develop and strengthen our compassionate culture
    - Proactively address bullying, harassment and discrimination experienced by colleagues through the introduction of 'respectful resolutions' and mediation as a formal part of the complaints process, as recommended by DWC (see section 4.2 of annex 3 for further information)
    - Continue to improve experience of appraisals and access to education and talent development opportunities
    - Continued focus on the safety, health and wellbeing of colleagues

**Violence and Aggression**

The staff survey demonstrated some positive improvements in report of violence and aggression (V&A) however following a recent BDO audit changes have been made to the governance of V&A to improve the actions the Trust will take to support colleagues. A three year plan to improve V&A has been provided and will be measured through the new a V&A group which comprises of a broad range of experts recognising the influencing factors in the presentation of V&A such as the complexity of clinical conditions, clinical assessments, our physical environment, staff competency and supporting resources and equipment. The full report is Annex 4

**Next steps:**

The People and OD Directorate and People and OD Delivery Groups within the governance structure will continue to monitor performance against the strategic and operational People and OD dashboard measures. Check and challenge of these measures and staff survey action planning will take place as part of the Executive review process. Each division has a Leadership and OD resource aligned to the HRBP to allow for multidisciplinary support for the staff survey plans and assist to refine divisional plans to ensure these are SMART.

The Leadership and OD team will seek to learn from CQC Outstanding trusts which are performing the most highly in each of the five People and OD strategic priority themes. In addition this team will seek to develop the pilot cultural barometer/Insights framework supporting the DWC Big conversation report findings.

The respectful resolutions programme will commence with a change in policy and practice to ensure mediation becomes part of the complaints process. The ambition is this will serve to improve colleague experience especially of bullying and harassment.

The reduction of violence and aggression incidents and the solution building to reduce these will form part of the Health and Safety committee work plan and reporting cycle. This will be further reported to the People and OD committee as part of the Health and Safety agenda items.

Investments in new People and OD posts for the financial year 2021-2022 will provide additional resource to enable the Trust to reach its ambitions specifically in the Inclusion and colleague experience agenda.

**Recommendations**

**Performance report**: It is recommended that the Board are assured that three of the four key indicators are green. It is recognised that appraisal rates will be impacted by the challenges of working through a pandemic, however divisions remain focused in their efforts to improve these rates. Sufficient controls exist to monitor performance against key workforce priorities as articulated in the People and Organisational Development Strategy. Where operational improvements are required, actions are fed into the appropriate workstreams, monitored by the People and Organisational Development Delivery Group. Where Divisional exceptions are highlighted this is challenged and monitored through the Executive Review process.

**Staff survey:** The Board is asked to note the results and analysis undertaken and take assurance from the progress update against the 2-year trust-wide action plan. Further the Board is asked to be assured that work is underway to address the findings and make improvements at both Trust-wide and divisional level over the next 12 months especially with Bullying and harassment.

**Violence and Aggression**: It is recommended the Board are assured that a robust governance structure in now in place to manage and monitor the risk of Violence and aggression and a comprehensive multidisciplinary programme has been developed with a view to preventing and reducing V&A incidents

**Impact Upon Strategic Objectives**

This report reflects known pressures and priorities relating to the delivery of a compassionate, skilful and sustainable workforce, organised around the patient that describes us as an outstanding employer who attracts, develops and retains the very best people. The staff survey also impacts upon the Involved People objective.

Health and Safety issues can impact upon our objectives in relation to outstanding care and quality improvement. The Trust cannot provide consistent and best practice care if the Trust is not compliant with safety regulations, nor can we achieve improvements in quality if agreed practice and procedures are not followed.

**Impact Upon Corporate Risks**

Workforce stability is a critical part of our plans to mitigate the risk associated with the limited supply of key occupational groups such as Nurses, AHPs and Medical staff. We are on track to achieve the measures outlined within our People and OD strategy, whilst recognising the risks and issues associated with turnover in key roles/ departments.

The delivery of the actions within the staff survey report seek to mitigate the risks on the People and OD risk register relating to staff engagement and inclusion.

**RiskC2803POD:** The risk that colleague motivation and engagement at work is eroded by significant external events and/or workplace experiences, which in turn impacts upon workplace effectiveness and patient safety.

Failure to provide a safe working environment can result in a risk to patient, public and staff safety and could result in financial implications (fines) or the need to make work-based improvements and investments. Failure to provide a safe environment for staff could become a reputational risk.

**Regulatory and/or Legal Implications**

The report are designed in such a way to provide assurance that the Trust are operating in accordance with:
NHSI/E requirements
Best practice and employment legislation, including the Equality Act.
The aspirations of the NHS People Plan.
Health and Safety legislation.

**Equality & Patient Impact**

There is a known researched link between employee experience, stability, retention and patient experience. The People and Organisational Development Strategy promotes a culture of 'caring for those who care', who in turn will enhance the experience of our patients.

There will be a positive impact on patients and staff if workplace safety is improved.

The staff survey results give insight to the experiences of our colleagues. Results can be viewed

| against certain protected characteristics, and also inform the annual WRES and WDES submissions. | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Resource Implications** | | | | | | | |
| Finance | √ | Information Management & Technology | | | | | |
| Human Resources | √ | Buildings | | | | | |
| | | | | | | | |
| **Action/Decision Required** | | | | | | | |
| For Decision | | For Assurance | √ | For Approval | | For Information | √ |

| **Date the paper was presented to previous Committees** | | | | | | |
|---|---|---|---|---|---|---|
| **Quality & Performance Committee** | **Finance Committee** | **Audit & Assurance Committee** | **People and OD Committee** | **Remuneration Committee** | **Trust Leadership Team** | **Other (specify)** |
| | | | 27th April 2021 | | | |
| **Outcome of discussion when presented to previous Committees** | | | | | | |
| **Performance dashboard:** The committee were assured with progress made and asked for further assurance on job planning compliance and future innovations to the dashboard. The committee noted the intention to create a Just and Learning culture dashboard to assist in embedding the new approach to managing Employee Relations cases<br><br>**Staff Survey:** The committee were assured of the detail of the report following the analysis of the raw data in February 2021. The committee asked for an overview of the plans to introduce pulse surveys to reduce the time lag between completing the survey and attaining the results. A plan for pulse surveys and the Insights/cultural barometer development was shared. How to seek engagement from some colleagues who appeared to be less likely to engage was discussed and a view held that the current interventions needed to embed and there was a view that the WRES data in 2021 might demonstrate some shifts in experience.<br><br>**Violence and Aggression audit**: The committee were assured by the new governance processes and noted that the Corporate Risk Manager/Health and Safety Manager did not support one of the BDO audit recommendations regarding lack of support to staff involved in incidents. It was noted that additional information and support provided had not been seen by the auditors. The committee welcomed the 3 year plan for measuring changes to incidents and asked for a future report to outline how the new governance processes were embedding. | | | | | | |

Gloucestershire Hospitals
NHS Foundation Trust

| PERFORMANCE DASHBOARD SUMMARY AND INSIGHTS | | |
|---|---|---|
| **WORKFORCE SUSTAINABILITY - Vacancy Factor and Supply Pipelines** | | |
| **Strategic Measure** | **Performance** | **Exception Report** |
| Reduce Vacancy factor from 9% to 5% (long term plan) reduce by 0.75-1% per annum as a minimum.<br><br>Improve attraction and pipeline of Nurses – establish a pipeline that looks to improve the supply of Nurses by 5-10% annually. |  <br>For full performance trend see SPC charts appendix 1 | The February vacancy rate was recorded at 5.63%; a reduction to the last reported rate of 6.07%. This rate has been calculated from establishment data loaded onto ESR. It is recognised that this data requires ongoing reconciliation to the purchase ledger and that accurate vacancy capture continues to be a challenge as areas have reconfigured staffing to support the pandemic and recovery phases.<br><br>The % Rate represents 392 vacancies Trustwide, a decrease of approximately 30 vacancies since the November figures reported to PODC in December. We remain on track to meet the long term strategic measure. (See Tab 2 of annex 1 for detailed trend information).<br><br>**Nurse Vacancies**<br>Using ESR establishment data the combined February Staff Nurse/ODP vacancy rate is 13.75, compared to 15.26% in December 2020. Registered Nursing & Midwifery as a staff group has a vacancy rate of 8.58% (196 vacancies). Medicine Division has a VR of 21% (99 vacancies) Surgery has a VR of 6.49% (38 vacancies).<br><br>**Medical Staffing**<br>The Medical staffing vacancy rate is reported at 2.12 %, translating to a shortfall of 19.3 fte.<br><br>**D&S Division**<br>Radiography has the highest vacancy rates but this is continuing to reduce with a further reduction from 17.84 FTE (vacancy rate 15.19%) to 11.98 FTE ( vacancy rate 9.41%). Departmental support is in place to ensure new recruits have good induction and training. The Division is working with the Yeovil international recruitment team, 10 Band 5 posts were offered in January, these start dates are being finalised. The first cohort of Radiography trainees from Gloucestershire University commenced in January, which signalled a positive step for our long term recruitment strategy. |

| | | |
|---|---|---|
| **WORKFORCE SUSTAINABILITY - Turnover** | | |
| Reduce Turnover to meet top quartile in model hospital. Aim in year 1 to achieve national median and in year 2 next best peer. By year 5 match best in model hospital peers (moving year on year target)<br><br>Reduce Health Care Assistant turnover from 15.5% to 10% **by 2024**, by reducing by 1% year on year.<br><br>Reduce Admin and Clerical turnover from 13% to 10% **by 2024**, by reducing by 0.75% year on year. |  <br>For full performance trend see SPC charts, appendix 1 | The rolling annual turnover rate shows a consistent gradual decrease since 2019 and is reported at 9.53%, placing the Trust in the top quartile for retention when benchmarked to the Model Hospital Peer Group. Registered Nurse Retention figures remain consistently higher than Model Hospital Peers and show a gradual improvement during 2020.<br><br>It is fair to reflect that we do not yet know the impact that reducing Covid numbers will have on turnover in the long term; however we do know that during the past 12 months turnover has remained low as some staff have chosen to delay retirement plans / pause planned career moves - staying with the Trust to support our response to the pandemic; therefore it is reasonable to assume that our turnover could increase as we continue into a period of recovery.<br><br>**Non-Registered Nurse Turnover** has reduced further to 12.05 (compared to 16.46% in March 2020), keeping us on track to achieve our long term strategic measure of a reduction to 10% by 2024. **Medicine Division** has the highest Turnover rate for non-registered nursing staff at 15.44% (Feb 21), However this figure has reduced significantly in the past six months. The People and OD Committee will receive a more detailed update regarding the Divisions progress on key workforce priorities during the April 2021 meeting. By comparison and to give this figure context, the Women & Children turnover rate is 10.15% and Surgery is reported at 10.07%. |

| Operational Measure | Performance | Exception Report |
|---|---|---|
| Appraisal 90% |  <br>For full performance trend see SPC charts appendix 1 | Trust Appraisal rate is currently 80%, falling below the 90% target.<br><br>The lowest Divisional Appraisal rate is Corporate at 77%. This is the Division which will have the highest proportion of staff working from home. No Division has reached target**, The Medicine Division has the highest rate with 84%.**<br><br>**Diagnostic & Specialties** recovery plans have supported a further increase in Division to 84% compliance. |

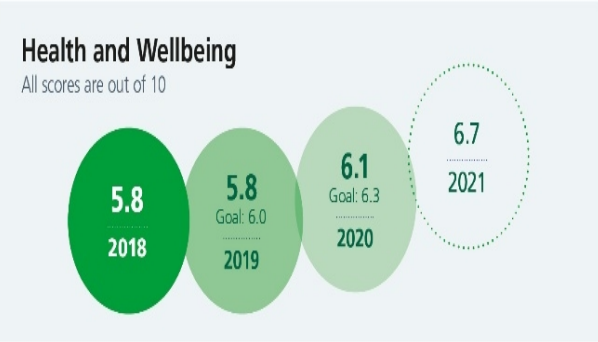
| | | |
|---|---|---|
| | | **Women and Children's** appraisal rates have reduced to 81%, the Division continue to scrutinise recovery plans.<br><br>**Surgery**, rates reflected a temporary improvement, however have since reduced to 82%<br><br>**Medicine Division** Appraisal rates for the division have varied between 85-87% in the last 6 months and currently report at **83% compliance**. |
| Statutory/Mandatory Training 90% |  <br>For full performance trend see SPC charts, appendix 1 | Trust compliance overall remains high at 92%, supported by the increased digitalization of programmes using more videos and eLearning. **All divisions have achieved the target of 90%,** ranging from medicine at 91% to 95% by both Corporate and D&S.<br>Equality and Diversity, Health and Safety Awareness, Infection Control level 1 and Safeguarding adults and children L1 are all at 100%. Having embarked on a Virtual Learning Project in June 2020, the education centres are being upgraded to support our ability to deliver and receive more courses face to face, *virtually* through the purchase of headsets, webcams, licenses to aid delivery such as SLiDO and three soundproof acoustic pods to be built in the library quiet room. Areas for concern this month are the reduced overall compliance of Medical Consultants AHPs and Healthcare Scientists – who usually score the highest compliance rates but show as amber across a majority of subjects. This drop is currently being investigated. The Medical Trainee group who have been our lowest scoring group for many years are now in green (over 90%) in all subjects demonstrating that the changes incorporated over recent years to move to the national system enabling a training passport is finally working.<br><br>One further issue to note: In 2021, the eLearning platform we have used for many years is undergoing a significant upgrade: This requires all eLearning programmes (cc 250) to be converted and will also lead to a significant price rise in license fees (over double). This has precipitated the need to move all eLearning away from Kallidus in the next year to the national learning platform linked to ESR and although there are many benefits in this (including in-time reporting data, improved WRES data), it is a less attractive platform and we anticipate some staff may find it harder to use initially. Communications and support is in place to support colleagues but we anticipate a small reduction in compliance as the moves are made. |

| Strategic Measure | Performance | Exception Report |
|---|---|---|
| Absence rate to meet best peers from model hospital and aim to reduce by 1% per annum |  For full performance trend see SPC charts, appendix 1 | **Non-Covid absence** remains low and below 2019 figures (3.49%). However, with Covid-19 sickness absence the rolling annual sickness rate is reported at 6.13%.<br><br>As reported to the P&OD Committee previously, during 2020 we observed a 7% increase to sickness absence related to mental health. We are preparing our staff support and wellbeing services for a continued increase to this trend during 2021 as we anticipate a rise in mental health concerns, exhaustion and staff experiencing the effects/ after effects of 'burnout'. We have successfully recruited to our new Psychology Link Worker posts, funded by NHS Charities together, and have integrated the former 'staff support' service into the People and OD Department, supporting the psychology link worker activity and face to face counselling support as required. In addition we are rolling out further training in TRiM for nominated TRiM Managers and Peer Support staff, whilst we prepare a trauma training package for managers (to be delivered by our new Psychology Link worker staff). |

## PEOPLE AND OD STRATEGY MEASURES/OBJECTIVES LINKED TO STAFF SURVEY RESULTS

The graphic below provides a view of progress against goals set as part of our People and OD strategy. Scores relate to staff survey results.

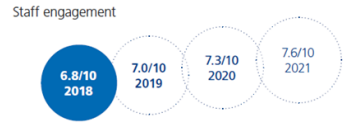


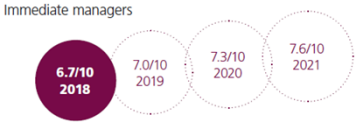




**Progress against People and OD strategic priorities**

In the People and OD Strategy 2019-24 we identified five staff survey themes where we would like to make significant progress by March 2022.

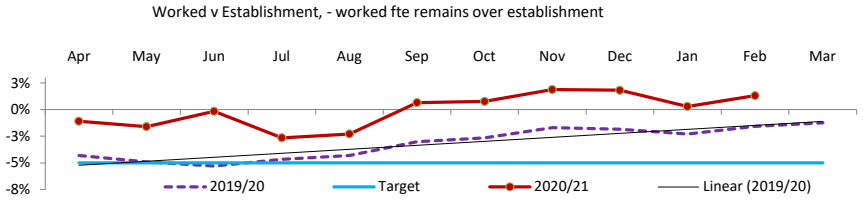
| Staff Survey Theme | Staff Survey 2018 | Staff Survey 2019 actual | Staff Survey 2020 target<br><br>RAG shows if on target | Staff Survey 2020 actual<br><br>RAG shows change since 2019 | Analysis |
|---|---|---|---|---|---|
| **Staff Engagement**<br>  | 6.8 | 6.9 | 7.3 | 6.9 | Score has remained stagnant and we are 0.4 below the 2020 target. This theme comprises 9 questions.<br>• There have been significant improvements in questions on recommending the organisation as a place to work/receive treatment.<br>Questions where the scores have dropped, thereby sustaining the current score relate to:<br>• Motivation (looking forward to going to work; enthusiasm for job; time passing quickly)<br>• Ability to contribute to improvements (opportunities to show initiative; ability to make suggestions; ability to make improvements happen) |
| **Equality Diversity and Inclusion**<br>  | 9.2 | 9.1 | 9.5 | 9.0 | Score has dropped for the second consecutive year. This theme comprises four questions. Of these:<br>• One question has seen an improvement (employer making adequate adjustments to carry out work) and we are above the average<br>Three questions have dropped<br>• Organisation acting fairly with regard to career progression/promotion<br>• Experiencing discrimination from patients/public<br>• Experiencing discrimination from manager/colleagues |

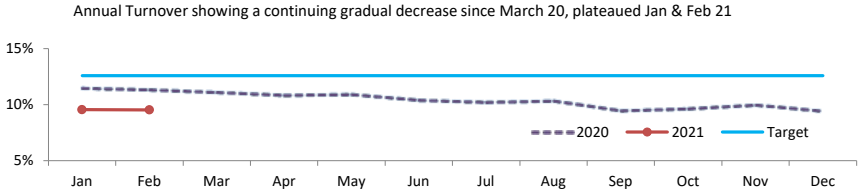
| Staff Survey Theme | Staff Survey 2018 | Staff Survey 2019 actual | Staff Survey 2020 target<br><br>RAG shows if on target | Staff Survey 2020 actual<br><br>RAG shows change since 2019 | Analysis |
|---|---|---|---|---|---|
| **Health and Wellbeing**<br>  | 5.8 | 5.8 | 6.3 | 6.1 | Score has improved significantly compared to 2019 although we remain below target.<br>There are five questions comprising this theme:<br>• Three questions have seen an improvement (flexible working; organisation taking positive action on health-wellbeing; coming to work despite not feeling well)<br>• Two question scores have dropped negatively (experiencing MSK problems due to work; becoming unwell as a result of work-related stress) |
| **Immediate Managers**<br>  | 6.7 | 6.8 | 7.3 | 6.8 | Score remains stable and now 0.5 below target. Theme comprised of five questions:<br>• Four questions have improved, and three of these are exceed or are equal to the average (support from manager; feedback on my work; positive interest in my health-wellbeing; values my work)<br>• Just one question has seen a drop in score (asking my opinion before making decisions) |
| **Morale**<br>  | 6.0 | 6.1 | 6.4 | 6.2 | Score is below target but has improved by 0.1 every year since 2018 (when this theme was first introduced).<br>Comprised of nine questions:<br>• Seven questions have improved since 2018 (unrealistic time pressures; choice in how I do my work; strained relationships; manager encourages me; thinking of leaving the organisation; will look for a new job in the next 12 months/as soon as I can)<br>• Two questions have dropped adversely (involved in deciding changes that affect my work/team; receive the respect I deserve from colleagues) |

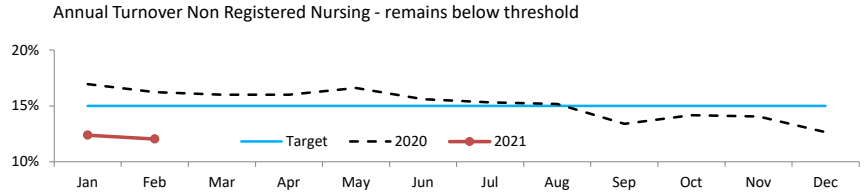
Plans for improving these areas are discussed in more detail in section 3.

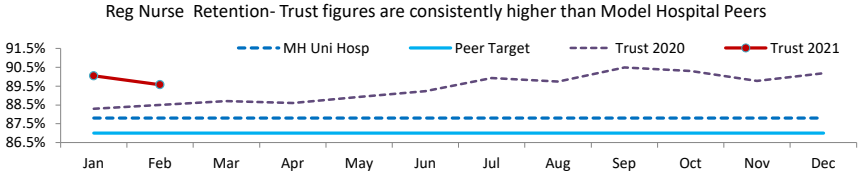
**Note:** given increased focus on developing a compassionate and inclusive culture, along with the knowledge that our ethnic minority colleagues experience considerably greater levels of bullying, harassment and discrimination in our Trust; we are now adopting the Bullying and Harassment theme to both inform and measure our strategic progress. The Bullying & Harassment theme is a more effective measure of behaviours and how people experience these within our Trust. Bullying & Harassment was also identified as a priority area in the 2019 staff survey results. Therefore, this report and future analysis will focus on the Bullying & Harassment theme in place of the Morale theme.

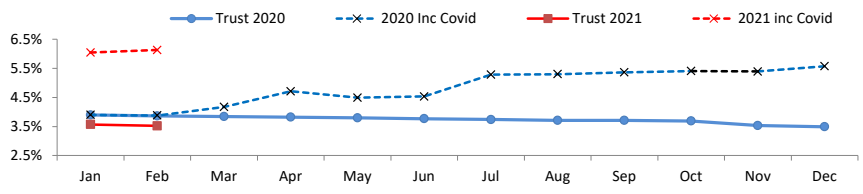
# Gloucestershire Hospitals NHS Foundation Trust

| Measure | Description | Mar-20 | Feb-21 | Trend | Variation |
|---|---|---|---|---|---|
| Worked vs Estab% | The difference between the establishment and worked fte as a percentage of establishment. Target in line with Monthly BI reporting. (0 to -5% is 'green')) | -1.25% | 1.30% |   | July & August saw a reduction in worked numbers as the effect of Covid eased. With its return, November through to February has seen a big increase in worked fte, particularly in Registered & Non-registered Nursing. There was a slight dip in January, there was a reduction in worked for Admin & Estates and also Jnr Medical staff. |

| Measure | Description | Mar-20 | Feb-21 | Trend | Variation |
|---|---|---|---|---|---|
| 12 Month Rolling Turnover<br>Link to SPC chart | Turnover is the no of leavers (in fte) expressed as a % of the ave numbers (fte )over the period. It is based on permanent contracts only.Trust target 12.6% (Top quartile of Model Hospital Peer Group) The target was set in 2019. Nationally all Turnover % have since reduced as a result of Covid 19. | 12.60% | 9.53% |   | Additional Clinical Services & AHPs as Staff Groups have the highest turnover to Feb 21 at 11.5% - ACS is the group where non-registered nursing staff are located. All other Staff Groups are below 10% turnover. Medicine Division Have the highest TO rate at 12.3 %, Surgery is 9.25%<br>The other three Clinical Divisions have a turnover rate below 9% Turnover since March 20 has been consistently lower than at the same period the previous year. |

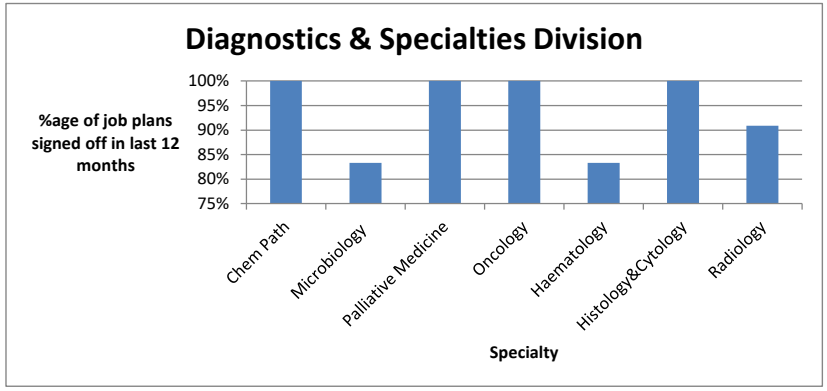
| Measure | Description | Mar-20 | Feb-21 | Trend | Variation |
|---|---|---|---|---|---|
| Non- Reg Nursing 12 Month Turnover | Non - registered nursing includes HCAs, Apprentice HCAs, Trainee Nursing Assistants. Threshold 15% This figure not avail from MH. | 16.46% | 12.05% |   | Of the clinical divisions, Medicine has the highest Turnover rate for non registered nursing staff at 15.44% (47 fte leavers). To give this figure context, Women & Children TO rate is 10.15% & Surgery is 10.07%.<br>Surgery employs a similar number of Non Reg nursing staff as Medicine.<br>Within Medicine Division, Gastroenterology/Nephrology is the Service Line with the highest turnover rate at 26% (13.6fte leavers) |

| Measure | Description | Mar-20 | Feb-21 | Trend | Variation |
|---|---|---|---|---|---|
| Nurse Retention Rate % | The percentage of nursing and health visitors that remained stable over 12 months period. Latest data from Model Hospital is Dec 18. University/Teaching Peer rate was 87%, MH recommended Peer rate 86.8% (NB excludes Midwifery) | 88.71% | 89.58% |   | Model Hospital data is calculated slightly differently to ESR, resulting in a figure approx 0.5% higher. The latest available from MH is December 18 (no update as at Feb 21).<br>Trust Nurse retention is showing a very slight decrease in February. |

| Measure | Description | Mar-20 | Feb-21 | Trend | Variation |
|---|---|---|---|---|---|
| Annual Sickness Absence %<br>Link to SPC Chart | Sickness Absence is expressed as a percentage of fte lost /available fte. The Uni/Teaching Hospital Peer rate from MH is 4.05%. MH recommended peer rate is 4.01% | 3.84% | 3.49% |   | Without Covid , Trust annual sickness absence is still reducing and remains below 2020 figures. From the beginning of March 20, absence due to self-isolation or actual Covid infection has a marked effect on the annual absence rate. The rolling 12 month figure incl of Covid absence is 6.13% For Feb 21 month only, 'normal' sickness was 3.35% and Covid absence was another 1.81% for a totalof 5.16%. Additional Clinical Service & Nursing and Midwifery for February inc Covid were 7.56% and 6.85% respectively. Surgery Division had the highest covid inclusive rate for Feb 21, at 5.59%. |

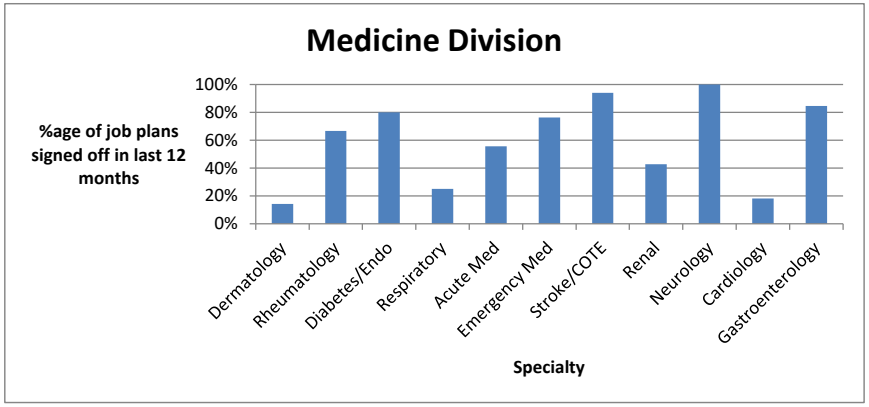
| Specialty | Total No Consultants | No. JPs signed off in last 12 months as @ early Apr 21 | Notes |
|---|---|---|---|
| Chem Path | 2 | 2 | |
| Microbiology | 6 | 5 | |
| Palliative Medicine | 4 | 4 | |
| Oncology | 17 | 17 | |
| Haematology | 6 | 5 | |
| Histology&Cytology | 15 | 15 | |
| Radiology | 33 | 30 | |
| Total | 83 | 78 | |

| Specialty | Total No Consultants | % JPs signed off in last 12 months as @ early Apr 21 |
|---|---|---|
| | | |
| Chem Path | 2 | 100% |
| Microbiology | 6 | 83% |
| Palliative Medicine | 4 | 100% |
| Oncology | 17 | 100% |
| Haematology | 6 | 83% |
| Histology&Cytology | 15 | 100% |
| Radiology | 33 | 91% |
| | | |
| TOTAL | 83 | 94% |



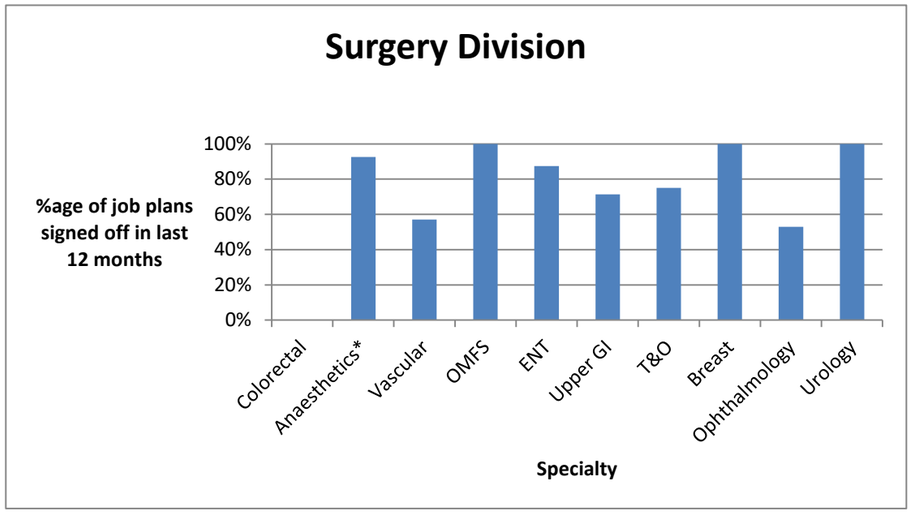
| Specialty | Total No Consultants | No. JPs signed off in last 12 months as @ early Apr 21 | Notes |
|---|---|---|---|
| Dermatology | 7 | 1 | |
| Rheumatology | 6 | 4 | |
| Diabetes/Endo | 5 | 4 | |
| Respiratory | 8 | 2 | |
| Acute Med | 9 | 5 | |
| Emergency Med | 17 | 13 | |
| Stroke/COTE | 17 | 16 | |
| Renal | 7 | 3 | |
| Neurology | 5 | 5 | |
| Cardiology | 11 | 2 | |
| Gastroenterology | 13 | 11 | |
| Total | 105 | 66 | |

| Specialty | Total No Consultants | % JPs signed off in last 12 months as @ early Apr 21 |
|---|---|---|
| | | |
| Dermatology | 7 | 14% |
| Rheumatology | 6 | 67% |
| Diabetes/Endo | 5 | 80% |
| Respiratory | 8 | 25% |
| Acute Med | 9 | 56% |
| Emergency Med | 17 | 76% |
| Stroke/COTE | 17 | 94% |
| Renal | 7 | 43% |
| Neurology | 5 | 100% |
| Cardiology | 11 | 18% |
| Gastroenterology | 13 | 85% |
| | | |
| TOTAL | 105 | 63% |



| Specialty | Total No Consultants | No. JPs signed off in last 12 months as @ early Apr 21 | Notes |
|---|---|---|---|
| Colorectal | 8 | 0 | |
| Anaesthetics* | 68 | 63 | |
| Vascular | 7 | 4 | |
| OMFS | 10 | 10 | |
| ENT | 8 | 7 | |
| Upper GI | 7 | 5 | |
| T&O | 28 | 21 | |
| Breast | 6 | 6 | |
| Ophthalmology | 17 | 9 | |
| Urology | 10 | 10 | |
| Total | 169 | 135 | |

# One cons on mat leave, number reduced



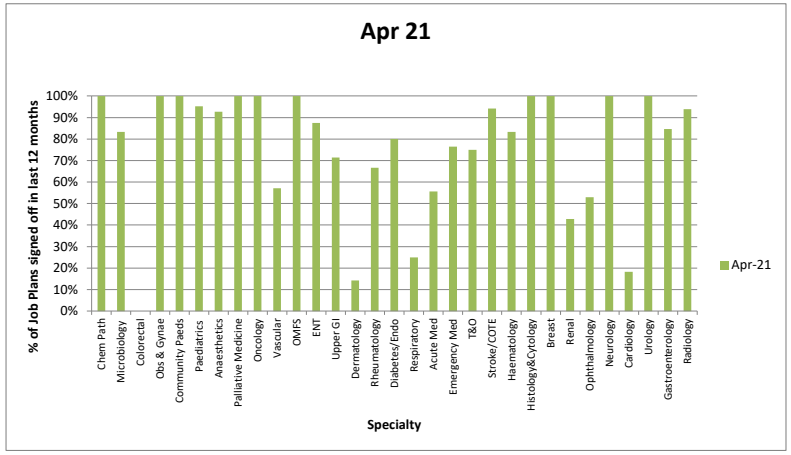

| Specialty | Total No Consultants | % JPs signed off in last 12 months as @ early Apr 21 |
|---|---|---|
| | | |
| Colorectal | 8 | 0% |
| Anaesthetics* | 68 | 93% |
| Vascular | 7 | 57% |
| OMFS | 10 | 100% |
| ENT | 8 | 88% |
| Upper GI | 7 | 71% |
| T&O | 28 | 75% |
| Breast | 6 | 100% |
| Ophthalmology | 17 | 53% |
| Urology | 10 | 100% |
| | | |
| TOTAL | 169 | 80% |

| Specialty | Total No Consultants | No. JPs signed off in last 12 months as @ early Apr 21 |
|---|---|---|
| Chem Path | 2 | 2 |
| Microbiology | 6 | 5 |
| Colorectal | 8 | 0 |
| Obs & Gynae# | 17 | 17 |
| Community Paeds | 7 | 7 |
| Paediatrics | 21 | 20 |
| Anaesthetics# | 68 | 63 |
| Palliative Medicine | 4 | 4 |
| Oncology | 17 | 17 |
| Vascular | 7 | 4 |
| OMFS | 10 | 10 |
| ENT | 8 | 7 |
| Upper GI | 7 | 5 |
| Dermatology | 7 | 1 |
| Rheumatology | 6 | 4 |
| Diabetes/Endo | 5 | 4 |
| Respiratory | 8 | 2 |
| Acute Med | 9 | 5 |
| Emergency Med | 17 | 13 |
| T&O | 28 | 21 |
| Stroke/COTE | 17 | 16 |
| Haematology | 6 | 5 |
| Histology&Cytology | 15 | 15 |
| Breast | 6 | 6 |
| Renal | 7 | 3 |
| Ophthalmology | 17 | 9 |
| Neurology | 5 | 5 |
| Cardiology | 11 | 2 |
| Urology | 10 | 10 |
| Gastroenterology | 13 | 11 |
| Radiology | 33 | 31 |
| Total | 402 | 324 |

# One cons on mat leave, number reduced

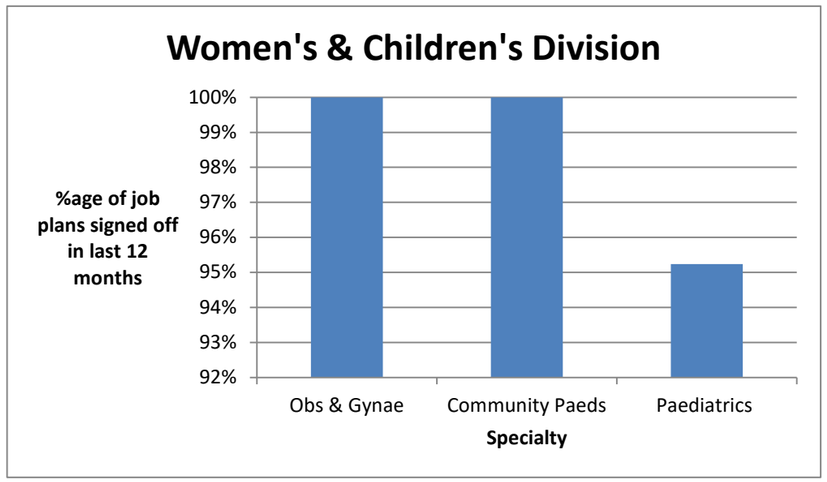
Notes

| Specialty | Total No Consultants | % JPs signed off in last 12 months as @ early Apr 21 |
|---|---|---|
| | | Apr-21 |
| Chem Path | 2 | 100% |
| Microbiology | 6 | 83% |
| Colorectal | 8 | 0% |
| Obs & Gynae | 17 | 100% |
| Community Paeds | 7 | 100% |
| Paediatrics | 21 | 95% |
| Anaesthetics | 68 | 93% |
| Palliative Medicine | 4 | 100% |
| Oncology | 17 | 100% |
| Vascular | 7 | 57% |
| OMFS | 10 | 100% |
| ENT | 8 | 88% |
| Upper GI | 7 | 71% |
| Dermatology | 7 | 14% |
| Rheumatology | 6 | 67% |
| Diabetes/Endo | 5 | 80% |
| Respiratory | 8 | 25% |
| Acute Med | 9 | 56% |
| Emergency Med | 17 | 76% |
| T&O | 28 | 75% |
| Stroke/COTE | 17 | 94% |
| Haematology | 6 | 83% |
| Histology&Cytology | 15 | 100% |
| Breast | 6 | 100% |
| Renal | 7 | 43% |
| Ophthalmology | 17 | 53% |
| Neurology | 5 | 100% |
| Cardiology | 11 | 18% |
| Urology | 10 | 100% |
| Gastroenterology | 13 | 85% |
| Radiology | 33 | 94% |
| | | |
| TOTAL | 402 | 81% |



| Specialty | Total No Consultants | No. JPs signed off in last 12 months as @ early Apr 21 | Notes |
|---|---|---|---|
| Obs & Gynae# | 17 | 17 | |
| Community Paeds | 7 | 7 | |
| Paediatrics | 21 | 20 | |
| Total | 45 | 44 | |

# One cons on mat leave, number reduced




| Specialty | Total No Consultants | % JPs signed off in last 12 months as @ early Apr 21 |
|---|---|---|
| | | |
| Obs & Gynae | 17 | 100% |
| Community Paeds | 7 | 100% |
| Paediatrics | 21 | 95% |
| | | |
| TOTAL | 45 | 98% |

# 2020 Staff Survey:
# Results Summary and Action Plan Progress Update

## 1.0 Summary of results and key themes

### 1.1 Trust headlines

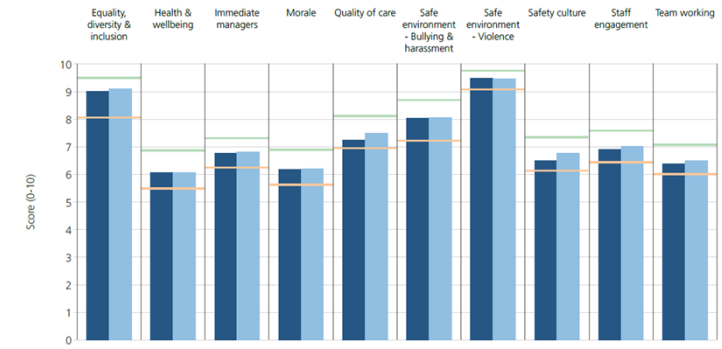
- The annual NHS staff survey ran from 1st October-28th November 2020.
- 22% increase in the response rate from ethnic minority colleagues (383 responses in 2019; 462 responses in 2020)
- Overall response rate of 48% of eligible participants. This has fallen by 1% since 2019 although 30 more colleagues completed the survey (total 3519). This is 3% above the median response rate for 128 Acute and Acute & Community Trusts (45%).
- Statistically significant improvement in the theme: **Health & Wellbeing**
- Improvements also reported in the following themes: **Morale; Safe Environment - Violence**
- Scores in five themes remain unchanged since 2019: **Immediate Managers; Quality of Care; Safe Environment – Bullying and Harassment; Safety Culture; Staff Engagement**
- One theme has been omitted this year: **Quality of Appraisals.** This is due to COVID, as the "Your Personal Development" section on the survey was replaced with a section asking about people's experience of COVID-19.
- Scores have dropped in two themes:
    - **Equality Diversity and Inclusion**. This has fallen for the second consecutive year (2018: 9.2/10; 2020: 9.0/10) and is now just below the average for our comparator group (9.1/10). See section 1.4 for more details.
    - **Team Working**. The score for this theme has wavered between 6.4-6.5/10 since 2016, so overall is relatively stagnant.
- **Staff Friends and Family** questions have seen significant improvements:
    - **Recommending the Trust as a place to work**. Increased by 4.8% points to 64.3%. Score remains below the average (66.9%)
    - **Happy with standard of care if friend/relative needed treatment**. Increased by 5.8% points to 70.5%. Score remains below the average (74.3%)

The table below presents the ten themes listed in the national benchmark report, and shows how we compare to the average for Acute Trusts, and against best and worst scores.

Survey Coordination Centre

**2020 NHS Staff Survey Results > Theme results > Overview**

NHS England

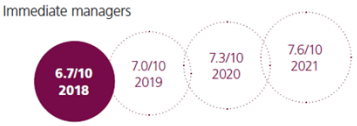



| | Equality, diversity & inclusion | Health & wellbeing | Immediate managers | Morale | Quality of care | Safe environment - Bullying & harassment | Safe environment - Violence | Safety culture | Staff engagement | Team working |
|---|---|---|---|---|---|---|---|---|---|---|
| Best | 9.5 | 6.9 | 7.3 | 6.9 | 8.1 | 8.7 | 9.8 | 7.4 | 7.6 | 7.1 |
| Your org | 9.0 | 6.1 | 6.8 | 6.2 | 7.3 | 8.0 | 9.5 | 6.5 | 6.9 | 6.4 |
| Average | 9.1 | 6.1 | 6.8 | 6.2 | 7.5 | 8.1 | 9.5 | 6.8 | 7.0 | 6.5 |
| Worst | 8.1 | 5.5 | 6.2 | 5.6 | 7.0 | 7.2 | 9.1 | 6.1 | 6.4 | 6.0 |
| Responses | 3,491 | 3,509 | 3,508 | 3,507 | 3,080 | 3,490 | 3,500 | 3,510 | 3,517 | 3,466 |

## 1.2 Progress against People and OD strategic priorities

In the People and OD Strategy 2019-24 we identified five staff survey themes where we would like to make significant progress by March 2022.

| Staff Survey Theme | Staff Survey 2018 | Staff Survey 2019 actual | Staff Survey 2020 target<br>RAG shows if on target | Staff Survey 2020 actual<br>RAG shows change since 2019 | Analysis |
|---|---|---|---|---|---|
| **Staff Engagement**<br>  | 6.8 | 6.9 | 7.3 | 6.9 | Score has remained stagnant and we are 0.4 below the 2020 target. This theme comprises 9 questions.<br>• There have been significant improvements in questions on recommending the organisation as a place to work/receive treatment.<br>Questions where the scores have dropped, thereby sustaining the current score relate to:<br>• Motivation (looking forward to going to work; enthusiasm for job; time passing quickly)<br>• Ability to contribute to improvements (opportunities to show initiative; ability to make suggestions; ability to make improvements happen) |
| **Equality Diversity and Inclusion**<br>  | 9.2 | 9.1 | 9.5 | 9.0 | Score has dropped for the second consecutive year. This theme comprises four questions. Of these:<br>• One question has seen an improvement (employer making adequate adjustments to carry out work) and we are above the average<br>Three questions have dropped<br>• Organisation acting fairly with regard to career progression/promotion<br>• Experiencing discrimination from patients/public<br>• Experiencing discrimination from manager/colleagues |

| Staff Survey Theme | Staff Survey 2018 | Staff Survey 2019 actual | Staff Survey 2020 target<br><br>RAG shows if on target | Staff Survey 2020 actual<br><br>RAG shows change since 2019 | Analysis |
|---|---|---|---|---|---|
| **Health and Wellbeing**<br>  | 5.8 | 5.8 | 6.3 | 6.1 | Score has improved significantly compared to 2019 although we remain below target.<br>There are five questions comprising this theme:<br>• Three questions have seen an improvement (flexible working; organisation taking positive action on health-wellbeing; coming to work despite not feeling well)<br>• Two question scores have dropped negatively (experiencing MSK problems due to work; becoming unwell as a result of work-related stress) |
| **Immediate Managers**<br>  | 6.7 | 6.8 | 7.3 | 6.8 | Score remains stable and now 0.5 below target. Theme comprised of five questions:<br>• Four questions have improved, and three of these are exceed or are equal to the average (support from manager; feedback on my work; positive interest in my health-wellbeing; values my work)<br>• Just one question has seen a drop in score (asking my opinion before making decisions) |
| **Morale**<br>  | 6.0 | 6.1 | 6.4 | 6.2 | Score is below target but has improved by 0.1 every year since 2018 (when this theme was first introduced).<br>Comprised of nine questions:<br>• Seven questions have improved since 2018 (unrealistic time pressures; choice in how I do my work; strained relationships; manager encourages me; thinking of leaving the organisation; will look for a new job in the next 12 months/as soon as I can)<br>• Two questions have dropped adversely (involved in deciding changes that affect my work/team; receive the respect I deserve from colleagues) |

Plans for improving these areas are discussed in more detail in section 3.

**Note:** given increased focus on developing a compassionate and inclusive culture, along with the knowledge that our ethnic minority colleagues experience considerably greater levels of bullying, harassment and discrimination in our Trust; we are now adopting the Bullying and Harassment theme to both inform and measure our strategic progress. The Bullying & Harassment theme is a more effective measure of behaviours and how people experience these within our Trust. Bullying & Harassment was also identified as a priority area in the 2019 staff survey results. Therefore, this report and future analysis will focus on the Bullying & Harassment theme in place of the Morale theme.

## 1.3 Divisional and Staff Group headlines

The table below summarises divisions specific strengths/development areas in light of the eleven staff survey themes:

| Staff Group | Strongest performing themes (scores significantly above Trust average) | Weakest performing themes (scores below Trust average) |
|---|---|---|
| **Add Prof Sci Tech** | • EDI (+0.4)<br>• Bullying and harassment (+0.7)<br>• Violence (+0.4) | No themes below the Trust average |
| **Additional Clinical Services** | • Quality of care (+0.5) | • Health and wellbeing (-0.4)<br>• Morale (-0.2)<br>• Bullying and harassment (-0.3)<br>• Team working (-0.2) |
| **Admin and Clerical (A&C)** | • Health and wellbeing (+0.4)<br>• Bullying and harassment (+0.5)<br>• Violence (+0.4) | • Safety culture (-0.1)<br>• Team working (-0.1) |
| **Allied Health Professionals (AHP)** | • EDI (+0.2)<br>• Bullying and harassment (+0.6)<br>• Violence (+0.2)<br>• Team working (+0.2) | • Immediate managers (-0.1)<br>• Morale (-0.1) |
| **Healthcare Scientists** | • EDI (+0.2)<br>• Bullying and harassment (+0.6)<br>• Violence (+0.5) | • Immediate managers (-0.6)<br>• Team working (-0.3) |
| **Medical and Dental** | • EDI (+0.1)<br>• Health and wellbeing (+0.4)<br>• Team working (+0.2) | • Immediate managers (-0.2)<br>• Quality of care (-0.2)<br>• Bullying and harassment (-0.2)<br>• Safety culture (-0.2) |
| **Nursing and Midwifery** | • Safety culture (+0.2)<br>• Team working (+0.1) | • EDI (-0.4)<br>• Bullying and harassment (-0.7)<br>• Violence (-0.4) |

Data showing the breakdown against staff groups reinforces the importance of continuing to focus on developing our compassionate culture (addressing EDI, management/leadership style, team working and morale), bullying and harassment, and health-wellbeing. See section 3 for more details.

The table below shows performance against the themes by division. Further analysis and provisional actions/priorities for each division then follows.

| Division | Strongest performing themes (scores significantly above Trust average) | Weakest performing themes (scores below Trust average) |
|---|---|---|
| **Corporate** | • Health and Wellbeing (+0.7)<br>• Immediate managers (+0.4)<br>• Bullying and harassment (+0.8)<br>• Violence (+0.4) | No themes are below the Trust average |

| Division | Strongest performing themes (scores significantly above Trust average) | Weakest performing themes (scores below Trust average) |
|---|---|---|
| **Diagnostic & Specialities (D&S)** | • Equality Diversity & Inclusion (EDI) (+0.2)<br>• Bullying and harassment (+0.4)<br>• Violence (+0.2) | • Immediate managers (-0.2)<br>• Team working (-0.1) |
| **Medicine** | No themes above the Trust average | Themes with the biggest gap:<br>• EDI (-0.6)<br>• Health and wellbeing (-0.4)<br>• Morale (-0.4)<br>• Quality of care (-0.4)<br>• Bullying and harassment (-0.9)<br>• Violence (-0.8) |
| **Surgery** | • Immediate managers (+0.1)<br>• Quality of care (+0.4) | • EDI (-0.1)<br>• Bullying and harassment (-0.1)<br>• Violence (-0.2)<br>• Team working (-0.1) |
| **Women and Children (W&C)** | • EDI (+0.2)<br>• Violence (+0.2) | • Health and wellbeing (-0.1)<br>• Immediate managers (-0.1)<br>• Bullying and harassment (-0.5) |

Further analysis of themes and questions has been undertaken for divisions, and departments/cost centres where this is available. This has been shared with all divisions except Corporate, which is scheduled to take place in mid-late April (date tbc). Therefore, the table for Corporate currently identifies strengths and areas of concern/focus.

A summary of key findings and priority areas that each division will focus on is listed below. Clearer, SMART-er objectives are currently being refined and agreed with divisional Leads and delivery will be monitored through monthly Executive Reviews.

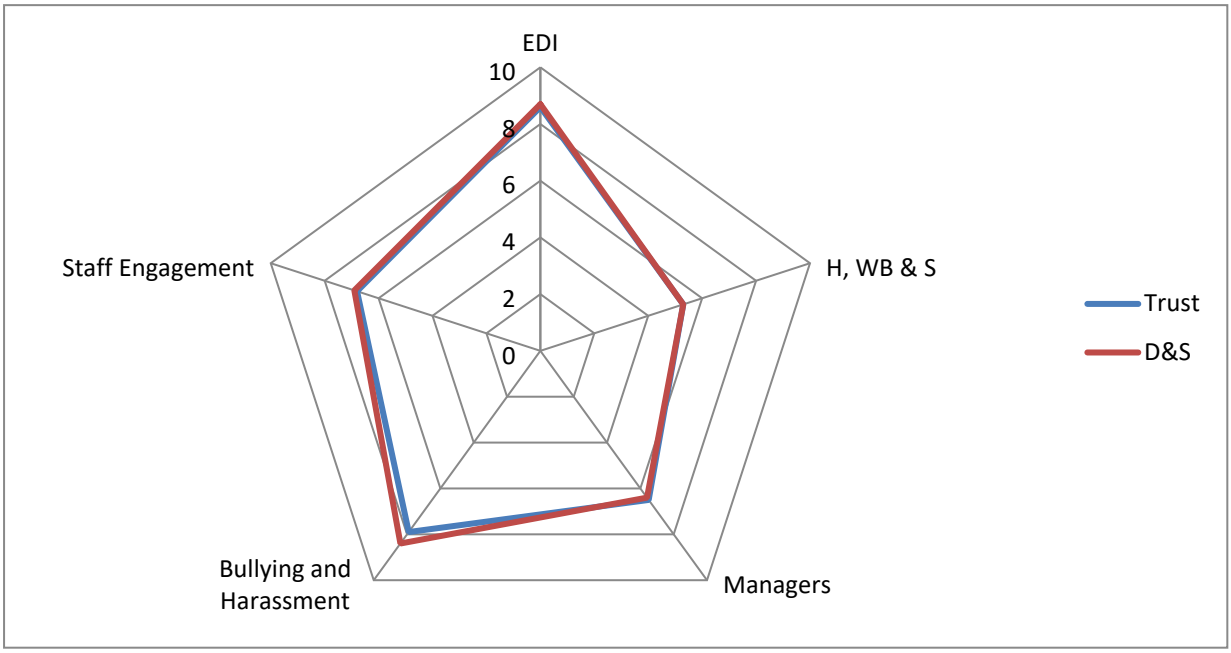
These will also tie into the broader Trust-wide 2-year priorities (see section 3).

### 1.3.1 D&S division

| Positives/ Strengths | Areas of concern/focus |
|---|---|
| • Six out of ten theme scores improved compared to 2019. Two theme scores have not changed.<br><br>Departments with most positive question responses:<br>• Support<br>• Pharmacy<br>• AHP services | • Two theme scores dropped: EDI and Team Working<br>Departments with most negative question responses:<br>• OHP (Haem and Oncology)<br>• Radiology<br>• Pathology<br>• Health Psychology<br>• Histopathology |
| **Divisional priorities and actions/deliverables in 21/22** | |
| **1. Immediate Managers**<br>• Focus on improving ways to seek/give feedback, asking opinions before making decisions, valuing/appreciating work, health and wellbeing support.<br>Specifically: OHP; Radiology; Pathology; staff groups in D&S: additional clinical services; A&C; Healthcare Scientists<br>**2. Team Working** | |

| |
|---|
| • Creating shared team objectives<br>• Hosting regular meetings<br>Specifically: OHP; Radiology; Pathology; staff group in D&S: A&C<br>**3. Health and Wellbeing**<br>• Promotion of organisation offer<br>• Promotion of flexible working<br>• Focus on MSK and work-related stress<br>**4. Safety Culture**<br>• Focus on errors and near-misses; reporting and giving feedback on incidents reported<br>• Raising people's safety to raise concerns; taking action on these concerns<br>• Focus on addressing violence<br>Specifically: OHP; AHP services. Staff groups: Additional Clinical Services; Nursing & Midwifery |

The spider chart below shows how the D&S division performs against the five priority staff survey themes.



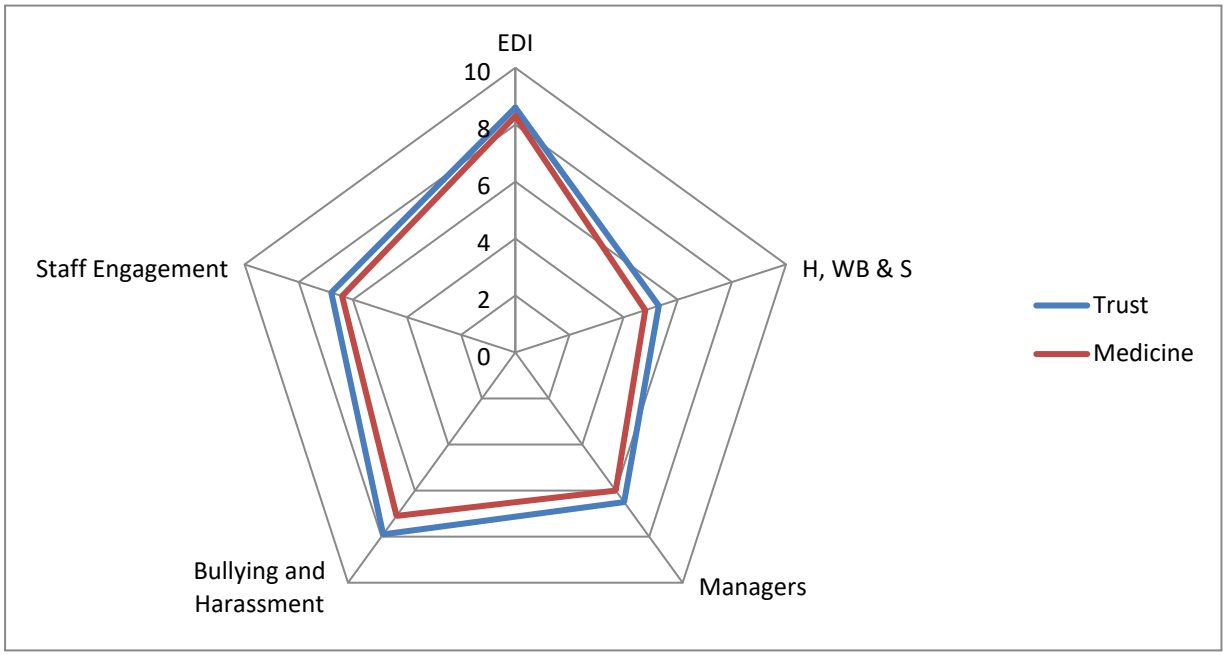

This illustrates that D&S perform largely in line with the Trust for all indicators, with slightly better performance around Bullying & Harassment.

### 1.3.2 Medicine division

| Positives/ Strengths | Areas of concern/focus |
|---|---|
| • Two out of ten theme scores improved compared to 2019 | • Eight theme scores dropped: EDI; Immediate managers; Morale; Quality of care; Bullying & Harassment; Violence; Staff engagement; Team working<br>Departments with most negative question responses:<br>• ED<br>• Acute Medicine<br>• General Medicine<br>• Old Age Medicine |

| | |
|---|---|
| | • Neurology<br>• Cardiology |
| **Divisional priorities and actions/deliverables in 21/22** | |
| **1. Bullying and harassment**<br>• Specifically focus on ED, Cardiology, General Medicine (although generally across all service lines)<br>**2. Equality Diversity and Inclusion**<br>• Specifically focus on Acute Medicine, Cardiology, ED, Gastro<br>**3. Immediate Managers**<br>• Specifically focus on ED, Acute Medicine, Diabetes, Rheumatology<br>**4. Violence**<br>• Specifically focus on Acute Medicine, ED, General & Old Age Medicine, Neurology<br>**5. Health and Wellbeing**<br>• Specifically focus on Acute Medicine, ED, General & Old Age Medicine, Neurology | |

The spider chart below shows how the Medicine division performs against the five priority staff survey themes.



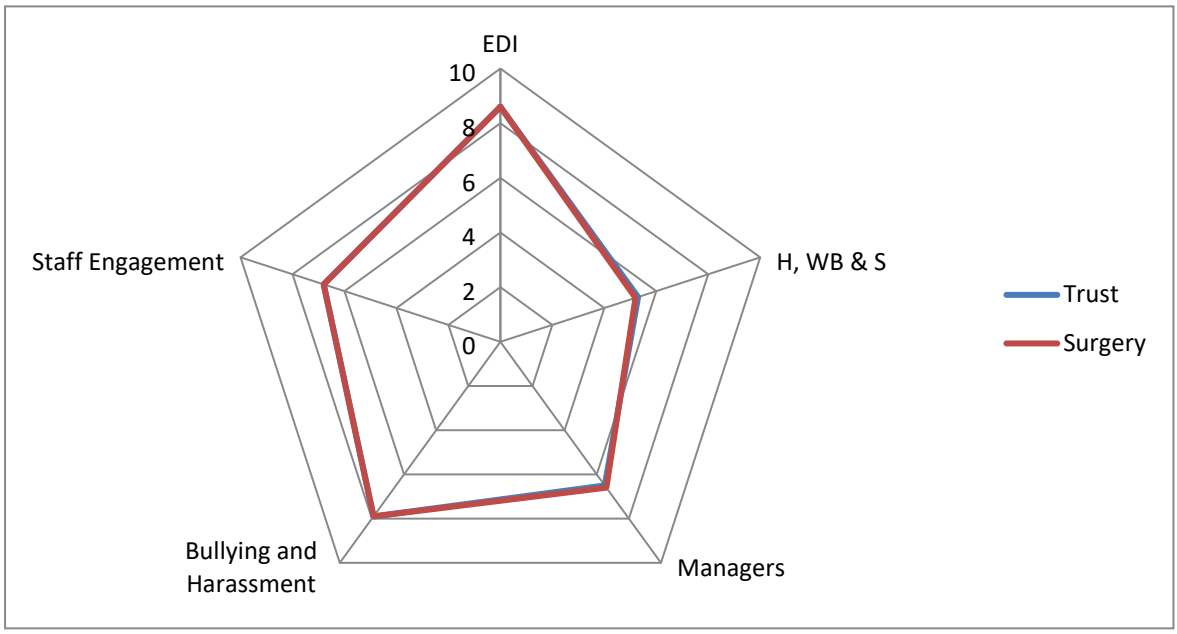

We can see that Medicine performs below the Trust average fairly consistently.

### 1.3.3 Surgery division

| Positives/ Strengths | Areas of concern/focus |
|---|---|
| • Nine out of ten theme scores improved compared to 2019<br><br>Departments with most positive question responses:<br>• ICU departments<br>• Anaesthetic<br>• Breast<br>• OMF surgery<br>• Upper GI | • Two theme scores dropped: EDI and Team Working<br>Departments with most negative question responses:<br>• Surgery division-wide<br>• T&O<br>• Theatres<br>• Urology |

| Divisional priorities and actions/deliverables in 21/22 |
|---|
| **1. Bullying and harassment**<br>• Reduce the number of colleagues that report feeling bullied/harassed at work<br>• Promote anti-bullying culture and support available for staff e.g. FTSU, mediation<br>This is seen as a priority for the whole division and is a prime focus for all.<br>**2. Equality Diversity and Inclusion**<br>• Promote 'allyship'<br>• Eliminate discrimination in the workplace<br>• Ensure all colleagues who require it get adequate adjustments to their workplace<br>• Ensure fairness with career progression/promotion regardless of protected characteristics<br>Specific focus on: Critical Care – Dept and Outreach; ENT OPD; Lead Nurses; Dixton Ward<br>**3. Safe Environment – Violence**<br>• Eliminate staff experiencing violence from patients/public/managers/colleagues<br>This is seen as a priority for the whole division and is a prime focus for all.<br>**4. Health and Wellbeing**<br>• Offering of decompression sessions – linking with Colleague wellbeing psychology team<br>• Proactive links with 2020 Hub, Datix, HRA team to identify and support colleagues experiencing stress/anxiety/depression<br>• Review of flexible working within the division<br>Specific focus on: Bibury Ward; Ward 5b Colorectal; Dixton Ward; Critical Care |

The spider chart for Surgery illustrates that this division performs largely in line with the Trust average for all of the five priority themes.

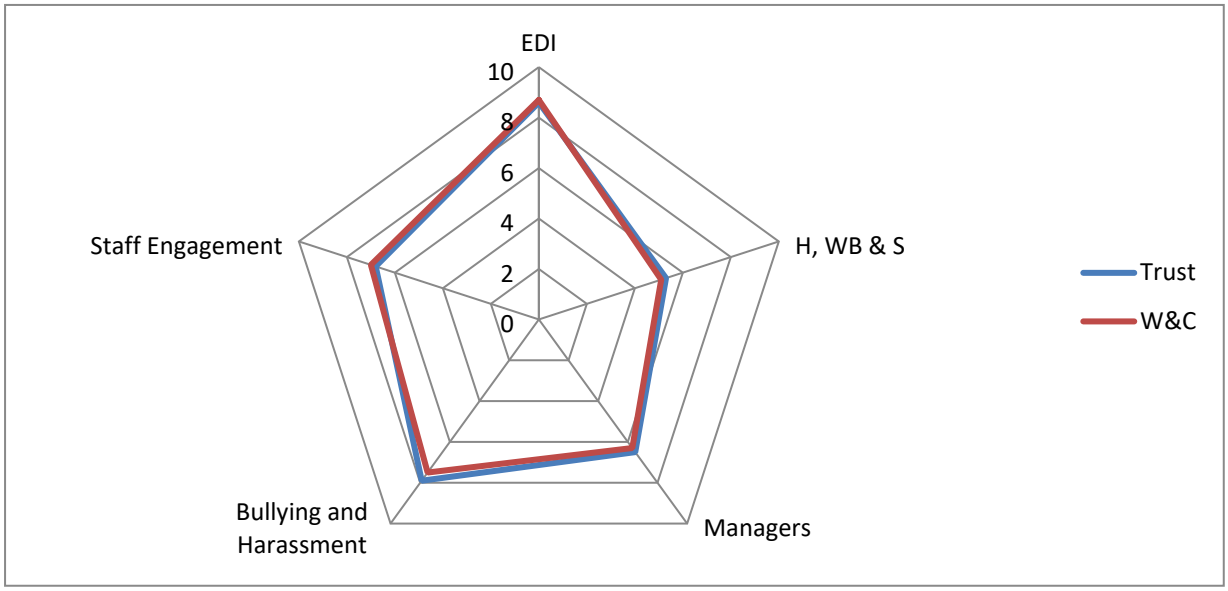



### 1.3.4 W&C division

| Positives/ Strengths | Areas of concern/focus |
|---|---|
| • Two theme scores have not changed.<br><br>Departments with most positive question responses: | • Eight theme scores have dropped since 2019: EDI; Immediate Managers; Morale; Quality of Care; Bullying/harassment; Violence; Safety Culture; Staff |

| | |
|---|---|
| • Paediatrics | Engagement.<br>• In spite of the drop, all of these remain above the Trust average except: Immediate managers; Bullying/ Harassment<br>Departments with most negative question responses:<br>• Gynaecology<br>• Maternity |
| **Divisional priorities and actions/deliverables in 21/22** | |
| **1. Bullying & Harassment**<br>Focus on this area across all services in W&C<br>**2. Immediate Managers**<br>• Focus on giving/receiving feedback; asking for opinion; valuing and appreciating work; and health-wellbeing support<br>Specifically: Gynaecology; Paediatrics<br>**3. Health and Wellbeing**<br>• Promotion of organisation offer<br>• Promotion of flexible working<br>• Focus on MSK and work-related stress<br>• Addressing 'presenteeism'<br>Specifically: Gynaecology; Maternity<br>**4. Gynaecology**<br>General focus on this department as it has the most negative responses for eight of eleven themes. | |

The spider chart for W&C against the five priority themes:

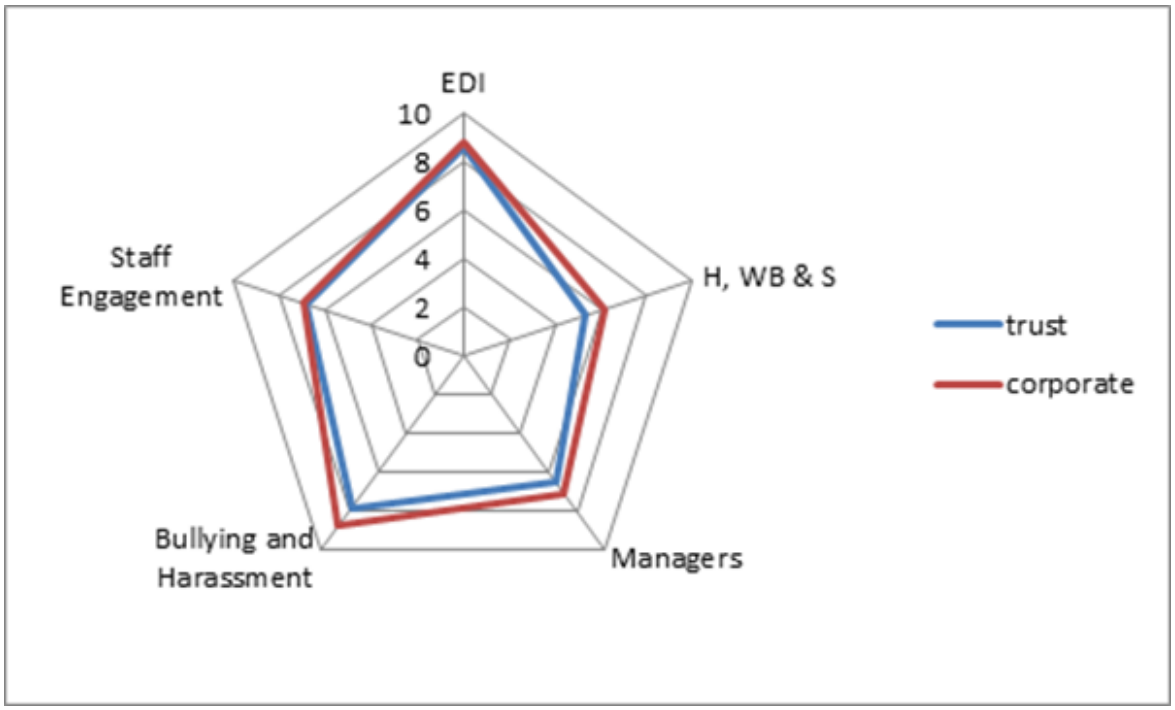



This illustrates that the division as a whole performs slightly below average for three of the themes (Bullying & Harassment; Immediate Managers; Health & Wellbeing). They are slightly above average for the Staff Engagement theme.

### 1.3.4 Corporate

| Positives/ Strengths | Areas of concern/focus |
|---|---|
| • Six theme scores improved compared to 2019.<br>• Three theme scores have not changed.<br><br>Departments with most positive question responses:<br>• Clinical Strategy<br>• Patient Experience<br>• Training | • One theme score has dropped since 2019: Safety Culture<br><br>Departments with most negative question responses:<br>• IT Shared Service<br>• Procurement Shared Service<br>• Service Delivery |
| **Divisional priorities and actions/deliverables in 21/22** | |
| To follow. | |

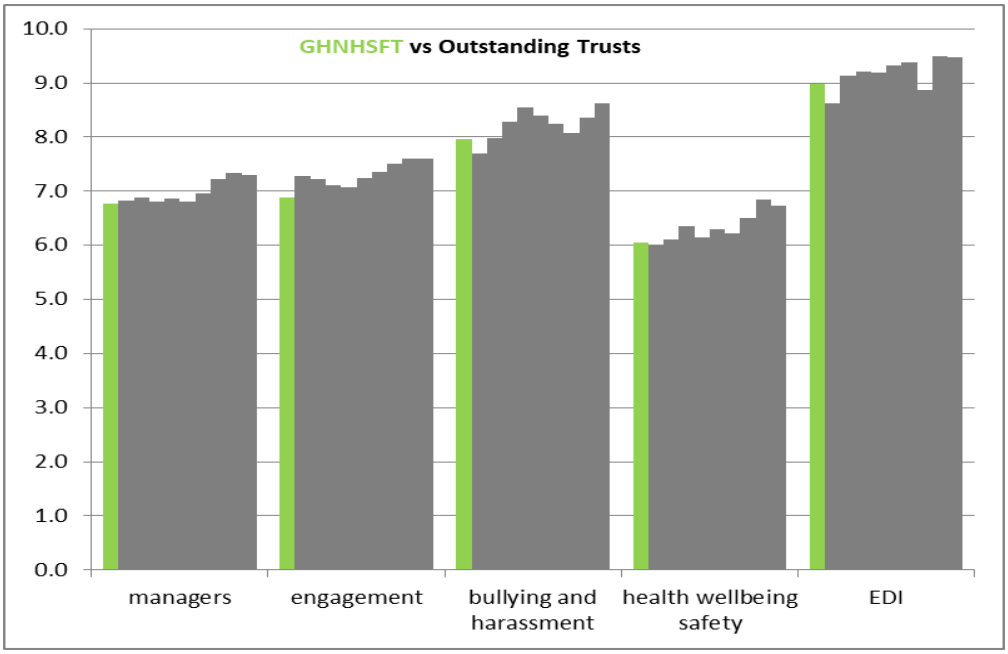
The spider chart illustrates that the Corporate division exceeds Trust performance in most of the priority themes. Interestingly, whilst the Staff Engagement theme is just above the Trust average, out of nine questions in this theme, three questions which relate to motivation are the lowest scoring division for “I am enthusiastic about my job” and “time passes quickly”, and below average for “I look forward to going to work”.



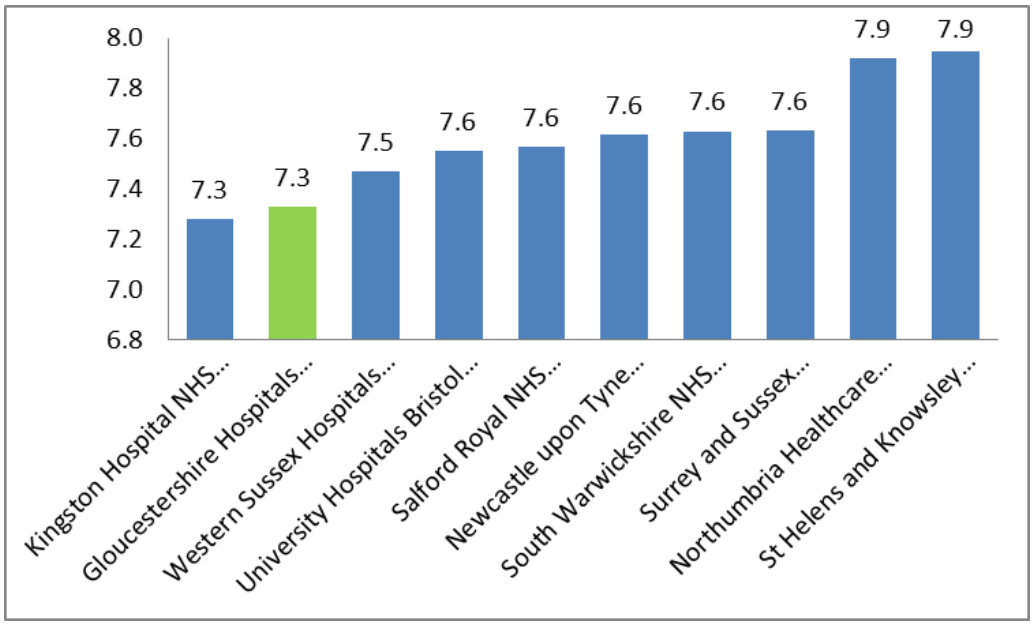

### 1.4 Comparison against CQC Outstanding Trusts

Our performance in the five themes identified in section 1.2 of the report have been analysed against the nine Acute Trusts which have received a CQC Outstanding rating.

The table below displays how GHT (in green) performs the lowest for the Staff Engagement theme and is joint bottom (with two other Trusts) for Immediate Managers. We are second from bottom for Health, Safety and Wellbeing; and in the bottom-half for EDI and Bullying & Harassment.




When the theme scores for each Trust are averaged, we are joint bottom along with Kingston Hospital NHS Foundation Trust. This demonstrates that higher performance in these themes is associated with achieving an outstanding CQC rating.



## 2.0 Analysis of Staff Survey results by protected characteristics

Several of the questions in the Staff Survey feed into the annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) experience indicators.

### 2.1 WRES Experience Indicators

**Indicator**

**Scores 2017-20 and analysis**

Experienced bullying, harassment and abuse from patients

| | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| White: Your org | 29.0% | 27.3% | 28.5% | 27.0% |
| BME: Your org | 32.1% | 31.7% | 33.4% | 32.7% |
| White: Average | 27.1% | 27.0% | 27.6% | 25.4% |
| BME: Average | 27.5% | 28.9% | 29.5% | 28.0% |
| White: Responses | 3,096 | 2,688 | 2,908 | 2,987 |
| BME: Responses | 390 | 325 | 383 | 462 |

- BAME score consistently above average for acute Trusts.
- In the last year the score has fallen positively for both White and BME colleagues

Experienced bullying harassment and abuse from colleagues

| | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| White: Your org | 25.2% | 24.5% | 25.3% | 25.0% |
| BME: Your org | 27.5% | 32.7% | 29.9% | 35.1% |
| White: Average | 23.9% | 24.9% | 24.5% | 24.4% |
| BME: Average | 27.6% | 28.7% | 28.6% | 29.1% |
| White: Responses | 3,099 | 2,695 | 2,909 | 2,994 |
| BME: Responses | 389 | 327 | 381 | 464 |

- BAME score consistently above average
- In the last year the score for BME colleagues has increased by 5.2%, yet fallen slightly for White colleagues

Believe org provides equal opps for career progression/ promotion

| | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| White: Your org | 86.7% | 86.7% | 86.7% | 84.6% |
| BME: Your org | 79.4% | 72.4% | 70.1% | 60.7% |
| White: Average | 87.1% | 86.8% | 87.2% | 87.7% |
| BME: Average | 75.0% | 73.1% | 74.1% | 72.5% |
| White: Responses | 1,966 | 1,744 | 1,934 | 1,991 |
| BME: Responses | 228 | 192 | 234 | 303 |

- BME colleagues score has dropped 9.4% in the last year, and overall has dropped 18.7% over a 4 year period vs. White colleagues which has fallen 2.1% in the same period (and only fallen for the first time this year)
- BME colleague score is below average for the third consecutive year

Experienced discrimination from manager/ colleagues

| | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| White: Your org | 7.3% | 4.6% | 5.9% | 6.2% |
| BME: Your org | 15.5% | 19.6% | 18.7% | 23.6% |
| White: Average | 6.5% | 6.3% | 5.8% | 6.1% |
| BME: Average | 14.8% | 14.6% | 14.2% | 16.8% |
| White: Responses | 3,099 | 2,678 | 2,864 | 2,974 |
| BME: Responses | 387 | 327 | 375 | 458 |

- BAME score consistently above average, and has jumped 4.9% in the last 12 months

Whilst there has been a small improvement regarding bullying and harassment from patients, overall these scores present a disappointing and concerning picture with deteriorating or stagnant experience of our BME colleagues in the organisation compared to White colleagues, and compared against the national picture.

## 2.2 WDES Experience Indicators

(WDES introduced for the first time in 2018 hence only three data points)

<table>
<tr><th>Indicator</th><th>Scores 2018-20 and analysis</th></tr>
<tr><td>Experienced bullying, harassment and abuse from patients</td><td>
<table>
<tr><th></th><th>2018</th><th>2019</th><th>2020</th></tr>
<tr><td>Staff with a LTC or illness: Your org</td><td>34.7%</td><td>35.0%</td><td>31.7%</td></tr>
<tr><td>Staff without a LTC or illness: Your org</td><td>26.6%</td><td>27.8%</td><td>26.9%</td></tr>
<tr><td>Staff with a LTC or illness: Average</td><td>33.6%</td><td>33.2%</td><td>30.9%</td></tr>
<tr><td>Staff without a LTC or illness: Average</td><td>26.5%</td><td>26.4%</td><td>24.5%</td></tr>
<tr><td>Staff with a LTC or illness: Responses</td><td>484</td><td>583</td><td>694</td></tr>
<tr><td>Staff without a LTC or illness: Responses</td><td>2,556</td><td>2,736</td><td>2,768</td></tr>
</table>
<ul><li>Both group's scores have decreased yet both remain slightly above the national average</li></ul>
</td></tr>
<tr><td>Experienced bullying harassment and abuse from manager</td><td>
<table>
<tr><th></th><th>2018</th><th>2019</th><th>2020</th></tr>
<tr><td>Staff with a LTC or illness: Your org</td><td>20.0%</td><td>18.6%</td><td>18.0%</td></tr>
<tr><td>Staff without a LTC or illness: Your org</td><td>12.2%</td><td>11.8%</td><td>11.2%</td></tr>
<tr><td>Staff with a LTC or illness: Average</td><td>19.6%</td><td>18.5%</td><td>19.3%</td></tr>
<tr><td>Staff without a LTC or illness: Average</td><td>11.7%</td><td>10.8%</td><td>10.8%</td></tr>
<tr><td>Staff with a LTC or illness: Responses</td><td>481</td><td>582</td><td>694</td></tr>
</table>
<ul><li>Staff with long term conditions has continued to decrease, and is now below national average</li><li>Staff without long term conditions has also decreased, but remains above national average</li></ul>
</td></tr>
<tr><td>Experienced bullying harassment and abuse from colleagues</td><td>
<table>
<tr><th></th><th>2018</th><th>2019</th><th>2020</th></tr>
<tr><td>Staff with a LTC or illness: Your org</td><td>26.8%</td><td>28.3%</td><td>26.1%</td></tr>
<tr><td>Staff without a LTC or illness: Your org</td><td>17.5%</td><td>17.8%</td><td>19.2%</td></tr>
<tr><td>Staff with a LTC or illness: Average</td><td>27.7%</td><td>27.7%</td><td>26.9%</td></tr>
<tr><td>Staff without a LTC or illness: Average</td><td>18.0%</td><td>17.5%</td><td>17.8%</td></tr>
<tr><td>Staff with a LTC or illness: Responses</td><td>481</td><td>575</td><td>687</td></tr>
<tr><td>Staff without a LTC or illness: Responses</td><td>2,532</td><td>2,690</td><td>2,735</td></tr>
</table>
<ul><li>Staff with long term conditions has decreased and is now below national average</li><li>Staff without long term conditions has increased – remains above national average</li></ul>
</td></tr>
<tr><td>Reported the last time I experienced bullying harassment or abuse</td><td>
<table>
<tr><th></th><th>2018</th><th>2019</th><th>2020</th></tr>
<tr><td>Staff with a LTC or illness: Your org</td><td>38.8%</td><td>42.1%</td><td>41.8%</td></tr>
<tr><td>Staff without a LTC or illness: Your org</td><td>40.8%</td><td>41.3%</td><td>43.2%</td></tr>
<tr><td>Staff with a LTC or illness: Average</td><td>45.5%</td><td>47.0%</td><td>47.0%</td></tr>
<tr><td>Staff without a LTC or illness: Average</td><td>45.0%</td><td>46.1%</td><td>45.8%</td></tr>
<tr><td>Staff with a LTC or illness: Responses</td><td>201</td><td>280</td><td>311</td></tr>
<tr><td>Staff without a LTC or illness: Responses</td><td>822</td><td>950</td><td>972</td></tr>
</table>
<ul><li>Staff with long term conditions has decreased slightly and remains below the national average</li></ul>
</td></tr>
<tr><td>Believe org provides equal opps for career progression/ promotion</td><td>
<table>
<tr><th></th><th>2018</th><th>2019</th><th>2020</th></tr>
<tr><td>Staff with a LTC or illness: Your org</td><td>79.0%</td><td>79.6%</td><td>78.6%</td></tr>
<tr><td>Staff without a LTC or illness: Your org</td><td>86.3%</td><td>85.7%</td><td>81.9%</td></tr>
<tr><td>Staff with a LTC or illness: Average</td><td>78.4%</td><td>79.3%</td><td>79.6%</td></tr>
<tr><td>Staff without a LTC or illness: Average</td><td>85.5%</td><td>86.1%</td><td>86.3%</td></tr>
<tr><td>Staff with a LTC or illness: Responses</td><td>300</td><td>382</td><td>468</td></tr>
<tr><td>Staff without a LTC or illness: Responses</td><td>1,649</td><td>1,794</td><td>1,833</td></tr>
</table>
<ul><li>Staff with long term conditions has dropped slightly, below national average</li><li>Staff without long term conditions has decreased by almost 5% and is also below the national average</li></ul>
</td></tr>
<tr><td>Felt pressure from manager to come into work despite not feeling</td><td>
<table>
<tr><th></th><th>2018</th><th>2019</th><th>2020</th></tr>
<tr><td>Staff with a LTC or illness: Your org</td><td>36.8%</td><td>32.3%</td><td>31.0%</td></tr>
<tr><td>Staff without a LTC or illness: Your org</td><td>23.8%</td><td>22.7%</td><td>23.2%</td></tr>
<tr><td>Staff with a LTC or illness: Average</td><td>33.2%</td><td>32.6%</td><td>33.0%</td></tr>
<tr><td>Staff without a LTC or illness: Average</td><td>22.8%</td><td>21.8%</td><td>23.4%</td></tr>
<tr><td>Staff with a LTC or illness: Responses</td><td>359</td><td>412</td><td>451</td></tr>
<tr><td>Staff without a LTC or illness: Responses</td><td>1,310</td><td>1,460</td><td>1,138</td></tr>
</table>
<ul><li>Staff with long term conditions has decreased, and we are performing more strongly than the national average</li></ul>
</td></tr>
</table>

<table>
<tr><th>Indicator</th><th>Scores 2018-20 and analysis</th></tr>
<tr><td>well enough</td><td>• Staff without long term conditions has slightly increased</td></tr>
<tr><td>Satisfied with extent that organisation values their work</td><td>
<table>
<tr><th></th><th>2018</th><th>2019</th><th>2020</th></tr>
<tr><td>Staff with a LTC or illness: Your org</td><td>31.7%</td><td>38.5%</td><td>38.0%</td></tr>
<tr><td>Staff without a LTC or illness: Your org</td><td>41.0%</td><td>42.2%</td><td>45.2%</td></tr>
<tr><td>Staff with a LTC or illness: Average</td><td>36.8%</td><td>37.9%</td><td>37.4%</td></tr>
<tr><td>Staff without a LTC or illness: Average</td><td>47.8%</td><td>49.9%</td><td>49.3%</td></tr>
<tr><td>Staff with a LTC or illness: Responses</td><td>486</td><td>582</td><td>698</td></tr>
<tr><td>Staff without a LTC or illness: Responses</td><td>2,558</td><td>2,731</td><td>2,766</td></tr>
</table>
• Score has dropped slightly for long term conditions yet remains above the national average<br>• Staff without long term conditions has increased yet remains below the national average
</td></tr>
<tr><td>Employer has made adequate adjustments to enable them to do their work</td><td>
<table>
<tr><th></th><th>2018</th><th>2019</th><th>2020</th></tr>
<tr><td>Staff with a LTC or illness: Your org</td><td>75.8%</td><td>73.3%</td><td>77.7%</td></tr>
<tr><td>Staff with a LTC or illness: Average</td><td>73.1%</td><td>73.4%</td><td>75.5%</td></tr>
<tr><td>Staff with a LTC or illness: Responses</td><td>269</td><td>363</td><td>376</td></tr>
</table>
• Staff with long term conditions have increased by 4.4%. We are now above the national average
</td></tr>
<tr><td>Staff Engagement Score</td><td>
<table>
<tr><th></th><th>2018</th><th>2019</th><th>2020</th></tr>
<tr><td>Organisation average</td><td>6.8</td><td>6.9</td><td>6.9</td></tr>
<tr><td>Staff with a LTC or illness: Your org</td><td>6.5</td><td>6.6</td><td>6.7</td></tr>
<tr><td>Staff without a LTC or illness: Your org</td><td>6.9</td><td>6.9</td><td>6.9</td></tr>
<tr><td>Staff with a LTC or illness: Average</td><td>6.6</td><td>6.7</td><td>6.7</td></tr>
<tr><td>Staff without a LTC or illness: Average</td><td>7.1</td><td>7.1</td><td>7.1</td></tr>
</table>
• Staff engagement for colleagues with a long term condition has increased by 0.1 yet remains below the organisation's average.<br>• We are now in line with the national average for staff with long term conditions (6.7)
</td></tr>
</table>

The survey presents a mixed picture, with improvements in some areas and a few areas where more work needs to be done to enable a more consistent experience between colleagues with and without long term conditions.

## 2.3 Highlights from other protected characteristics

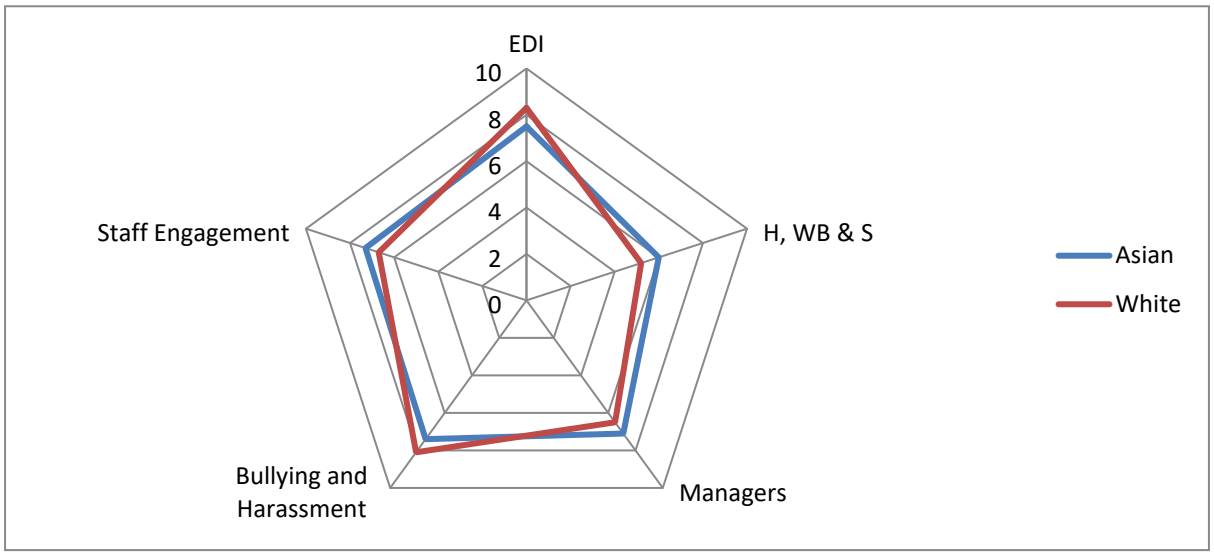
In addition to race and disability, the staff survey scores can also be looked at against the following characteristics: age, gender, religion and sexual orientation. The following identifies key themes and trends we have identified for these protected characteristics. We have also noted trends relating to ethnicity and disability characteristics' results which fall outside of the WRES and WDES.

### Ethnic background

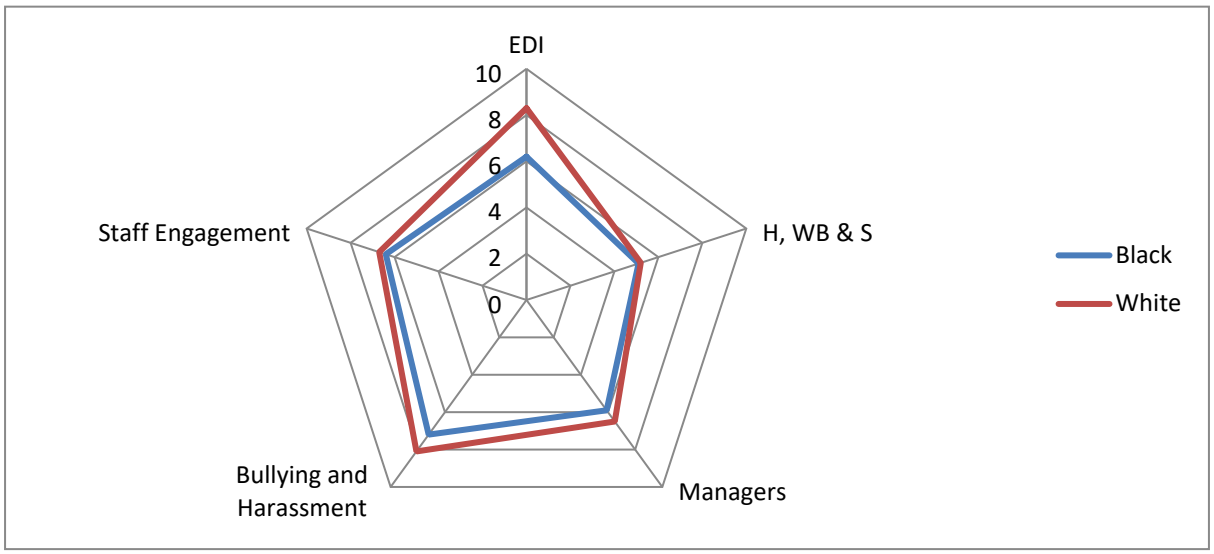
- Whilst ethnic minority colleagues report a worse experience in the WRES indicators listed above, they actually report a better experience than White colleagues in six of the ten survey themes:
    - Immediate Managers; Quality of Care; Quality of Safety Culture; health and wellbeing, Staff Engagement; Team Working
- White colleagues have reported a slight decreased score in the themes of Immediate Managers, Morale, Quality of care and Team working.
- The greatest differences between BME and White colleagues exist for the following themes:
    - Equality Diversity and Inclusion (White +2)
    - Quality of Care (BME +0.5)

- Quality of safety Culture (BME +0.7)
- Health and Wellbeing (BME 0.4)
- Staff Engagement (BME 0.3)

When looking at the ethnicity scores against the five priority themes, we can observe that compared to White colleagues, Asians colleagues in the Trust actually report a better experience in 3 of the themes: Health & Wellbeing; Immediate Managers; Staff Engagement.




When a similar analysis is undertaken to look at the experience of Black colleagues, we can observe that they overall have reported a worse experience across all themes (except Health & Wellbeing) with a significant gap in the Equality Diversity & Inclusion theme.




This further analysis of ethnicities which make up the Ethnic Minority/BME group underlines the variation which exists, and highlights that Black colleagues in particular require more attention and support to better understand and address the challenges they experience working in our Trust.

**Disability**

- Colleagues with a disability or long-term health condition scored below the Trust average for all themes.

- In particular, for the theme of Bullying and harassment the score remains below both the Trust and national average (8.0 vs. 7.5)
- The Health & Wellbeing theme score remains considerably below the trust average (6.1 vs. 5.0).
- There have been improvements in the scores for four themes (Morale; Bullying & Harassment; Safety Culture; Staff Engagement).
- There has been a slight decrease in scores for themes: Quality of Care; Immediate Managers and Team Working.
- There has been no change to the theme scores for: EDI; Health & Wellbeing; Violence
- Respondents with no disability or long term health condition scored equal to or above the Trust average for all themes.

**Age**

- The most noticeable differences in experience compared to the other age groups appear within the youngest and oldest age brackets
- The Health and Wellbeing, Immediate Managers Bullying & Harassment, Violence, Safety Culture and Team Working theme scores have fallen for 16-20 year olds since 2019.
- There are 5 themes which have dropped for 66+ years age group since 2019: EDI; Morale; Quality of Care; Violence; Staff Engagement
- All age groups' theme scores have improved for Morale except 66+ years where this has fallen by 0.4
- For the EDI theme, scores have improved for 16-30 year olds since 2019. They have dropped consecutively for all age groups aged 31 years+ over the last 2 years.

**LGBTQ+**

- Colleagues who reported they are Lesbian Gay or Bisexual reported lower scores across five themes compared to heterosexual colleagues: Equality Diversity and Inclusion; Health & Wellbeing; Bullying and Harassment; Violence; Quality of Care. These remain unchanged since 2019 results.
- In spite of this, scores have improved across seven themes for Gay and Lesbian colleagues, static for one theme (Safety Culture) and dropped for two themes (Staff Engagement; Team Working).
- For Bisexual colleagues there has been an even case with half of the themes seeing an improvement in their score, and half reporting a drop.
- Scores for straight/heterosexual colleagues remain largely static, with a drop of 0.1 in two themes (EDI; team working) and an increase in Health and Wellbeing (+0.2) and Violence (+0.1)

**Gender**

- Compared to 2019, Female respondents' score for EDI dropped 0.1 to meet the Trust average (9.0) whilst Male score remained static (9.0).
- Male respondents' Health and wellbeing score jumped significantly from 6.1 to 6.5. Female respondents also reported an improvement although less dramatic (from 5.8 to 6.0). The Male score for Quality of Care also jumped from 6.9 to 7.2, whereas the Female score remained static (7.2).
- Overall Male respondents reported an improvement in eight themes, and static in the remaining two.
- Overall Female respondents reported an improvement in two themes (health and wellbeing; violence), static in six themes, and a drop in two themes (EDI, team working).

**Religion**

- Six religions are cited in the Staff Survey results: Christian (50%), Buddhist (0.4%), Hindu (1.2%), Muslim (1.6%), Jewish (0.1%) and Sikh (0.1%). Three additional categories include 'no religion' (40%), 'any other religion' (1.4%) and 'prefer not to say' (5.1%).
- All groups except 'no religion' have reported a drop in the EDI theme, and are below the Trust average score (9.0). The biggest drop was for the 'any other religion' theme (which includes Jewish and Sikh) where the score fell from 9.0 to 8.1. The 'no religion' group remains above average (9.3).
- Bullying and harassment: the Christian and Hindu groups reported an increased score in this theme, and the no religion group remained static (and above the Trust average). Buddhists, Muslims and those belonging to another religion reported a drop. Muslims and any other religion groups are significantly below the Trust average (8.0) – 7.5 and 6.5 respectively.
- Violence: the theme score for Christians improved and remained static for those of no religion. The score for minority religions – Buddhist, Hindu, Muslim, and any other religion – all dropped compared to the previous year.
- Staff Engagement: scores improved or remained static for all groups with the exception of Buddhists where this dropped from 7.3 to 6.7. Groups which are below the Trust average score (6.9) are no religion (6.8) and Buddhist (6.7).

## 3.0 Developing a Cultural Barometer

In addition to the analysis already completed, a new "Cultural Barometer" is being piloted and currently in the early stages of being shared and circulated across divisions. A key aim of the Cultural Barometer is to support our aspirations to establish a truly compassionate and inclusive culture.

The Barometer provides deeper analysis and insight into protected characteristics, departments, and cost centres (where data available) to identify areas of strength and weakness/concern against the People and OD strategic priorities (page 2). As the focus of the barometer is around culture, compassion and inclusion we have also included the Bullying & Harassment theme.

In an effort to raise standards across the Trust our first focus is on identifying departments which are outliers. In other words:

- They are below average across the five People and OD strategic priority themes (including Bullying and Harassment; excluding Morale); or
- They are an outlier in some theme in a significant theme

We will also be using other sources of current and recent data to triangulate with and sense-check the staff survey responses. For example this is likely to include:

- Freedom to Speak Up themes

- Outputs and highlighted areas of concern identified through the “Big Conversation”/ Widening Participation Review, which has been led by DWC Consulting
- Themes from patient surveys
- Other relevant HR data (including relevant grievance and disciplinary cases, turnover, sickness absence)

Departments/cost centres identified through this type of analysis will firstly be shared with the relevant Divisional Tris and the line managers of these services. Relevant interventions/ support will be agreed and any new departments identified through this process will be incorporated into the divisional action plans (see section 1.3).

## 4.0 Staff Survey Priorities and Action Plan April 2020 – March 2022

Following the 2019 staff survey results, combined with the challenges of the Covid-19 pandemic which was announced days after these results were published, the actions we have identified covered a two-year period.

We agreed to review this action plan in light of the 2020 staff survey results and act on any new or unusual findings which we were not expecting.

This data this year, therefore is primarily being used to track our progress against the actions identified below. We will use the upcoming 2021 Staff Survey results to formally evaluate the success/completion of these actions in March 2022, and use the data to inform the next set of actions.

### 4.1 Trust-wide Priorities and Actions 2020-2022

The table overleaf lists the four priorities we identified, with an update on the actions already achieved and planned.

It has also been updated to reflect which divisions/departments/ staff groups and protected characteristics we will target in the year ahead.

| Priorities April 2020-March 2022 | Priority divisions/ departments/ staff groups/protected characteristics in 21/22 | Activities undertaken in 20/21, and planned 21/22 |
|---|---|---|
| **1. Develop and strengthen our compassionate culture**<br><br>**Linked SS themes**<br>• Immediate Managers<br>• Team Working<br>• Staff Engagement<br>• EDI | **Divisions/departments**<br>• D&S<br>  ○ OHP<br>  ○ Radiology<br>  ○ Pathology<br>• Medicine<br>  ○ ED<br>  ○ Acute Medicine<br>  ○ General/Old Age Medicine<br>  ○ Rheumatology<br>• Surgery<br>  ○ All departments<br>• Women & Children<br>  ○ Gynaecology<br>  ○ Paediatrics<br><br>**Staff groups**<br>• Healthcare Scientists<br>• Medical & Dental<br><br>**Protected characteristic groups**<br>• 16-20 and 21-30 year olds<br>• BAME | **Completed 20/21:**<br>• Compassionate behaviours framework launched<br>• Compassionate Leadership core module launched. Mandatory for all leaders and managers<br>**Planned 21/22:**<br>• Continued rollout of compassionate culture (programme of work to be refined and monitored by PACE)<br>• Targeted delivery of Compassionate Leadership training and other leadership/management development offers to areas where they have performed less well in relevant SS themes<br>• Longer Compassionate Leadership programme scheduled launch Autumn 21<br>• Incorporating Compassionate Leadership content into other leadership development programmes (IManage; IAspire) |
| **2. Proactively address bullying, harassment and discrimination experienced by colleagues**<br><br>**Linked SS themes** | **Divisions/departments**<br>• Medicine:<br>  ○ ED<br>  ○ Cardiology<br>  ○ General Medicine<br>• Surgery<br>  ○ All departments<br>• Women and Children | **Completed 20/21:**<br>• Additional FTSU Guardians identified and trained, including EDI/BAME Lead<br>• Updated Reasonable Adjustments section on 2020 Hub pages, including launch of “About My Health & Wellbeing Booklet” which is aimed at people with disabilities and long term health conditions<br>• Elements of Civility Saves Lives materials incorporated into Compassionate Leadership training (see above) |

| Priorities April 2020-March 2022 | Priority divisions/ departments/ staff groups/protected characteristics in 21/22 | Activities undertaken in 20/21, and planned 21/22 |
|---|---|---|
| • Bullying & harassment<br>• EDI<br>• Safety Culture | ○ All departments<br><br>**Staff groups**<br>• Medical & Dental<br>• Nursing & Midwifery<br><br>**Protected characteristic groups**<br>• BAME<br>• Disabled<br>• 21-30 year olds<br>• LGBT+ | • Sub-networks of the Umbrella Diversity Network established for: BAME; Disabled/Shielding; LGBT+<br>**Planned 21/22:**<br>• Launch of 'Respectful Resolution' campaign which includes: face to face training and online learning; refresh/review of Dignity at Work Policy<br>• Launch of Mediation faculty |
| **3. Continue to improve experience of appraisals and access to education and talent development opportunities**<br><br>**Linked SS themes**<br>• Quality of appraisals | **Priority divisions/departments**<br>• Medicine<br>○ Acute Medicine<br>○ Cardiology<br>○ ED<br>○ Gastro<br>• Surgery<br>○ All departments<br>• Women & Children<br>○ All departments<br><br>**Staff groups**<br>Medical & Dental<br><br>**Protected characteristic groups**<br>• BAME<br>• Disabled | **Completed 20/21:**<br>• Launched revised/refreshed appraisal paperwork, and associated training materials<br>• Mentoring faculty and mentoring skills workshop launched<br>**Planned 21/22:**<br>• ICS-wide Positive Action leadership development programmes aimed at: BAME, Disabled, LGBT+<br>• Align medical appraisal paperwork with non-medical paperwork, incorporating values/behaviours and health-wellbeing questions<br>• Positive action to encourage participation in the Accelerated Development Pool (ADP) at divisional level, and minority protected characteristics<br>• Launch reciprocal mentoring scheme |
| **4. Continued focus on the safety, health and wellbeing of** | **Priority divisions/departments**<br>• D&S<br>○ OHP | **Completed 20/21:**<br>• Expanded 2020 Hub team and Colleague Wellbeing Psychology service<br>• Additional FTSU Guardians identified and trained |

| Priorities April 2020-March 2022 | Priority divisions/ departments/ staff groups/protected characteristics in 21/22 | Activities undertaken in 20/21, and planned 21/22 |
|---|---|---|
| **colleagues**<br><br>**Linked SS themes**<br>• Health and wellbeing<br>• Safety culture<br>• Violence | ○ AHP services<br>• Medicine<br>○ ED<br>○ Acute Medicine<br>○ General/Old Age Medicine<br>○ Neurology<br>• Surgery<br>○ All departments<br>• Women & Children<br>○ Gynaecology<br>○ Maternity<br><br>**Staff groups**<br>• Additional Clinical Services<br>• Nursing & Midwifery<br>• Healthcare Scientists<br>• Medical & Dental<br><br>**Protected characteristic groups**<br>• BAME<br>• Disabled<br>• 21-30 year olds<br>• LGBT+ | • Launched TRiM Practitioner training/model<br>• Launched Trauma Awareness Training for Managers<br>• Launched wellness check-in toolkit<br>• Incorporated health-wellbeing questions into the appraisal paperwork<br>**Planned 21/22:**<br>• Embed new Psychology Link Workers<br>• Devise and implement annual health-wellbeing work plan<br>• Embed TRiM model into Business as Usual<br>• Grow the Peer Support Network by 50% (appoint an additional 12 volunteer colleagues) |

## 4.2 Focus on Bullying and harassment, and Violence and Aggression

As listed above, one of the main priorities identified last year (no.2) is to proactively address bullying, harassment and discrimination. Work on this has been limited in the last 12 months has focused on preparation and groundwork, and strengthening complementary support and referral systems for those who may feel they are experiencing this kind of treatment from colleagues or patients/visitors.

In 2021/22 our attention will concentrate on generating conversations, growing awareness, skills, and implementing robust structures for directly addressing bullying, harassment and inappropriate behaviours. This will build on our Compassionate Behaviours framework.

We have commissioned A Kind Life Ltd who will work with us to launch a suite of resources (under the heading “Respectful Resolution”) to support and train colleagues in how to: identify bullying behaviours, how to respond to these effectively, and develop skills in having conversations around inappropriate and unhelpful behaviours that we experience first-hand or witness. In July 2021 we will launch and begin to embed the following:

- A revised Dignity at Work policy, which is co-produced with key stakeholders including Staff-Side and colleagues who have previously contributed to the Big Conversation/Widening Participation Review
- E-learning which is available to all colleagues in Respectful Resolution. This is a highly interactive e-learning module with videos and case studies. It also includes a module on giving effective feedback
- A train the trainer workshop open to trainers, OD Specialists and managers to enable them to facilitate workshops and discussions around bullying behaviours and respectful resolution
- A clear five-step process for dealing with bullying/inappropriate behaviours. This will exist as a standalone process, with accompanying help guides, as well we be embedded into the new Dignity at Work policy
- Help guides for: someone who experiences bullying; someone accused of bullying; someone who witnesses bullying; a manager who is asked to investigate bullying
- Adding mediation as a formal part of complaints resolution

Alongside plans to improve support for colleagues around bullying and inappropriate behaviours, a new Violence & Aggression Group has recently been formed – co-chaired by the Director of Safety and Head of Health & Safety. This group will focus on V&A incidents which occur in the Trust – overwhelmingly by patients and their families. Further details of this are covered in a separate paper which is going to the POD Committee.

## 5.0 Next Steps

To support the achievement of the 21/22 action plan and improvement in the upcoming 2021 Staff Survey, we will undertake the following:

- Refine the divisional action plans to ensure these are SMART
- Connect with and learn from the CQC Outstanding Trusts which are performing the most highly in each of the five People and OD strategic priority themes

- Host webinars with members of the Diversity Network and sub networks (for ethnic minorities, disabled, and LGBTQ+ colleagues) to share the data relevant to them and identify what steps they think we can take to make improvements. This will coincide with the launch of the DWC “Big Conversation” report findings
- Pilot the Cultural Barometer with divisions. Work with and provide tailored support to departments/cost centres that have been identified through this process.

**Abigail Hopewell**
**Head of Leadership & OD**

**Coral Boston**
**Equality Diversity & Inclusion Lead**

Gloucestershire Hospitals
NHS Foundation Trust

**BOARD COMMITTEE – MAY 2021**

**VIOLENCE AND AGGRESSION INTERNAL AUDIT**

## 1. Introduction

In 2020 internal auditors BDO conducted an audit into the Trust's management of violence and aggression (V&A). The audit took place between 15 August 2020 and 10 September 2020.

Areas of good practice were noted including quarterly reporting of calls to the V&A Response Team, an Enhanced Care Programme to support vulnerable patients and V&A training resources.

The findings of the audit also noted that while the Trust had a generally sound system of internal control, rated as moderate, there was limited evidence of the effectiveness of the system. Five areas of concern were identified; all rated a medium risk to the system.

Each finding is outlined below, along with the Trust's response to the finding.

## 2. Audit Findings

### Audit Finding 1 (Medium)

There is no clear accountability for violence and aggression in terms of an accountable officer or group. The Security Management Group and Quality Delivery Group cover some aspects but neither is responsible for overall monitoring of incidents, and they are not referenced in the violence and aggression policy.

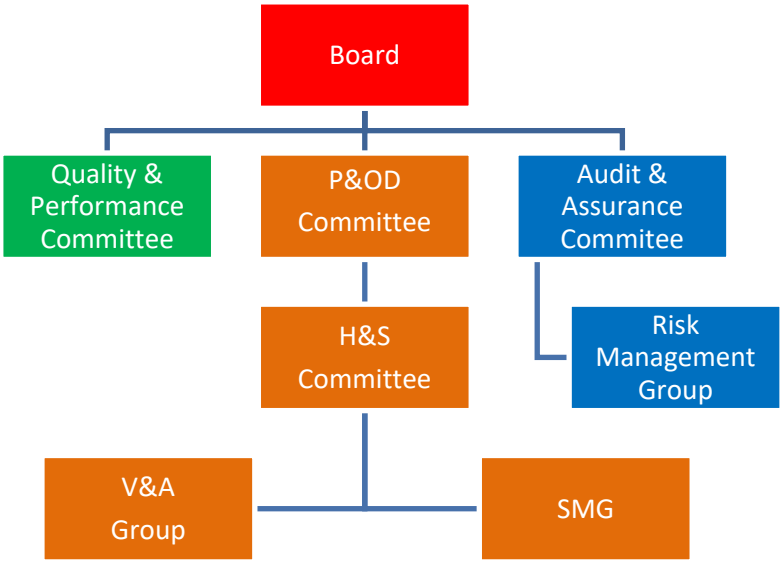
### Response to Audit Finding 1:

### Governance

The previous V&A Working Group had initially been absorbed into the work stream of the Security Management Group (SMG) on account of the clear link between the two and the cross-over in key stakeholders. However, it became apparent that the security agenda, which encompassed business continuity planning, required significant resources and work focused on addressing security and resilience. It was agreed that a separate V&A Group (V&AG) would need to be re-established to further the work for the V&A agenda. At the time of the audit this sub-group had not been re-established and, as a result, the governance of the V&A risk had not been given sufficient attention.

A monthly V&A sub-group (V&AG) was established in early 2021. The Group is now chaired by the Director for Safety and Quality Improvement who is the responsible officer for the work stream. The Director for Safety and Quality Improvement is supported by the Head of Risk, Health & Safety.

As shown in the governance chart below both the V&AG and SMG are now accountable to the Trust Health & Safety Committee (H&SC). However, exception reports can still be provided to the Quality Performance Committee in relation to the Enhanced Care Programme which is a key aspect of reducing V&A incidents. In addition, V&A risks will be managed through our Risk Management Process and referred to the Risk Management Group should they escalate.




**Responsibilities**

The group operates under an agreed Terms of Reference which reflects the Plan, Do, Check Act cycle outlined in the National Violence Prevention and Reduction Standard. Responsibilities include, but are not limited to:

- Agree the V&A policy Policies and Procedures
- Support the risk assessment and risk management processes; reviewing risk register entries
- Assess how well the risks are controlled and determine if the aims have been achieved
- Develop and monitor the delivery of the Violence Prevention & Reduction Standard.
- Review the training needs of staff, commission new training as required and monitoring training compliance and effectiveness
- Establish an annual improvement plan based on local data and the requirements of the national standards
- Involve NHS staff and key stakeholders in their delivery
- Deliver regular V&A reports to relevant the Committees
- Establish and monitor the Sanctions process
- Ensure staff support and debriefs are being delivered
- Monitor progress of the annual plan
- Establish V&A KPIs and dashboard
- To critically review V&A performance to direct and inform changes to policies or plans in response to any localised lessons learnt and incident data collected in respect of violence prevention and reduction

**Finding 2 (Medium)**

There is no evidence of review of the quarterly Violence and Aggression report due to the absence of clear accountability as per Finding One.

**Response to Audit Finding 2:**

**V&A Objective**

A V&A objective has been agreed within the H&S Plan 2021-24:

*Improve the organisational understanding, approach and response to incidents of abuse and physical aggression by patients to staff; thereby reversing the current upward trajectory of physical harm incidents to staff. We will reduce harm incidents reported by staff in the NHS survey to 8% or less.*

Progress against the V&A Objective and V&A incidents will be monitored on a bi-monthly basis through the Trust Health & Safety Report presented to the H&SC. An exceptions report is also provided to the H&SC by the Chair of the V&AG detailing progress of the working group. Divisions will also monitor proactive V&A work, incidents and lessons learnt through their Divisional H&S Meetings.

**V&A Multidisciplinary Work Programme**

The V&A Group coordinate a proactive programme of work via key V&A stakeholders including the Health & Safety, Safeguarding Team, Mental Health Team, V&A Response Team / GMS and key clinical staff.

The programme of work will include:

- A review our policy on abuse and aggression
- Ensure specialities and departments exposed to this risk have a valid and current risk assessment on abuse and aggression
- Ensure the consistent implementation of Mental Health Risk Assessments, Enhanced Care Risk Assessments or other patient-specific risk assessments / documentation which will improve our understanding of patient needs and enhance the way in which we communicate and care for this group of patients
- Development and implementation of a Vulnerability Framework
- The Mental Health Strategy and Development Group will develop and support the implementation of an agreed training requirement in relation to mental health patients and de-escalation techniques; including the frequency of such training and who should receive it
- Agreed training will be rolled out to relevant staff
- Explore the discrepancies in reporting of incidents
- Develop and Implement an investigation pro-forma for abuse and aggression incidents to support lessons learnt and feedback
- Review our environmental provisions through the Mental Health Strategy and Development Group and agree a standard for the acute Trust setting
- Ensure the V&A Response Team are appropriately licensed and trained in safer holding and mental health awareness
- Review the recording mechanism of the V&A Response Team
- Re-establish the Sanctions Process, including good governance and an escalation process for persistently challenging behaviours in relation to patients with capacity
- Continued communications around staff support

**Measuring Success**

It is acknowledged that the wider mental health programme will be a key role in the success of prevention and reduction strategies. A broad multidisciplinary programme is required which will consider influencing factors such as the complexity of clinical conditions, clinical assessments, our physical environment, staff competency and supporting resources and equipment. Year on year progress against the objective will be measured as follows:

- Year 1 (31 March 2022)
    - A consistent format will be in place for departmental abuse and aggression risk assessments
    - 95% of specialties and departments exposed to the abuse and aggression risk have a valid and current risk assessment stored in the Risk Assessment Library
    - A training course(s) will be developed and staff will have been invited to book as required. 30% of staff exposed to this risk will have completed the agreed training
    - The investigation pro-forma is introduced all abuse and aggression incidents and lessons / feedback are filtered to the appropriate staff / groups
    - A Vulnerability Framework will be published
    - The Policy on abuse and aggression will be reviewed and re-published
    - 12% or less of staff reporting physical harm caused by a patient, visitor or public via the NHS survey

- Year 2 (31 March 2023)
    - All specialties and departments exposed to the abuse and aggression risk have a valid and current risk assessment stored in the Risk Assessment Library
    - 60% of staff exposed to this risk will have completed the agreed training
    - Pulse surveys or audits show an improved staff perception and experience for abuse and aggression
    - The investigation pro-forma is completed for all abuse and aggression incidents and lessons / feedback are filtered to the appropriate staff / groups
    - 10% or less of staff reporting physical harm caused by a patient, visitor or public via the NHS survey

- Year 3 (31 March 2024)
    - All staff exposed to this risk will have completed the agreed training
    - Pulse surveys or audits show improved staff perception and experience for V&A
    - 8% or less of staff reporting physical harm caused by a patient, visitor or public via the NHS survey

**Finding 3 (Medium)**

There is no evidence of post-incident treatment or support provided to staff exposed to violence and aggression incidents.

**Response to Audit Finding 3:**

The BDO audit does not appear to have taken account of all the available evidence in regard to staff support. At the time of the audit evidence was available in relation to the support provided to staff involved in some of the more distressing V&A incidents.

The following staff support services are already well-established and information is provided to staff via the intranet Wellbeing & Support pages and through direct contact with the 2020 Hub. Neither these services nor the global communications around access to staff support are referenced in the BDO report. Services include:

- The 2020 Hub is open from 8am to 6pm
- Employee Assistance Programme which gives access to fully funded counselling sessions
- Colleague Health & Wellbeing Guide
- Peer Support Network which can assist in supporting staff who have experienced distressing or challenging situations
- Wellness Check-in Tool which can assist in structuring a wellness conversation between employee and manager
- Chaplaincy Team can provide spiritual and emotional wellbeing support
- Freedom to Speak Up Guardians provide a safe and confidential environment in which staff can speak to a Guardian
- Referral to an Occupational Health Nurse or Physician
- Well-being Support Group – meets weekly to discuss intervention where staff are identified as needing support
- Supporting Colleagues Toolkit for managers and leaders
- NHS annual survey which takes account of staff perception and experience of V&A in the workplace

The Trust has also introduced two further support initiatives since the audit:

- Trust Psychology Link Worker - provides direct support to teams where staff are identified as needing support such as decompression sessions, supervision and supporting managers caring for staff

- Trauma Risk Incident Management model (known as TRIM) which offers an alternative peer based support model for staff

The BDO recommendation appears to have focused on the V&A Response Team log which was designed to capture the attendance and immediate actions of the Team. This was not intended to capture the outcome of the incident, lessons learnt or staff support. These latter elements should be captured on the incident report on DATIX. The recommendation to update the Response Team De-briefing Form will be considered as part of the wider review of the Response Team's structure, competencies and responsibilities. GMS had already commenced this review at the time of the audit.

GMS is an employer in its own right and as such will remain legally responsible for reporting and monitoring V&A incidents involving their staff (namely porters) via their own internal H&S Committee. GMS will report V&A attendances on a quarterly basis to the V&AG, which in turn reports to the Trust H&SC Committee and effectively brings the two elements together.

**Finding 4 (Medium)**

Analysis on under-reporting of violence and aggression incidents is not being undertaken or reported.

**Response to Audit Finding 4:**

It is accepted that there is a discrepancy between the number of call logs recorded by the V&A Response Team (GMS) and the number of incidents reported on DATIX by GHFT staff. A percentage of this can be explained in that multiple attendances by the V&A Response Team to the same patient are logged individually by GMS, whereas GHFT staff may report this as the continuation of one incident over the period of one shift. However, divisional H&S meetings and the Trust H&SC will examine and address the discrepancy moving forward.

**Finding 5 (Medium)**

Categorisation of violence and aggression incidents is not detailed within the Violence and Aggression policy.

**Response to Audit Finding 5:**

The H&S Plan for 2021-2024 includes a requirement to review the existing V&A Policy within the financial year of 2021-2022. This review will take account of the recommendation by BDO to detail the incident reporting sub-categories for V&A.

## 3. Conclusion

Assurance is provided that a robust governance structure in now in place to manage and monitor the risk of V&A. A comprehensive multidisciplinary programme will be developed with a view to preventing and reducing V&A incidents.

Gloucestershire Hospitals NHS Foundation Trust

**REPORT TO TRUST BOARD – May 2021**

**From the People & Organisation Development Committee Chair – Alison Moon, Non-Executive Director**

This report describes the business conducted at the People and Organisational Development Committee on 27 April 2021 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

| | Report/Key Points | Challenges | Assurance | Residual Issues / gaps in controls or assurance |
|---|---|---|---|---|
| **Current Pressures and Impact on People and OD strategy** | Cost implications and cost pressure processes complete with success in securing support for new roles to develop health and wellbeing, equality, diversity and inclusion and HR Business Partner services.<br><br>A recovery plan is in draft for delayed progress related to COVID, such as OD activities in Divisions and Employee Relations Case management. | Has the funding been released into the 21/22 budget?<br><br>Can we have updates on progress with roles as they are filled<br><br>Is the Equality, Diversity and Inclusion (EDI) team appropriate and senior leadership sufficient?<br><br>Will we see improvements with the investment?<br><br>What else do you wish to achieve with the new | Assurance that there is a plan to achieve all areas of the strategy and funding confirmed.<br>Progress on recruiting to the roles will be shared with the committee.<br><br>Assurance received that with the 3 roles being funded and the new Health and Wellbeing senior post, this will release the Head of Leadership and OD to fulfil her senior leadership role in EDI.<br><br>Improvements in performance with new roles will be tracked through the assurance reports.<br><br>New resources will prevent stagnation, potential | Future performance reports and strategic measure reports will reflect the arrival and benefit of new resources and any emerging risks of inability to recruit. |

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| | | resources and given dashboard is largely green? | backward steps and will enable faster pace of delivery. Assured that expectation strategic dashboard items to move more positively | |
| **Equality, Diversity and Inclusion (EDI) Action Plan update** | The report provided an overview of the status of the EDI Board approved action plan, with many items now closed and delivered. It was noted a full report on progress inclusive of DWC findings would be provided to the Board in July 2021. | How can we keep a view of impact on the closed items?<br><br>Do we look at ethnic minorities data of those in talent pools and can we track people across groups?<br><br>Do we have accurate information on the modes of employment – full time/part time/flexible | Impact will be measured through the EDI action plan and measures of success can be measured through items such as staff survey improvements.<br><br>Assurance given that he Trust has data across all protected characteristics in the talent pools. Divisions have a view of their progress in recommending staff into talent pools and the ask to achieve the Model Employer Aspirations<br><br>The Trust holds this information however in the model employer aspirations the mode of employment is not considered. Models are based on head count. | Future strategic reports will outline the Trusts progress against Model Aspiration targets |
| **People and Organisational Development Dashboard** | Significant progress noted to have been made in Radiology and Healthcare Assistant stability/reduction in turnover.<br><br>Continued work on improving | Why is job planning poor in some areas? | Assurance received of good progress in some areas. Re job planning, assurance given of the commitment to achieve, teams were commonly working outside | |

| | | | | |
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| | appraisals especially in corporate where many people are working from home.<br><br>Mandatory training and sickness compliance is stable. | Are there other areas you are worried about or have a need to develop | their speciality through COVID. As services are restored job planning will improve. Some figures are impacted by small team numbers and long term absence. Job planning reviewed monthly in executive review meetings<br><br>The People and OD team plan to develop a Just and Learning culture dashboard to support the oversight of case management<br><br>Noted that performance in some corporate areas less than in divisions and currently no equivalent of the executive review process in place. | |
| **ICS Update** | Good progress in OD, leadership and education programmes e.g. online leadership department and stepping up programmes.<br><br>Poorer collaboration in areas of resourcing and recruitment and some missed opportunities to work collaboratively.<br><br>Lack of capacity and resources within partners remains an issue | How can this be escalated to the ICS Executive? | ICS HR Directors noted to be considering priorities and benefit of the white paper to support progress. | A review of the People structure to ensure it reflects the South West regional people board may assist collaboration and any updates will be provided to the Committee as these are agreed. |

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| | | How does the People function differ from the Finance approach to collaboration? | Appears to be more imperative for financial partners to work together in system plans/finances as required by the regulator | |
| **Employee Relations Report update on action plan and case management data** | Data on ethnicity of those entering disciplinary processes shows a disproportionate number of ethnic minorities entering formal cases. A review is underway as part of the Just and Learning culture processes.<br><br>Good progress against Dido Harding objectives noted.<br><br>The committee were advised of how a contemporary case will be reviewed using the Serious Incident methodology as a pilot. | In terms of casework data 19/20 and 20/21 – why are there some outliers of case days? Why is there notable deterioration year on year in some areas? | Briefed that COVID and external use of investigators can increase time especially where cases are complex. | The next Employment Relations report will provide reasons for outliers and use SPC charts to provide trend analysis of those above 'averages' and will look to remove these from the 'typical, less complex' cases |
| **Health and safety objectives for 2021-2022 and Violence and Aggression audit response** | The Health and Safety objectives performance for the last two years was provided. Many were achieved, with some deferred through COVID. 6 x New Health and Safety objectives have been approved for the next three years. These include Violence and Aggression (V and A) metrics, manual handling, sharps, risk assessments, workplace inspections, slips, trips and falls. | Can the committee see the impact of the new V&A governance? | Assurance was received on;<br>- The progress against the H&S objectives set<br>- the new 3 year plan<br>- new governance of violence and aggression and measures of success to reduce incidents over the next 3 years. | Audit report will be shared with members<br><br>A review of the V&A governance and work plan will be added to August 2021 agenda. |

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| | Summary of BDO Internal Audit on violence and aggression shared with committee with detailed management response to findings. | Could the full BDO audit report on Violence and Aggression come to the Committee, noting management response to finding 3 which had gone to Audit and Assurance Committee in January and been signed off. | Assurance given that there is evidence to support achievement regarding finding 3. | |
| **Medicine Division Presentation** | Presentation delivered regarding colleague experience in the Medicine Division<br><br>Two areas were focussed on; Equality, Diversity and Inclusion, (EDI) and Health and Wellbeing.<br><br>Data was shared on ethnicity of staff survey responses, highlighting the poorer experiences of black colleagues within the Division.<br><br>New health and wellbeing initiatives were described alongside impact<br>- Support mentor for colleagues<br>- Exit control panels | Given the large agenda, how can you ensure progress is made and embedded in all areas?<br><br>How do Medicine integrate Corporate initiatives i.e. compassionate leadership?<br><br>If these initiatives generate best practice, how is this shared? | The Committee welcomed the presentation and was assured on the focus and energy of the local leadership and on progress being made on large agenda. Importance of the cultural shift needed noted. Operational leads assigned for work streams to embed and use of support mentor noted.<br><br>The Division described how they 'join the dots' and use corporate programmes to aid embedding of the local agenda.<br><br>HR Business Partner and OD specialists meet together monthly to ensure learning and areas of overlap and duplication are minimised. | Future update to be scheduled |

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| | - HCA turnover reduced by 6%<br>- HR Clinics for managers<br>- Pathways to excellence councils established for shared decision making<br>- Continue conference call to support leaders<br>- Kitchen table meetings<br><br>Post COVID senior Tri road shows are underway and patient experience and Staff experience groups established<br><br>EDI initiatives discussed<br>- Recruitment<br>- Lived experience sharing<br>- Adding EDI to all agendas | What are the key areas of pressure and is there resistance to delivery of plans? | Leadership capacity, support and development of leaders especially at service Tri level is a challenge. The importance of band 7 ward leaders and their development is key. There is no resistance reported but changes in behaviours are required. The Division is working on performance and conduct issues and supporting people to flourish, having difficult conversations with those where needed.<br><br>Cross over with red rated quality indicators noted and importance of staff and patient work aligning to common aim | |
| **Staff Health and Wellbeing Hub Update** | An update on the services in place over the previous year and new plans was received. New innovations supported with national and local funding described including: TRIM, psychology link workers, resilience and trauma support and training. A new role to lead health and wellbeing.<br>New resources were added into the hub, it operated on a 7/7 basis and introduced new support measures for staff. | Did we do everything we wanted to do? Did we do more than we expected to?<br><br>How does the past year impact on 2021/22? | COVID completely disrupted existing plans and services noted to have grown beyond expectation over the year.<br><br>Noted there is national attention to health and wellbeing and the phase 4 recovery plan details support for staff with timescales for delivery.<br><br>Assurance received of huge focus and development over | Future health and wellbeing reports will provide an update on plans with SMART objectives. |

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| | | | the year | |
| **Freedom to Speak Up Update** | In Quarter 3 there were 25 speaking up contacts with more anonymous concerns than Q2. Noted to be similar with other trusts.<br><br>GMS now have their own freedom to speak up guardian<br><br>From May 2021 there will be a change in line management function of Freedom to Speak up to the CEO. This will provide greater independence and is in part an outcome of the DWC report where the Guardians perceived impartiality was questioned . | Why do people choose Freedom to Speak up for bullying and harassment concerns when the original idea of guardians was to highlight patient safety issues?<br><br>Is the Medicine Division a hot-spot?<br><br>In terms of distinction of cases – Staff vs Patients, are the Freedom to Speak Up guardians trained to manage these? | Reported that It is not an unusual use of Freedom to speak up and the use of guardians to discuss civility issues is reported nationally. Limitations of national coding described which place many staff reports into the category of Bullying and Harassment. This is not ideal as it is not apparently a true reflection of issues raised and the National Guardian Office have been made aware.<br><br>The Medicine Division is not an outlier. Across the year there have been more reports from Women's and Children and GMS, however it is difficult to classify anonymous reports through the reporting system.<br><br>Assurance received that guardians undertake national training. Bi weekly meetings and supervision is in place and the SW network is a forum for sharing. The role of the guardian is to triage the concerns and encourage staff | |

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| | | | to resolve them for themselves. | |
| **Staff Survey Results Update (Divisional results, WRES and WDES, reflection on actions – corporate and divisional)** | Detailed analysis presented following high level data at previous meeting<br>Of note: 22% of responses were from ethnic minorities. There had been improvement in health and wellbeing and Friends and Family Test questions.<br><br>Granular analysis provided a view of Divisional strengths and areas of concern and continuation of the existing 2 year plan including new actions.<br><br>The survey results suggested Black colleagues report a worse experience than other ethnicities and appear less engaged. Work to understand this being undertaken by the EDI lead. . | The lead time of the survey and results is long. Is there scope for us to do pulse surveys?<br><br>Certain communities do not seem to participate in the survey and seem less engaged – what can we do differently to encourage involvement? | Pulse surveys are part of the action plan alongside the desire to introduce the new cultural barometer and roll out the app further.<br>Work on scaling up surveys and targeting of specific groups of staff was reported. Joint working with Engagement and Comms team noted.<br><br>The EDI lead described ongoing efforts and the view that she expects an improvement in results in 2021 but advised the committee that it was still early days and change may take time to embed.<br><br>Committee noted progress and improvement plans | Update on staff survey action plan to committee in October 2021 |

**Alison Moon**
**Chair of People and OD Committee, 27 April 2021**

Gloucestershire Hospitals
NHS Foundation Trust

**TRUST PUBLIC BOARD – 13 May 2021**
**Microsoft Teams – Commencing at 12:30**

| **Report Title** |
|---|
| **Guardian for Safe Working – Quarterly Report** |
| **Sponsor and Author(s)** |
| Author: Dr Simon Pirie, Guardian for Safe Working<br>Sponsor: Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO |
| **Executive Summary** |
| Purpose<br>This report covers the period of 1st January 2021 to 31st March 2021.<br><br>Key issues to note<br>There were 46 exception reports logged.<br>There were 0 fines levied.<br>No correlation with Datix clinical incident reports for this period.<br><br>Conclusions<br>The number of exceptions has reduced this quarter.<br><br>Implications and Future Action Required<br>The Guardian for Safe Working will continue to monitor exception reports and assist divisions and specialities where these arise to ensure improved compliance |
| **Recommendations** |
| The Board should be ASSURED that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly. |
| **Impact Upon Strategic Objectives** |
| Managing Junior Doctor hours and ensuring compliance with National Terms and conditions ensures colleagues have the rest and recuperation necessary for their own wellbeing and to deliver safe care. Safe working therefore assists the Trust in achieving its objectives, specifically around compassionate workforce and Outstanding Care. |
| **Impact Upon Corporate Risks** |
| Ensuring working hours are reasonable and in line with national terms and conditions assists in reducing the risk of errors, poor decision making or poor care due to tiredness and fatigue. |
| **Regulatory and/or Legal Implications** |
| Under the 2016 terms and conditions of service (TCS) for junior doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the board of compliance with safe working hour's limits. |
| **Equality & Patient Impact** |
| There is a risk that tired staff can make errors and this could be detrimental to patient care and outcomes. Ensuring Junior Drs have a similar experience across divisions and specialities in terms of working hours provides an equitable experience during training. |

| 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 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)** |
| | | | | | | | N/A |

| Outcome of discussion when presented to previous Committees/TLT |
|---|
| N/A |

# Quarterly Guardian Report on Safe Working Hours for Doctors and Dentists in Training

**For Presentation to the Main Board**

## 1. Executive Summary

1.1 This report covers the period of 1.1.21 – 31.3.21. There were 46 exception reports logged.

1.2 During this period, 0 fines were levied.

## 2. Introduction

2.1 Under the 2016 terms and conditions of service (TCS) for junior doctors, the trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The guardian oversees exception reports and assures the board of compliance with safe working hour's limits. The Terms and conditions have been updated in 2019, with further requirements being monitored.

2.3 The structure of this report follows guidance provided by NHS Employers.

**High level data**

| | |
|---|---|
| Number of doctors / dentists in training (total): | 378 |
| No. of trainees | 470 |
| Trust Doctors | 252 |
| Amount of time available in job plan for guardian: | 2PA |
| Administrative support: | 4Hrs |
| Amount of job-planned time for educational supervisors: | 0.25/0.125 PAs (first/additional trainees to maximum 0.5 SPA) |

## 3. Junior Doctor Vacancies

| Junior Doctor Vacancies by Department | | | | | |
|---|---|---|---|---|---|
| **Department** | **F1** | **F2** | **ST1-2** | **ST3-8** | **Additional training and trust grade vacancies** |
| **ED** | 0 | 0 | 0 | 0 | **1x Trust Doctor** |
| **Oncology** | 0 | 0 | 0 | 0 | **1x Clinical fellow**<br>**1x Specialty Dr Palliative care** |
| **T&O** | 0 | 0 | 0 | 0 | **1 Trust Dr**<br>**3 x Trust Dr (ST1)** |
| **Surgery** | 0 | 0 | 0 | 0 | **1xTrust VR Fellow Ophthalmology**<br>**1x Glaucoma Ophthalmology Fellow**<br>**1x Corneal Ophthalmology Fellow**<br>**4x Clinical Fellows Anaesthetics**<br>**1x Trust Dr Upper Gi/Colorectal** |
| **General Medicine** | 0 | 0 | 0 | 0 | **10x Trust Dr General Medicine**<br>**1x Trust Dr Orthogeris** |
| **Paeds** | 0 | 0 | 0 | 0 | |
| **Obs & Gynae** | 0 | 0 | 0 | 0 | **2x clinical fellows** |

## 4. Locum Bookings

4.1 Data from finance team:

Full data unavailable at time of writing.

## 5. Exception Reports (working hours)

| Specialty | Exceptions raised |
|---|---|
| **General/GI Surgery** | 9 |
| **Urology** | 1 |
| **Trauma/ Ortho** | 0 |
| **ENT** | 0 |
| **MaxFax** | 0 |
| **Ophthalmology** | 3 |
| **Orthogeriatrics** | 0 |
| **General/old age Medicine** | 5 |
| **Neurology** | 0 |
| **Cardiology** | 0 |
| **Respiratory** | 0 |
| **Gastro** | 0 |
| **Renal** | 1 |
| **Endocrine** | 0 |
| **Acute medicine/ ACUA** | 24 |
| **Emergency Department** | 2 |
| **Obstetrics and Gynaecology** | 0 |
| **Paediatrics** | 1 |
| **Anaesthetics** | 0 |
| **Oncology** | 0 |
| **Haematology** | 0 |
| **GP** | 0 |
| **Total** | **46** |

## 6. Fines this Quarter

6.1 This quarter, there have been no fines levied.

## 7. Issues Arising

7.1 There were 3 reports listed as 'immediate safety concern', no specific incidents occurred, these were related to degree of patient workload compared to the number of staff which was felt to be very high and a clinical risk. These were escalated to the supervising teams.

## 8. Actions Taken to Resolve Issues

8.1 As above.

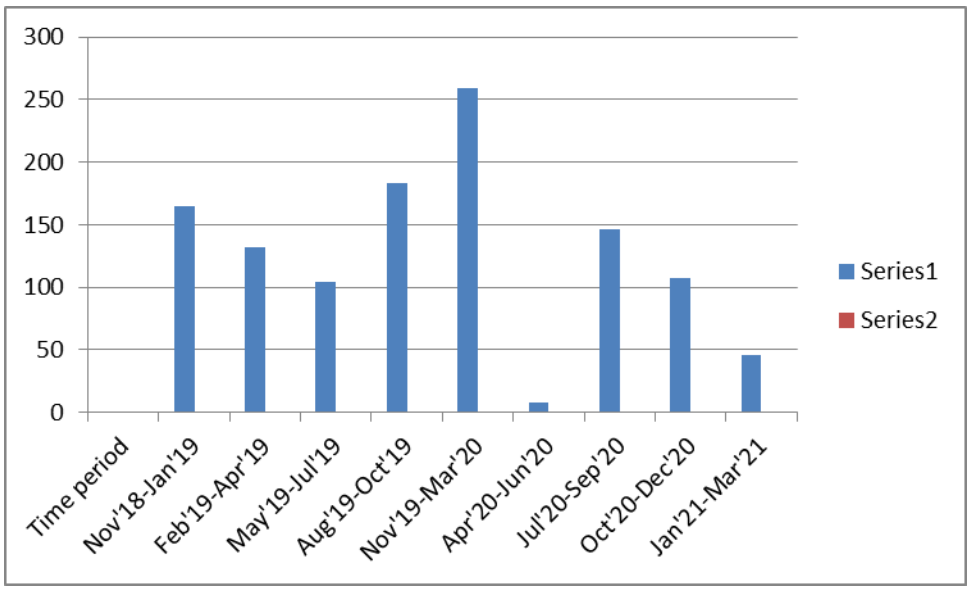
## 9. Correlations to Clinical Incident Reporting

9.1 There were no Datix reports of harm noted that correlated with dates of exception reports submitted during this period.

## 10. Junior Doctors Forum

10.1 The Junior Doctor's forum meets every other month. A sub-group is working on a plan for the utilization of the fatigue and facilities funding which needs to be used this financial year.

## 11. Trajectory of exception reports




The graph shows the number of exception reports per quarter.

## 12. Summary

11.1 A total of 46 working hour's exception reports have been made from the beginning of Jan '21 to the end of Mar '21. No fines were levied. The overall rate of exception reports has decreased markedly this quarter.

**Author:** **Dr Simon Pirie, Guardian of Safe Working Hours**

**Presenting Director:** **Prof Mark Pietroni**

Date 18/10/2020

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**Recommendation**

- To endorse
- To approve

**Appendices**

*Link to rota rules factsheet:*
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20August%202016%20v2.pdf

*Link to exception reporting flow chart (safe working hours):*
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Safe%20working%20flow%20chart.pdf

Gloucestershire Hospitals NHS Foundation Trust

**Public Trust Board – 13 May 2021**
**Microsoft Teams – Commencing 12:30**

| **Report Title** |
|---|
| **QUALITY AND PERFORMANCE REPORT** |
| **Sponsor and Author(s)** |
| Author: Felicity Taylor-Drewe, Director Planned Care / Deputy COO, Eve Olivant, Acting Deputy Chief Nurse<br>Sponsor: Rachael De Caux, Chief Operating Officer & Steve Hams, Chief Nurse |
| **Executive Summary** |


Purpose

This report summarises the key highlights and exceptions in Trust performance for the March 2021 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.

Patient Experience - Friends and Family Test and PALS data

In March, we reviewed all the FFT thresholds, to realign them with our performance over the last 12 months. In some cases this led to us decreasing the targets on specific surveys, to provide a greater sense of assurance around the trends, as previously the scores were only showing as red which didn't enable us to track any progress or deterioration in the reported experience. Overall our Trust positive score decreased slightly to 92.1%, with all surveys showing a decrease in positive score except for outpatients which has remained stable at 94.5%.

The national reporting will resume shortly, and we will be able to see how this compares with peer organisations. Additionally, we are expecting the results of a number of National Survey programmes soon, the results of which can be triangulated with the FFT feedback to support a Trust-wide improvement plan for adult inpatient areas.

The number of PALS concerns being closed within 5 days remains below the target of 95%. Additional resource has been put into the team, but the volume and complexity of cases continues to grow. This is on enhanced surveillance at QDG, and trends being monitored so that work can be done with divisions where there is a strong theme or trend (such as communication with the ward and lost property), which aims to improve the experience of patients and relatives and will reduce the volume of concerns coming through the PALS team.

C. difficile – infection rate per 100,000 bed days

During March 2021 the Trust had 3 hospital onset health care associated cases of C. difficile and 5 community onset health care associated cases of C. difficile. All hospital onset cases are having a post infection review to ascertain any lapses in care and quality associated with them. A local action plan will be generated with the affected ward to address any lapses identified. In April 2021, the Trust is launching new CDI treatment guidelines in line with NICE to optimise patient management and treatment, which we anticipate should prevent further CDI episodes. Joint audits of cleaning standards continue between the IPC team and GMS with estates works also being reviewed as part of this process. The AMS committee are also looking at implementing a new process of antibiotic

prescribing auditing which will bring rapid feedback to a speciality in a more engaging manner with prescribers.

Number of falls per 1000 bed days

The number of falls per 1000 bed days is currently high but has reduced slightly from February. Falls have increased due to a number of factors; increased deconditioning, reduced visiting which decreases supervision, inability to fill enhanced care requests, multiple bed moves and transfers including late at night, and registered nurse to healthcare assistance staffing ratios being below the optimal 60:40, particularly in care of the elderly wards. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in the Preventing Harm Hub. The plan was brought to QDG in April, with all divisions being asked to create a local falls improvement plan to support the corporate plan.

Hospital Standardised Mortality Ratio

HSMR remains "higher than expected" due to COVID. When the COVID codes are removed, actual indicator falls to within expected range and Peer review shows we are in line with COVID Peers determined by Dr Foster.

% C-section rate (planned and emergency)

A review of patients that underwent Induction of Labour will be undertaken to validate the appropriateness. The maternity team will also undertake benchmarking against peer hospitals and national datasets, to understand if we are an outlier or if there has been a national increase in this area.

## Performance

There remains significant focus and effort from operational teams to support performance recovery and restoration and to maximise activity within existing resources.
In March 2021, the trust performance against the 4hr A&E standard was 69.77% including system performance was 80%.

In respect of RTT, we are reporting 69.05 % for March 2021 un-validated, whilst this is below the national standard; this is within the context of the Covid-19 position. Operational teams continue to monitor and manage the patients through clinical urgency within the capacity constraints.
Our performance against the cancer standard saw delivery in delivery for the 2 week standard at 97% (un-validated) for March. Cancer 62 day Referral to Treatment (GP referral) performance for March was 82.2% un-validated.

<u>Key issues to note</u>

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. Further details are provided within the exception reports.
Quality delivery (with the exception of those areas discussed) remains stable, with exception reporting from divisions through QDG for monitoring and assurance.

**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 as we move forward to recovery.

**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. |
| **Regulatory and/or Legal Implications** |
| No fining regime determined for 2021 within C-19 at this time, activity recovery aligned with Elective Recovery Fund requirements / gateways. |

| **Resource Implications** | | | |
|---|---|---|---|
| Finance | | Information Management & Technology | |
| Human Resources | | Buildings | |
| | | | |

| **Action/Decision Required** | | | | | | | |
|---|---|---|---|---|---|---|---|
| For Decision | | For Assurance | ✓ | For Approval | | For Information | |

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

Gloucestershire Hospitals
NHS Foundation Trust

# Quality and Performance Report

## Reporting Period March 2021

***Presented at April 2021 Q&P and May 2021 Trust Board***

# Contents

Gloucestershire Hospitals NHS Foundation Trust

# Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we move forward with restoration and recovery of services. 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. 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.

The Trust is phasing in the support for increasing elective activity within April and currently meets the gateway targets for elective activity.

During March, 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 March was 69.77%, against the STP trajectory of 85.79%. The system did not meet the delivery of 90% for the system in March, at 80.00%.

The Trust did not meet the diagnostics standard for March at 19.48%. 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 97.0% in March but did not meet the standard for 62 day cancer waits at 83.1%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.40% (un-validated) in March, work continues to ensure that the performance is stabilised. Similar to other acute Trusts we have a significant number of patients waiting on our elective lists the number of patients waiting more than 52 weeks was 3,075 in March. 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. A recovery and restoration group has commenced in April to support all Divisional services.

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.

# Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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 | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Count of handover delays 30-60 minutes | Trajectory | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 |
| | Actual | 105 | 61 | 57 | 88 | 78 | 166 | 140 | 152 | 166 | 333 | 286 | 262 | 362 |
| Count of handover delays 60+ minutes | Trajectory | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Actual | 2 | 0 | 0 | 5 | 1 | 36 | 21 | 42 | 95 | 440 | 336 | 219 | 382 |
| 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 | 85.08% | 89.93% | 88.72% | 89.94% | 90.05% | 83.26% | 82.34% | 80.21% | 79.64% | 77.06% | 77.82% | 78.62% | 80.00% |
| ED: % total time in department – under 4 hours (type 1) | Trajectory | 85.79% | 85.32% | 85.37% | 85.17% | 85.90% | 85.22% | 85.61% | 85.89% | 86.04% | 85.99% | 86.19% | 85.36% | 85.79% |
| | Actual | 78.56% | 87.46% | 85.41% | 85.06% | 84.46% | 73.53% | 71.74% | 68.96% | 69.40% | 65.43% | 68.82% | 69.50% | 69.77% |
| Referral to treatment ongoing pathways under 18 weeks (%) | Trajectory | 81.00% | 81.00% | 81.00% | 81.00% | 81.00% | 81.00% | 81.00% | 81.00% | 81.00% | 81.00% | 81.00% | 81.00% | 81.00% |
| | Actual | 81.01% | 73.61% | 66.53% | 59.06% | 55.83% | 60.07% | 66.27% | 69.36% | 70.06% | 68.84% | 69.89% | 68.23% | 69.40% |
| Referral to treatment ongoing pathways over 52 weeks (number) | Trajectory | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Actual | 33 | 156 | 366 | 694 | 1037 | 1233 | 1279 | 1285 | 1411 | 1602 | 2234 | 2679 | 3075 |
| % waiting for diagnostics 6 week wait and over (15 key tests) | Trajectory | 0.98% | 0.99% | 0.99% | 0.99% | 0.99% | 0.99% | 0.99% | 0.99% | 0.99% | 0.99% | 0.99% | 0.99% | 0.00% |
| | Actual | 3.16% | 41.95% | 43.43% | 29.54% | 26.07% | 25.49% | 23.00% | 17.50% | 14.67% | 14.04% | 24.59% | 20.33% | 19.48% |
| 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 | 95.10% | 90.60% | 99.10% | 98.00% | 96.50% | 90.80% | 95.20% | 93.10% | 91.60% | 93.70% | 90.10% | 96.90% | 97.00% |
| 2 week wait breast symptomatic referrals | Trajectory | 93.20% | 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 | 98.40% | 87.90% | 97.80% | 95.70% | 96.40% | 95.90% | 93.40% | 97.10% | 85.20% | 91.80% | 70.60% | 98.70% | 99.00% |
| Cancer – 31 day diagnosis to treatment (first treatments) | Trajectory | 96.20% | 96.00% | 96.00% | 96.00% | 96.00% | 96.00% | 96.00% | 96.00% | 96.00% | 96.00% | 96.00% | 96.00% | 96.00% |
| | Actual | 95.50% | 96.60% | 96.00% | 95.30% | 98.10% | 96.70% | 96.40% | 99.30% | 99.30% | 97.60% | 97.70% | 99.10% | 98.60% |
| Cancer – 31 day diagnosis to treatment (subsequent – drug) | Trajectory | 98.00% | 98.00% | 98.00% | 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% | 94.00% | 97.00% | 100.00% | 100.00% | 100.00% | 100.00% | 98.00% | 98.10% | 96.60% | 99.30% |
| Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) | Trajectory | 95.10% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% |
| | Actual | 100.00% | 98.30% | 96.70% | 86.50% | 83.00% | 98.30% | 97.30% | 98.70% | 94.70% | 98.50% | 97.40% | 100.00% | 95.20% |
| Cancer – 31 day diagnosis to treatment (subsequent – surgery) | Trajectory | 94.80% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% | 94.00% |
| | Actual | 94.10% | 98.20% | 92.60% | 81.30% | 78.90% | 87.20% | 96.20% | 96.80% | 96.80% | 100.00% | 93.90% | 95.20% | 93.60% |
| Cancer 62 day referral to treatment (screenings) | Trajectory | 90.60% | 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 | 94.70% | 90.90% | 54.50% | 60.00% | 66.70% | 77.80% | 88.90% | 100.00% | 96.80% | 100.00% | 93.30% | 91.70% | 89.50% |
| 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 | 76.50% | 100.00% | 88.90% | 73.70% | 91.70% | 90.00% | 91.70% | 85.00% | 70.80% | 61.90% | 59.40% | 88.90% | 73.30% |
| Cancer 62 day referral to treatment (urgent GP referral) | Trajectory | 85.00% | 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 | 78.20% | 78.00% | 69.00% | 78.00% | 85.60% | 87.60% | 81.50% | 84.60% | 79.70% | 84.80% | 86.30% | 81.10% | 83.10% |

# Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Monthly (Mar) | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GP Referrals | 7,888 | 3,076 | 3,946 | 3,185 | 8,119 | 7,784 | 8,181 | 8,746 | 7,679 | 6,937 | 6,713 | 6,895 | 8,457 | 7.2% | -109.8% |
| OP Attendances | 10,637 | 26,018 | 30,419 | 40,646 | 44,330 | 39,151 | 49,790 | 51,948 | 51,957 | 46,742 | 45,157 | 45,359 | 57,227 | 438.0% | 713.9% |
| New OP Attendances | | 7,002 | 8,812 | 12,052 | 13,870 | 12,542 | 16,179 | 17,326 | 16,882 | 14,025 | 13,438 | 13,285 | 17,751 | | |
| FUP OP Attendances | | 19,016 | 21,607 | 28,594 | 30,460 | 26,609 | 33,611 | 34,622 | 35,075 | 32,717 | 31,719 | 32,074 | 39,476 | | |
| Day cases | 4,216 | 1,473 | 1,786 | 2,721 | 3,467 | 3,109 | 4,414 | 4,586 | 4,396 | 3,972 | 3,266 | 3,140 | 4,269 | 1.3% | -133.6% |
| All electives | 4,966 | 1,780 | 2,183 | 3,252 | 4,242 | 3,965 | 5,366 | 5,640 | 5,275 | 4,599 | 3,603 | 3,569 | 4,869 | -2.0% | -128.9% |
| ED Attendances | 9,721 | 6,861 | 8,913 | 9,819 | 10,957 | 11,636 | 10,903 | 10,279 | 9,475 | 9,309 | 8,290 | 8,021 | 10,687 | 9.9% | -72.2% |
| Non Electives | 3,874 | 3,110 | 3,728 | 4,205 | 4,421 | 4,320 | 4,495 | 4,584 | 4,233 | 4,202 | 3,973 | 3,725 | 4,534 | 17.0% | -35.9% |

# Trust Scorecard - Safe (1)

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

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 20/21 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Infection Control** | | | | | | | | | | | | | | | | | | |
| COVID-19 community-onset – First positive specimen <=2 days after admission | | | 250 | 64 | 9 | 5 | 4 | 18 | 48 | 224 | 193 | 444 | 112 | 29 | 585 | 1,395 | No target | |
| COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission | | | 68 | 7 | 1 | 1 | 0 | 1 | 3 | 57 | 71 | 42 | 11 | 3 | 56 | 265 | No target | |
| COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission | | | 38 | 1 | 2 | 1 | 0 | 0 | 0 | 55 | 48 | 41 | 5 | 1 | 47 | 192 | No target | |
| COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission | | | 33 | 4 | 1 | 1 | 1 | 0 | 0 | 57 | 56 | 30 | 3 | 2 | 35 | 188 | No target | |
| 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Zero | |
| Number of trust apportioned Clostridium difficile cases per month | 97 | 5 | 4 | 7 | 2 | 7 | 0 | 4 | 8 | 4 | 4 | 4 | 11 | 8 | 23 | 75 | 2019/20: 114 | |
| Number of hospital-onset healthcare-associated Clostridioides difficile cases per month | 5 | 2 | 1 | 4 | 1 | 2 | 6 | 1 | 1 | 2 | 1 | 2 | 5 | 3 | 10 | 29 | <=5 | |
| Number of community-onset healthcare-associated Clostridioides difficile cases per month | 45 | 3 | 3 | 3 | 1 | 5 | 6 | 3 | 7 | 2 | 3 | 2 | 6 | 5 | 13 | 46 | <=5 | |
| Clostridium difficile – infection rate per 100,000 bed days | 28.8 | 17.6 | 25.6 | 38.6 | 9.9 | 30.3 | | 15.7 | 29.2 | 15.8 | 15.2 | 19.2 | 21.8 | 30.9 | 31.9 | 22.7 | <30.2 | |
| Number of MSSA bacteraemia cases | 18 | 2 | 1 | 0 | 3 | 1 | 1 | 0 | 1 | 1 | 4 | 1 | 2 | 3 | 6 | 18 | <=8 | |
| MSSA – infection rate per 100,000 bed days | 5.3 | 7 | 6.4 | | 14.9 | 4.3 | 4 | | 3.6 | 3.9 | 15.2 | 3.8 | 5.9 | 11.6 | 8 | 6.4 | <=12.7 | |
| Number of ecoli cases | 46 | 2 | 1 | 3 | 2 | 4 | 3 | 0 | 6 | 3 | 1 | 2 | 3 | 2 | 7 | 30 | No target | |
| Number of pseudomona cases | 9 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 1 | 1 | 2 | 6 | No target | |
| Number of klebsiella cases | 18 | 1 | 1 | 2 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 3 | 0 | 2 | 5 | 12 | No target | |
| Number of bed days lost due to infection control outbreaks | 1,264 | 0 | | 0 | 0 | 4 | 0 | 0 | 5 | | | | | 0 | | 9 | <10 | >30 |

# Trust Scorecard - Safe (2)

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 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 | 6.4 | 6 | 7.9 | 7.2 | 7 | 7.3 | 7.5 | 6.9 | 7.7 | 8.5 | 8.6 | 7.5 | 6.6 | 7.6 | 7.4 | <=6 | |
| Number of falls resulting in harm (moderate/severe) | 4 | 0 | 2 | 4 | 4 | 3 | 4 | 3 | 6 | 6 | 5 | 4 | 6 | 6 | 16 | 53 | <=3 | |
| Number of patient safety incidents – severe harm (major/death) | 6 | 2 | 4 | 1 | 5 | 2 | 7 | 4 | 5 | 6 | 7 | 4 | 3 | 10 | 17 | 58 | No target | |
| Medication error resulting in severe harm | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | No target | |
| Medication error resulting in moderate harm | 2 | 1 | 2 | 3 | 2 | 6 | 1 | 2 | 1 | 1 | 1 | 6 | 6 | 4 | 16 | 35 | No target | |
| Medication error resulting in low harm | 12 | 11 | 9 | 15 | 7 | 8 | 14 | 14 | 9 | 15 | 8 | 14 | 10 | 11 | 35 | 134 | No target | |
| Number of category 2 pressure ulcers acquired as in-patient | 30 | 23 | 13 | 15 | 16 | 9 | 24 | 13 | 23 | 28 | 30 | 27 | 19 | 29 | 75 | 246 | <=30 | |
| Number of category 3 pressure ulcers acquired as in-patient | 5 | 1 | 0 | 1 | 0 | 1 | 3 | 4 | 5 | 3 | 1 | 0 | 1 | 1 | 2 | 20 | <=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 | | 3 | 3 | 4 | 7 | 4 | 5 | 9 | 7 | 6 | 4 | 2 | 3 | 1 | 6 | 55 | <=3 | |
| Number of deep tissue injury pressure ulcers acquired as in-patient | | 4 | 4 | 6 | 1 | 2 | 6 | 4 | 12 | 5 | 11 | 6 | 3 | 4 | 13 | 64 | <=5 | |
| **RIDDOR** | | | | | | | | | | | | | | | | | | |
| Number of RIDDOR | 35 | 2 | 2 | 1 | 5 | 3 | 0 | 2 | 1 | 3 | 3 | 3 | 2 | 4 | 10 | 55 | SPC | |
| **Safeguarding** | | | | | | | | | | | | | | | | | | |
| Number of DoLs applied for | | 33 | | | 41 | 59 | 38 | | | | 45 | 32 | 46 | 29 | 107 | 323 | No target | |
| Total attendances for infants aged < 6 months, all head injuries/long bone fractures | | | 1 | | | 18 | | | 9 | 6 | 7 | 0 | 7 | 3 | 10 | 50 | No target | |
| Total attendances for infants aged < 6 months, other serious injury | | | 17 | | | 30 | | | 3 | 1 | 0 | 0 | 0 | 1 | 1 | 52 | No target | |
| Total admissions aged 0-18 with DSH | | | 6 | | | 31 | | | 6 | 11 | 3 | 4 | 16 | 12 | 32 | 89 | No target | |
| Total ED attendances aged 0-18 with DSH | | | 26 | | | 55 | | | | 51 | 31 | 36 | 32 | 32 | 100 | 263 | No target | |
| Total number of maternity social concerns forms completed | | 31 | | | 48 | | | | | | | | 50 | 62 | 112 | 112 | No target | |

# Trust Scorecard - Safe (3)

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 20/21 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Safety Thermometer - National Data Collection Paused** | | | | | | | | | | | | | | | | | | |
| Safety thermometer – % of new harms | 97.1% | 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% | 68.00% | | | 68.00% | | | 74.00% | | | 67.00% | | | | | 71.00% | >=90% | <50% |
| **Serious Incidents** | | | | | | | | | | | | | | | | | | |
| Number of never events reported | 6 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 3 | 0 | 0 | 2 | 0 | 2 | 8 | Zero | |
| Number of serious incidents reported | 3 | 2 | 0 | 0 | 2 | 2 | 5 | 4 | 3 | 4 | 2 | 2 | 5 | 4 | 9 | 31 | No target | |
| Serious incidents – 72 hour report completed within contract timescale | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | >90% | |
| Percentage of serious incident investigations completed within contract timescale | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | >80% | |
| **VTE Prevention** | | | | | | | | | | | | | | | | | | |
| % of adult inpatients who have received a VTE risk assessment | 93.2% | 92.7% | | 90.1% | 94.0% | 93.8% | 90.7% | 87.0% | 89.8% | 94.6% | 91.0% | 90.4% | 89.2% | 92.2% | 90.7% | 91.2% | >95% | |

# Trust Scorecard - Effective (1)

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 20/21 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Dementia Screening** | | | | | | | | | | | | | | | | | | |
| % of patients who have been screened for dementia (within 72 hours) | 0.8% | 74.0% | 67.0% | 63.0% | 68.0% | 71.0% | 71.0% | 79.0% | 64.0% | 68.0% | 68.0% | 65.0% | 69.0% | 70.0% | 68.0% | 68.0% | >=90% | <70% |
| **Maternity** | | | | | | | | | | | | | | | | | | |
| % of women on a Continuity of Carer pathway | | 4.40% | 4.70% | 3.00% | 0.80% | 0.00% | 0.00% | 0.40% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.60% | No target | |
| % C-section rate (planned and emergency) | 28.39% | 28.90% | 27.73% | 28.82% | 25.94% | 26.51% | 27.80% | 31.13% | 32.91% | 28.09% | 34.76% | 28.12% | 26.79% | 31.67% | 29.16% | 29.44% | <=27% | >=30% |
| % emergency C-section rate | 15.74% | 14.48% | 12.73% | 15.27% | 12.08% | 12.73% | 16.20% | 15.14% | 19.50% | 15.73% | 20.09% | 15.65% | 12.24% | 17.71% | 15.41% | 15.56% | No target | |
| % of women booked by 12 weeks gestation | 88.9% | 89.7% | 89.6% | 93.1% | 93.3% | 93.0% | 92.4% | 95.0% | 92.3% | 95.4% | 92.7% | 94.2% | 93.1% | 93.6% | 94.0% | 92.8% | >90% | |
| % of women that have an induced labour | 28.65% | 27.98% | 27.50% | 28.60% | 29.70% | 35.49% | 31.20% | 32.41% | 28.72% | 32.58% | 32.51% | 33.91% | 30.72% | 30.63% | 31.89% | 31.42% | <=30% | >33% |
| % stillbirths as percentage of all pregnancies > 24 weeks | 0.22% | 0.23% | 1.14% | 0.00% | 0.20% | 0.42% | 0.00% | 0.21% | 0.83% | 0.68% | 0.22% | 0.25% | 0.23% | 0.62% | 0.38% | 0.39% | <0.52% | |
| % of women smoking at delivery | 10.95% | 12.39% | 9.55% | 10.97% | 11.29% | 9.39% | 13.80% | 11.30% | 12.58% | 11.24% | 11.06% | 8.80% | 9.24% | 10.21% | 9.49% | 10.90% | <=14.5% | |
| % breastfeeding (discharge to CMW) | | 56.8% | 58.0% | 61.1% | 56.4% | 57.8% | 57.1% | 57.8% | 51.7% | 59.4% | 56.2% | 58.5% | 60.2% | 56.7% | 58.58% | 57.5% | | |
| Percentage of babies <3rd centile born > 37+6 weeks | | | | | | | | | | | | | 1.8% | 1.0% | 1.6% | 1.7% | | |
| % breastfeeding (initiation) | | 80.8% | 79.7% | 81.4% | 76.1% | 80.5% | 79.7% | 77.5% | 76.6% | 80.8% | 80.4% | 81.1% | 83.1% | 82.4% | 82.2% | 79.9% | >=81% | |
| % Massive PPH >1.5 litres | | 5.9% | 3.9% | 4.7% | 5.9% | 4.8% | 3.7% | 5.8% | 3.8% | 4.3% | 4.5% | 3.9% | 2.5% | 5.2% | 4.0% | 4.4% | <=4% | |
| Number of births less than 27 weeks | | 1 | 2 | 0 | 2 | 0 | 0 | 2 | 1 | 3 | 2 | 2 | 1 | 3 | 6 | 19 | | |
| Number of births less than 34 weeks | | 13 | 6 | 12 | 5 | 6 | 10 | 9 | 8 | 8 | 16 | 6 | 7 | 10 | 23 | 104 | | |
| Number of births less than 37 weeks | | 38 | 30 | 41 | 33 | 30 | 43 | 29 | 38 | 21 | 34 | 23 | 27 | 29 | 79 | 379 | | |
| Number of maternal deaths | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | | |
| Total births | | 442 | 438 | 473 | 511 | 481 | 497 | 472 | 482 | 443 | 445 | 408 | 437 | 483 | 1,328 | 5,570 | | |

# Trust Scorecard - Effective (2)

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 20/21 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 | 1.0 | | | | | | 1.0 | NHS Digital | |
| Hospital standardised mortality ratio (HSMR) | 108 | 108 | 111.3 | 110.7 | 107.1 | 104.6 | 105.1 | 104.7 | 103.9 | 105.2 | 108.2 | | | | | 108.2 | Dr Foster | |
| Hospital standardised mortality ratio (HSMR) – weekend | 112.7 | 112.7 | 117.4 | 117.5 | 114.4 | 110.8 | 108.8 | 107.4 | 105.5 | 108.9 | 109.8 | | | | | 109.8 | Dr Foster | |
| Number of inpatient deaths | 1,964 | 192 | 252 | 126 | 112 | 120 | 143 | 147 | 142 | 182 | 245 | 278 | 160 | 129 | 567 | 2,036 | No target | |
| Number of deaths of patients with a learning disability | 15 | 0 | 4 | 2 | 0 | 1 | 3 | 4 | 1 | 1 | 1 | 2 | 1 | 0 | 3 | 19 | No target | |
| **Readmissions** | | | | | | | | | | | | | | | | | | |
| Emergency re-admissions within 30 days following an elective or emergency spell | 7.0% | 8.3% | 9.5% | 8.5% | 7.2% | 7.9% | 8.5% | 7.4% | 7.8% | 8.0% | 7.7% | 9.0% | 8.2% | | | 8.0% | <8.25% | >8.75% |
| **Research** | | | | | | | | | | | | | | | | | | |
| Research accruals | | | 1,079 | 633 | 54 | 126 | 350 | 629 | 461 | 578 | 382 | 177 | 110 | 220 | 507 | 4,152 | No target | |
| **Stroke Care** | | | | | | | | | | | | | | | | | | |
| Stroke care: percentage of patients receiving brain imaging within 1 hour | 49.5% | 46.2% | 37.0% | 53.0% | 45.0% | 63.5% | 60.9% | 52.9% | 46.6% | 54.7% | 51.7% | 56.1% | 62.5% | 54.4% | 58.6% | 53.2% | >=43% | <25% |
| Stroke care: percentage of patients spending 90%+ time on stroke unit | 87.7% | 90.4% | 88.5% | 78.0% | 84.0% | 95.1% | 89.7% | 96.9% | 81.3% | 87.5% | 90.1% | 84.6% | 88.4% | | | 83.5% | >=85% | <75% |
| % of patients admitted directly to the stroke unit in 4 hours | 54.80% | 49.30% | 49.00% | 21.00% | 65.00% | 74.50% | 50.70% | 51.60% | 34.50% | 36.50% | 16.10% | 24.40% | 38.80% | 49.20% | 37.50% | 45.00% | >=75% | <55% |
| % patients receiving a swallow screen within 4 hours of arrival | 70.70% | 65.20% | 68.00% | 76.00% | 65.00% | 78.60% | 59.30% | 62.70% | 63.50% | 64.70% | 70.60% | 71.80% | 74.60% | 60.70% | 69.00% | 68.00% | >=75% | <65% |
| **Trauma & Orthopaedics** | | | | | | | | | | | | | | | | | | |
| % of fracture neck of femur patients treated within 36 hours | 55.7% | 48.6% | 75.0% | 62.4% | 72.7% | 56.7% | 71.9% | 63.6% | 60.7% | 85.1% | 77.0% | 75.8% | 61.5% | 64.1% | 67.1% | 69.0% | >=90% | <80% |
| % fractured neck of femur patients meeting best practice criteria | 54.90% | 48.60% | 53.10% | 60.60% | 70.91% | 56.70% | 70.20% | 62.10% | 58.80% | 83.00% | 73.00% | 75.80% | 61.50% | 64.10% | 67.10% | 66.00% | >=65% | <55% |

# Trust Scorecard - Caring (1)

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 20/21 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Friends & Family Test** | | | | | | | | | | | | | | | | | | |
| Inpatients % positive | 90.7% | 91.1% | 90.0% | 90.2% | 91.9% | 87.0% | 86.0% | 88.7% | 86.4% | 85.7% | 84.8% | 89.7% | 89.4% | 89.6% | 89.6% | 88.4% | >=90% | <86% |
| ED % positive | 82.1% | 79.6% | 90.2% | 85.8% | 86.8% | 81.8% | 77.2% | 73.0% | 75.4% | 83.7% | 77.6% | 87.2% | 83.9% | 77.5% | 83.0% | 81.4% | >=84% | <81% |
| Maternity % positive | 97.4% | 100.0% | 97.2% | 100.0% | 90.2% | 100.0% | 85.2% | 93.9% | 88.9% | 88.4% | 96.7% | 98.6% | 92.9% | 92.6% | 95.2% | 92.9% | >=97% | <94% |
| Outpatients % positive | 93.0% | 94.3% | 94.0% | 93.6% | 93.9% | 93.7% | 93.5% | 92.8% | 94.0% | 94.1% | 94.2% | 94.7% | 94.7% | 94.5% | 94.6% | 94.0% | >=94.5% | <93% |
| Total % positive | 91.2% | 92.2% | 92.9% | 91.8% | 92.4% | 91.3% | 90.0% | 90.1% | 91.7% | 92.2% | 91.9% | 93.2% | 92.9% | 92.1% | 92.7% | 91.8% | >=93% | <91% |
| Number of PALS concerns logged | | | | | | | | 273 | 312 | 227 | 163 | 137 | 204 | 262 | 597 | 2,394 | No Target | |
| % of PALS concerns closed in 5 days | | | | | | | | 73% | 75% | 81% | 82% | 86% | 86% | 83% | 84% | 79% | >=95% | <90% |
| **MSA** | | | | | | | | | | | | | | | | | | |
| Number of breaches of mixed sex accommodation | 82 | 8 | 6 | 13 | 21 | 23 | 1 | 0 | 0 | 0 | 0 | 2 | 0 | 1 | 3 | 67 | <=10 | >=20 |

# Trust Scorecard - Responsive (1)

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 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% | 78.3% | 77.8% | 76.3% | 75.2% | 78.0% | 75.7% | 75.1% | No target | |
| Cancer – 28 day FDS breast symptom two week wait | | | 91.4% | 95.7% | 98.6% | 99.1% | 80.6% | 98.3% | 77.1% | 95.4% | 77.8% | 97.9% | 96.8% | 100.0% | 98.0% | 97.1% | No target | |
| Cancer – 28 day FDS screening referral | | | 76.0% | 50.0% | 76.9% | 100.0% | 78.6% | 65.4% | 77.1% | 61.8% | 77.8% | 52.8% | 82.6% | 86.5% | 75.9% | 72.3% | No target | |
| Cancer – urgent referrals seen in under 2 weeks from GP | 92.5% | 95.1% | 90.6% | 99.1% | 98.0% | 96.5% | 90.8% | 95.2% | 93.1% | 91.6% | 93.7% | 90.1% | 96.9% | 97.0% | 94.9% | 94.7% | >=93% | <90% |
| 2 week wait breast symptomatic referrals | 97.5% | 98.4% | 87.9% | 97.8% | 95.7% | 96.4% | 95.9% | 93.4% | 97.1% | 85.2% | 91.8% | 70.6% | 98.7% | 99.0% | 90.7% | 92.5% | >=93% | <90% |
| Cancer – 31 day diagnosis to treatment (first treatments) | 93.4% | 95.5% | 96.6% | 96.0% | 95.3% | 98.1% | 96.7% | 96.4% | 99.3% | 99.3% | 97.6% | 97.7% | 99.1% | 98.6% | 98.3% | 97.9% | >=96% | <94% |
| Cancer – 31 day diagnosis to treatment (subsequent – drug) | 99.4% | 100.0% | 100.0% | 100.0% | 94.0% | 97.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.0% | 98.1% | 96.6% | 99.3% | 98.9% | 99.4% | >=98% | <96% |
| Cancer – 31 day diagnosis to treatment (subsequent – surgery) | 93.6% | 94.1% | 98.2% | 92.6% | 81.3% | 78.9% | 87.2% | 96.2% | 96.8% | 96.8% | 100.0% | 93.9% | 95.2% | 93.6% | 95.5% | 95.2% | >=94% | <92% |
| Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) | 94.9% | 100.0% | 98.3% | 96.7% | 86.5% | 83.0% | 98.3% | 97.3% | 98.7% | 94.7% | 98.5% | 97.4% | 100.0% | 95.2% | 98.8% | 98.0% | >=94% | <92% |
| Cancer 62 day referral to treatment (urgent GP referral) | 73.1% | 78.2% | 78.0% | 69.0% | 78.0% | 85.6% | 87.6% | 81.5% | 84.6% | 79.7% | 84.8% | 86.3% | 81.1% | 83.1% | 83.8% | 83.3% | >=85% | <80% |
| Cancer 62 day referral to treatment (screenings) | 95.4% | 94.7% | 90.9% | 54.5% | 60.0% | 66.7% | 77.8% | 88.9% | 100.0% | 96.8% | 100.0% | 93.3% | 91.7% | 89.5% | 90.3% | 90.8% | >=90% | <85% |
| Cancer 62 day referral to treatment (upgrades) | 72.2% | 76.5% | 100.0% | 88.9% | 73.7% | 91.7% | 90.0% | 91.7% | 85.0% | 70.8% | 61.9% | 59.4% | 88.9% | 73.3% | 79.3% | 83.0% | >=90% | <85% |
| Number of patients waiting over 104 days with a TCI date | 170 | 3 | 4 | 8 | 8 | 21 | 2 | 3 | 3 | 1 | 0 | 3 | 0 | 0 | 3 | 50 | Zero | |
| Number of patients waiting over 104 days without a TCI date | 407 | 20 | 33 | 79 | 66 | 38 | 15 | 8 | 8 | 9 | 13 | 14 | 14 | 12 | 34 | 269 | <=24 | |
| **Diagnostics** | | | | | | | | | | | | | | | | | | |
| % waiting for diagnostics 6 week wait and over (15 key tests) | 3.16% | 3.16% | 41.95% | 43.43% | 29.54% | 26.07% | 25.49% | 23.00% | 17.50% | 14.67% | 14.04% | 24.59% | 20.33% | 19.48% | 19.48% | 19.48% | <=1% | >2% |
| The number of planned / surveillance endoscopy patients waiting at month end | 825 | 825 | 1,035 | 1,230 | 1,367 | 1,465 | 1,569 | 1,648 | 1,665 | 1,772 | 1,949 | 1,969 | 1,946 | 1,919 | 1,945 | 1,919 | <=600 | |
| **Discharge** | | | | | | | | | | | | | | | | | | |
| Patient discharge summaries sent to GP within 24 hours | 56.5% | 57.7% | 55.4% | 57.8% | 60.1% | 60.0% | 57.5% | 61.2% | 60.7% | 58.3% | 52.3% | 53.5% | 59.4% | | | 58.0% | >=88% | <75% |

# Trust Scorecard - Responsive (2)

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 20/21 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Emergency Department** | | | | | | | | | | | | | | | | | | |
| ED: % total time in department – under 4 hours (type 1) | 81.58% | 78.56% | 87.46% | 85.41% | 85.06% | 84.46% | 73.53% | 71.74% | 68.96% | 69.40% | 65.43% | 68.82% | 69.50% | 69.77% | 69.39% | 75.11% | >=95% | <90% |
| ED: % total time in department – under 4 hours (types 1 & 3) | 87.40% | 85.08% | 89.93% | 88.72% | 89.94% | 90.05% | 83.26% | 82.34% | 80.21% | 79.64% | 77.06% | 77.82% | 78.62% | 80.00% | 79.03% | 83.18% | >=95% | <90% |
| ED: % total time in department – under 4 hours CGH | 93.70% | 94.10% | 95.42% | 96.43% | 98.93% | 99.85% | 99.91% | 99.95% | 99.84% | 99.94% | 99.88% | 99.92% | 100.00% | 99.52% | 99.77% | 98.98% | >=95% | <90% |
| ED: % total time in department – under 4 hours GRH | 81.59% | 71.69% | 84.28% | 80.59% | 84.01% | 84.46% | 73.53% | 71.74% | 68.96% | 69.40% | 65.43% | 68.82% | 69.50% | 69.77% | 69.39% | 73.95% | >=95% | <90% |
| ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) | 2 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 14 | 36 | 95 | 21 | 1 | 117 | 168 | Zero | |
| ED: % of time to initial assessment – under 15 minutes | 71.2% | 70.1% | 80.4% | 77.0% | 72.7% | 72.5% | 63.7% | 61.3% | 66.9% | 66.5% | 61.3% | 64.5% | 62.4% | 48.8% | 57.6% | 66.0% | >=95% | <92% |
| ED: % of time to start of treatment – under 60 minutes | 31.3% | 40.9% | 68.0% | 57.5% | 52.0% | 44.5% | 31.4% | 30.9% | 38.1% | 41.8% | 40.8% | 48.9% | 44.2% | 27.8% | 39.1% | 42.6% | >=90% | <87% |
| % of ambulance handovers that are over 30 minutes | 2.40% | 2.87% | 2.09% | 1.74% | 2.57% | 2.04% | 4.17% | 3.67% | 3.95% | 4.59% | 8.70% | 8.14% | 8.06% | 9.82% | 8.71% | 5.00% | <=2.96% | |
| % of ambulance handovers that are over 60 minutes | 0.07% | 0.05% | 0.00% | 0.00% | 0.15% | 0.03% | 0.90% | 0.55% | 1.09% | 2.63% | 11.50% | 9.57% | 6.74% | 10.36% | 8.97% | 3.67% | <=1% | >2% |
| **Operational Efficiency** | | | | | | | | | | | | | | | | | | |
| Cancelled operations re-admitted within 28 days | 74.03% | 74.03% | -120.00% | 100.00% | 100.00% | 94.00% | 86.67% | 94.74% | 95.83% | 90.50% | 78.30% | 14.30% | 76.50% | 92.30% | 69.40% | 74.29% | >=95% | |
| Urgent cancelled operations | 8 | 0 | 0 | 0 | 0 | 11 | 2 | 10 | 7 | 4 | 14 | 4 | 3 | 3 | 10 | 66 | No target | |
| Number of patients stable for discharge | 86 | 70 | 14 | 33 | 45 | 66 | 68 | 72 | 99 | 84 | 71 | 118 | 136 | 110 | 121 | 54 | <=70 | |
| Number of stranded patients with a length of stay of greater than 7 days | 423 | 358 | 204 | 213 | 248 | 288 | 332 | 325 | 379 | 392 | 417 | 403 | 380 | 366 | 383 | 329 | <=380 | |
| Average length of stay (spell) | 5.14 | 6.16 | 5.22 | 4.49 | 4.54 | 4.69 | 4.66 | 4.78 | 4.86 | 4.79 | 5.57 | 6.25 | 5.62 | 5.26 | 5.67 | 5.04 | <=5.06 | |
| Length of stay for general and acute non-elective (occupied bed days) spells | 5.73 | 6.9 | 5.37 | 4.75 | 4.81 | 5.13 | 5.15 | 5.34 | 5.44 | 5.43 | 6.04 | 6.42 | 5.95 | 5.59 | 5.96 | 5.46 | <=5.65 | |
| Length of stay for general and acute elective spells (occupied bed days) | 2.67 | 2.66 | 3.74 | 2.2 | 2.64 | 2.47 | 2.32 | 2.47 | 2.59 | 2.12 | 2.87 | 4.38 | 2.99 | 2.91 | 3.14 | 2.61 | <=3.4 | >4.5 |
| % day cases of all electives | 85.59% | 84.90% | 82.75% | 81.81% | 83.67% | 81.73% | 78.41% | 82.26% | 81.28% | 83.34% | 86.37% | 90.65% | 87.98% | 87.68% | 88.66% | 83.98% | >80% | <70% |
| Intra-session theatre utilisation rate | 87.20% | 85.60% | 91.80% | 87.60% | 84.05% | 87.30% | 88.60% | 86.70% | 85.70% | 87.70% | 77.40% | 79.30% | 84.40% | 88.30% | 84.00% | 88.30% | >85% | <70% |

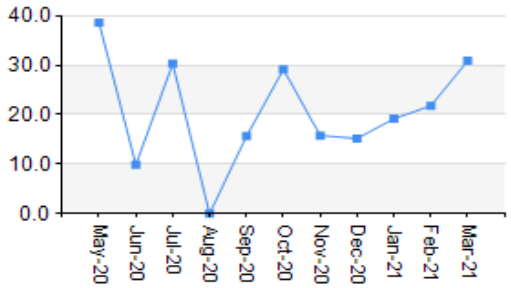
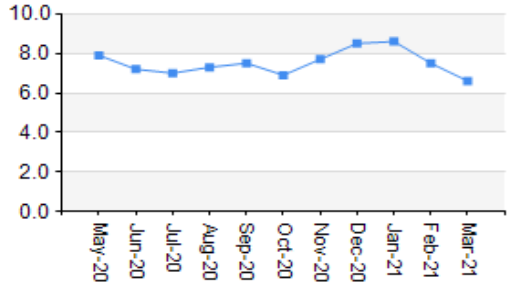
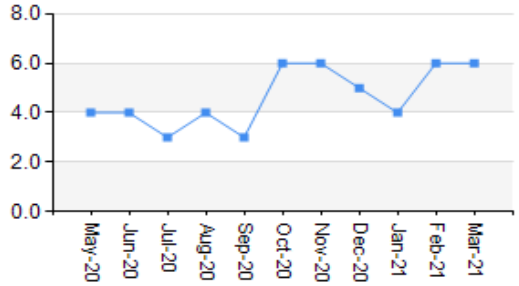
# Trust Scorecard - Responsive (3)

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 20/21 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outpatient** | | | | | | | | | | | | | | | | | | |
| Outpatient new to follow up ratio's | 1.88 | 2.04 | 2.49 | 2.32 | 2.28 | 2.03 | 1.99 | 1.94 | 1.88 | 1.96 | 2.15 | 2.14 | 2.22 | 2.08 | 2.14 | 2.09 | <=1.9 | |
| Did not attend (DNA) rates | 6.90% | 7.80% | 4.20% | 4.30% | 4.70% | 5.50% | 6.20% | 6.50% | 6.30% | 6.30% | 6.50% | 6.50% | 5.80% | 5.70% | 6.00% | 5.80% | <=7.6% | >10% |
| **RTT** | | | | | | | | | | | | | | | | | | |
| Referral to treatment ongoing pathways under 18 weeks (%) | 81.01% | 81.01% | 73.61% | 66.53% | 59.06% | 55.83% | 60.07% | 66.27% | 69.36% | 70.06% | 68.84% | 69.89% | 68.23% | 69.40% | 69.17% | 66.52% | >=92% | |
| Referral to treatment ongoing pathways 35+ Weeks (number) | 1,833 | 1,833 | 2,719 | 3,794 | 4,967 | 6,226 | 7,155 | 7,748 | 8,404 | 8,352 | 7,256 | 6,628 | 6,534 | 6,511 | 6,558 | 6,350 | No target | |
| Referral to treatment ongoing pathways 45+ Weeks (number) | | 334 | 707 | 1,197 | 1,768 | 2,172 | 2,724 | 3,084 | 3,253 | 3,035 | 3,854 | 4,787 | 4,374 | 3,763 | 4,308 | 2,888 | No target | |
| Referral to treatment ongoing pathways over 52 weeks (number) | 33 | 33 | 156 | 366 | 694 | 1,037 | 1,233 | 1,279 | 1,285 | 1,411 | 1,602 | 2,234 | 2,679 | 3,075 | 2,663 | 1,421 | Zero | |
| Referral to treatment ongoing pathways 70+ Weeks (number) | | 0 | 0 | 2 | 5 | 17 | 57 | 77 | 86 | 111 | 163 | 243 | 309 | 462 | 338 | 127 | No target | |
| **SUS** | | | | | | | | | | | | | | | | | | |
| Percentage of records submitted nationally with valid GP code | 99.7% | 99.9% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 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% | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% | | | 99.9% | >=99% | |

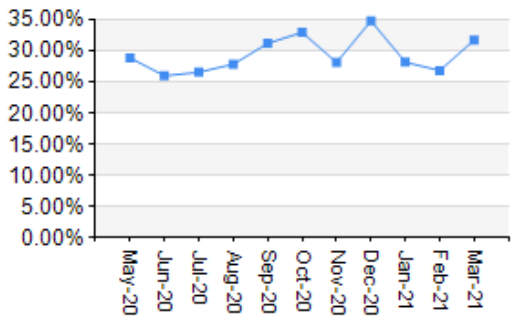
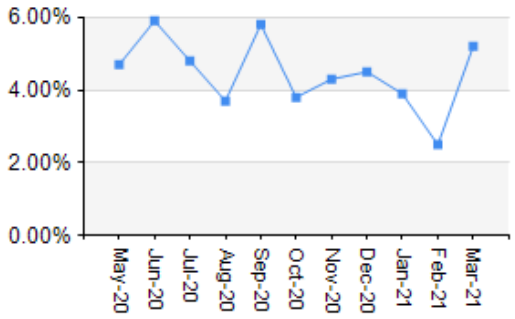
# Trust Scorecard - Well Led (1)

| | 19/20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | 20/21 Q4 | 20/21 | Standard | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Appraisal and Mandatory Training** | | | | | | | | | | | | | | | | | | |
| Trust total % overall appraisal completion | 82.0% | 85.0% | 85.0% | 85.0% | 78.0% | 80.0% | 82.0% | 84.0% | 83.0% | 83.0% | 82.0% | 80.0% | 80.0% | 83.0% | 83.0% | 83.0% | >=90% | <70% |
| Trust total % mandatory training compliance | 92% | 90% | 90% | 90% | 90% | 91% | 91% | 94% | 93% | 93% | 93% | 93% | 92% | 90% | 90% | 90% | >=90% | <70% |
| **Finance** | | | | | | | | | | | | | | | | | | |
| Total PayBill Spend | | 30.2 | 32.5 | 33.8 | 34.3 | 33.2 | 33.9 | 34.7 | | | | | | | | | | |
| YTD Performance against Financial Recovery Plan | | 1.5 | 0 | -.1 | 0 | 0 | 0 | 0 | | | | | | | | | | |
| Cost Improvement Year to Date Variance | | -8 | 0 | 0 | 0 | | | | | | | | | | | | | |
| NHSI Financial Risk Rating | | 3 | 3 | 3 | 3 | | | | | | | | | | | | | |
| Capital service | | 3 | 3 | 3 | 3 | | | | | | | | | | | | | |
| Liquidity | | 4 | 4 | 4 | 4 | | | | | | | | | | | | | |
| Agency – Performance Against NHSI Set Agency Ceiling | | 3 | 3 | 3 | 3 | | | | | | | | | | | | | |
| **Safe Nurse Staffing** | | | | | | | | | | | | | | | | | | |
| Overall % of nursing shifts filled with substantive staff | 97.40% | | | | 90.52% | 100.77% | 102.10% | 93.82% | 96.30% | 94.90% | 90.64% | 90.88% | 95.00% | 93.10% | 92.88% | 94.80% | >=75% | <70% |
| % registered nurse day | 98.20% | | | | 89.23% | 100.82% | 101.90% | 93.04% | 95.49% | 94.40% | 91.04% | 93.76% | 93.10% | 90.71% | 91.11% | 94.40% | >=90% | <80% |
| % unregistered care staff day | 100.20% | | | | 110.83% | 120.86% | 117.50% | 106.50% | 101.36% | 102.40% | 93.42% | 99.20% | 95.50% | 101.28% | 97.31% | 105.00% | >=90% | <80% |
| % registered nurse night | 95.70% | | | | 92.99% | 100.69% | 102.60% | 95.27% | 97.77% | 95.90% | 89.93% | 94.75% | 98.20% | 97.31% | 95.97% | 96.60% | >=90% | <80% |
| % unregistered care staff night | 106.20% | | | | 112.80% | 131.01% | 131.70% | 114.61% | 113.36% | 112.00% | 97.48% | 99.23% | 113.20% | 108.91% | 106.75% | 113.30% | >=90% | <80% |
| Care hours per patient day RN | 4.7 | | | | 6.2 | 5.8 | 5.6 | 5.2 | 5.2 | 5.7 | 5.4 | 6.1 | 6.4 | 5.9 | 6.1 | 5.7 | >=5 | |
| Care hours per patient day HCA | 3 | | | | 4.5 | 4.2 | 3.9 | 3.5 | 3.4 | 3.7 | 3.5 | 3.9 | 4 | 3.8 | 3.9 | 3.8 | >=3 | |
| Care hours per patient day total | 7.7 | | | | 10.8 | 10.1 | 9.5 | 8.6 | 8.6 | 9.4 | 8.9 | 10.1 | 10.3 | 9.7 | 10 | 9.5 | >=8 | |
| **Vacancy and WTE** | | | | | | | | | | | | | | | | | | |
| % total vacancy rate | | 6.15% | | | 5.97% | 5.14% | 7.10% | 5.26% | 5.74% | 6.03% | 5.99% | 5.57% | 4.36% | 4.75% | | | <=11.5% | >13% |
| % vacancy rate for doctors | | | | | 4.90% | 2.70% | 3.27% | 1.54% | 1.07% | 0.37% | 1.43% | 1.77% | 1.83% | 0.73% | | | <=5% | >5.5% |
| % vacancy rate for registered nurses | | 10.26% | | | 8.12% | 8.44% | 8.90% | 10.01% | 7.76% | 9.06% | 8.70% | 8.80% | 5.08% | 7.92% | | | <=5% | >5.5% |
| Staff in post FTE | | 6422.86 | 6421.87 | 6549.97 | 6573.86 | 6485.99 | 6463.25 | 6548.39 | 6557.43 | 6551.18 | 6546.28 | 6560.89 | 6666.58 | 6653.99 | | | No target | |
| Vacancy FTE | | 418.47 | | | 416.06 | 358 | 494.04 | 365.97 | 399.63 | 420.14 | 417.44 | 409.32 | 286.96 | 330.61 | | | No target | |
| Starters FTE | | 44.17 | 32.81 | 30.05 | 57.65 | 49.45 | 62.46 | 151.56 | 73.19 | 46.87 | 52.85 | 50.64 | 48.84 | 67.2 | | | No target | |
| Leavers FTE | | 58.37 | 43.37 | 46.93 | 38.57 | 96.43 | 106.66 | 66.41 | 76.11 | 68.76 | 40.52 | 50.03 | 34.82 | 45.79 | | | No target | |
| **Workforce Expenditure and Efficiency** | | | | | | | | | | | | | | | | | | |
| % turnover | | 11.1% | 10.8% | 10.9% | 10.4% | 10.2% | 10.3% | 10.3% | 9.6% | 10.1% | 9.5% | 9.5% | 9.5% | 9.2% | | | <=12.6% | >15% |
| % turnover rate for nursing | | 10.73% | 10.59% | 10.72% | 10.14% | 9.98% | 10.34% | 10.10% | 9.41% | 10.23% | 9.61% | 9.83% | 9.83% | 9.86% | | | <=12.6% | >15% |
| % sickness rate | | 3.5% | 3.8% | 3.8% | 3.8% | 3.7% | 3.7% | 3.7% | 3.7% | 3.7% | 3.7% | 3.7% | 3.7% | 3.6% | | | <=4.05% | >4.5% |

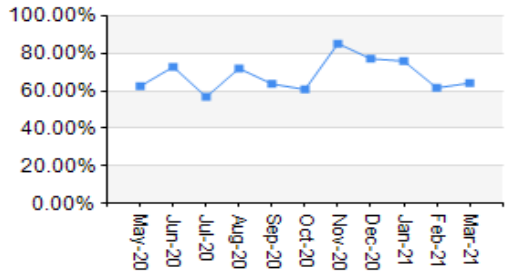
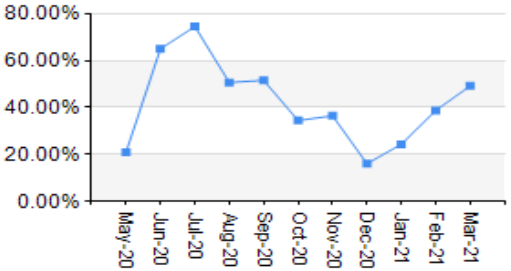
# Exception Reports - Safe (1)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **Clostridium difficile – infection rate per 100,000 bed days**<br><br>**Standard: <30.2** |  | During March 2021 the trust had 3 hospital onset health care associated cases of C. difficile and 5 community onset health care associated cases of C. difficile. All hospital onset cases are having a post infection review to ascertain any lapses in care and quality associated with them. A local action plan will be generated with the affected ward to address any lapses identified. In April 2021 the trust is launching new CDI treatment guidelines in line with NICE to optimise patient management and treatment. We anticipate this should prevent further CDI episodes; relapses and recurrences and subsequently minimising the risk of onward transmission of CDI to others as patients are likely to be discharged quicker and have fewer re-admissions with relapsing CDI. Joint audits of cleaning standards continue between the IPCT and GMS with estates works are also being reviewed as part of this process. The AMS committee are also looking at implementing a new process of antibiotics prescribing auditing which will bring rapid feedback to a speciality in a more engaging manner with prescribers. | **Associate Chief Nurse, Director of Infection Prevention & Control** |
| **Number of falls per 1,000 bed days**<br><br>**Standard: <=6** |  | The number of falls per 1000 bed days is currently high but has reduced slightly. Falls have increased due to a number of factors; increased deconditioning, reduced visiting which decreases supervision, inability to fill enhanced care requests, multiple bed moves and transfers including late night and registered nurse to healthcare assistant staffing rations being below the optimal 60:40, particularly in care of the elderly wards. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub. | **Associate Chief Nurse, Director of Infection Prevention & Control** |
| **Number of falls resulting in harm (moderate/severe)**<br><br>**Standard: <=3** |  | The number of falls resulting in harm has not risen in line with falls overall although there has been an increase over winter. Lack of falls assessments are a significant contributor to harm as interventions are unable to be put in place. Registered nurse to healthcare assistant staffing rations being below the optimal 60:40, particularly in care of the elderly wards. The falls reduction programme is active and all cases with moderate harm or above are rapidly reviewed in Preventing Harm Hub. | **Associate Chief Nurse, Director of Infection Prevention & Control** |

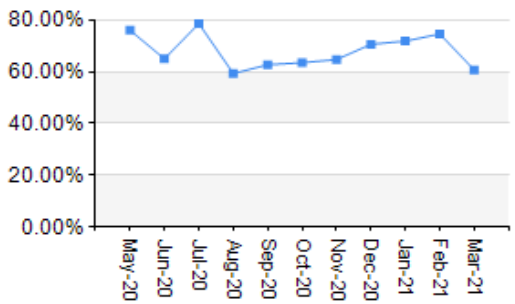
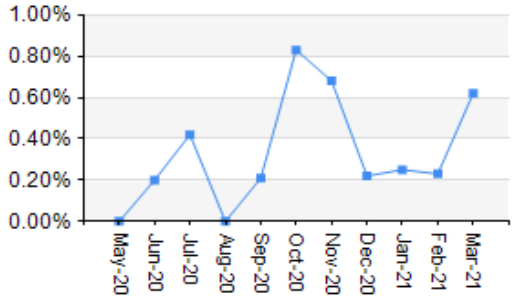
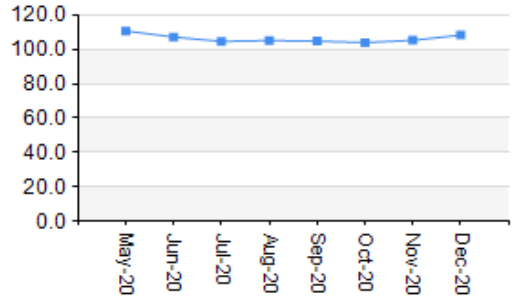
# Exception Reports - Effective (1)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **% C-section rate (planned and emergency)**<br><br>**Standard: <=27%** |  | It was agreed at Divisional Tri that we would look at trends rather than snapshots of the months.<br>A review of patients that underwent Induction of Labour will be undertaken to validate the appropriateness. We will also undertake some benchmarking against other hospitals and against the National figures, as the feeling is that rates have increased throughout the Country. | **Divisional Director of Quality and Nursing and Chief Midwife** |
| **% Massive PPH >1.5 litres**<br><br>**Standard: <=4%** |  | The PPHs included 3 peripartum hysterectomies, which were reviewed and all were appropriately handled. The PPH audit data for march has not yet been analysed | **Divisional Director of Quality and Nursing and Chief Midwife** |

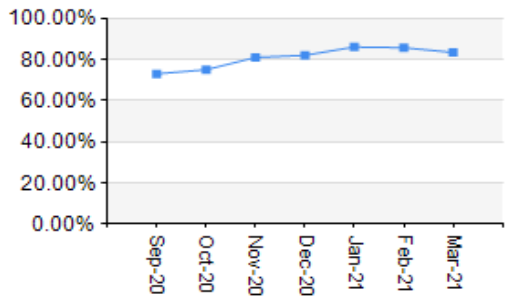
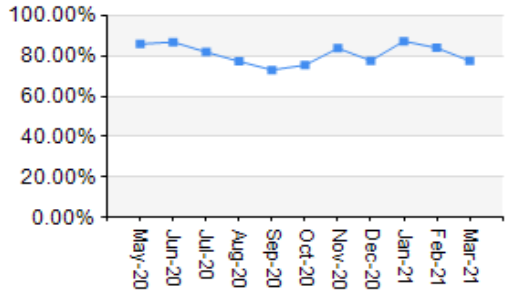
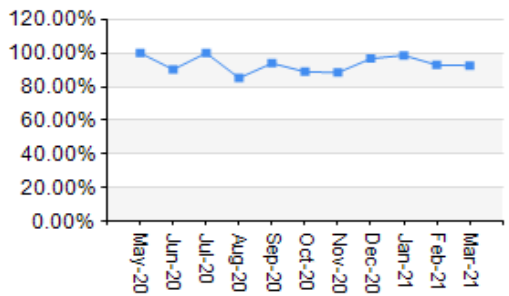
# Exception Reports - Effective (2)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **% of fracture neck of femur patients treated within 36 hours**<br><br>**Standard: >=90%** |  | Although performance against this metric is below standard, it should be noted that only 85-90% of all #NOF patients are expected to be fit enough for surgery within 36 hours.<br><br>The #NOF pathway works best when patients are cohorted on their 'home' ward of 3A. Overall as a specialty, we have had our Trauma bed-base reduced with the loss of 2A (21 beds) as part of the Emergency moves required for Covid. This means that there is additional demand placed on 3B for trauma beds and this has a knock-on effect for the availability of #NOF beds as we have to outlie patients.<br><br>Delays to theatre have occurred when high numbers (more than 3-4) of #NOF patients are admitted within a 24-hour period. In March, there were 6 days where there were 3 admissions, 2 days with 4 admissions and 1 day with 5 admissions in a 24-hour period.<br><br>The T&O pilot was discussed at the Trust's public board in February and 'Time to Theatre for Trauma' (not just #NOFs) was the only metric not achieved. The T&O Tri submitted a recovery plan to Divisional Tri in March, one key action on this plan included re-utilising sessions in Theatre 11 to create more trauma capacity; this is a big piece of work which involves job plan reviews and is nearing completion. | **Director of Operations - Surgery** |
| **% of patients admitted directly to the stroke unit in 4 hours**<br><br>**Standard: >=75%** |  | Improvement of 10.4% on February (38.8%). 33 patients breached the target in the month of March. Of these 33:<br>11 patients were delayed due to lack of HASU beds (shared space with Cardiology)<br>5 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests.<br>2 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<br>8 patients had an unknown breach reason listed<br>4 patients were either COVID positive or COVID exposed and therefore could not be placed on HASU<br>1 patient was already an inpatient<br>2 patients were referred to Southmead for Thrombectomy and therefore stayed in ED as per the pathway. | **Director of Unscheduled Care and Deputy Chief Operating Officer** |

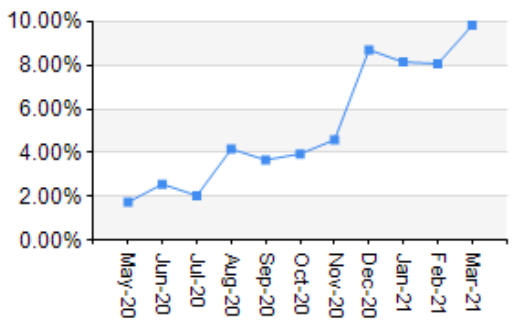
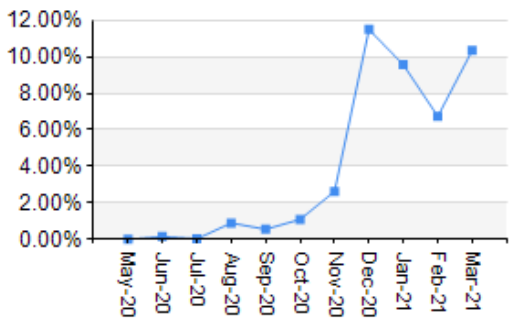
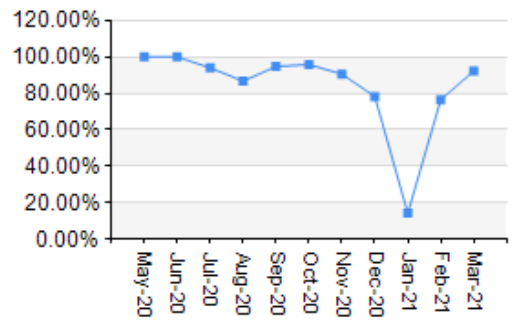
# Exception Reports - Effective (3)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **% patients receiving a swallow screen within 4 hours of arrival**<br><br>**Standard: >=75%** |  | Deterioration of 13.90% on February performance (74.60%). 24 patients breached the target in the month of March. Of those 24:<br>8 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening.<br>5 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests.<br>5 patients were too unwell to receive a swallow screen within the four hour target.<br>1 patient had an unknown breach reason listed<br>1 patient was already an inpatient on another ward at the time of the stroke<br>1 patient was COVID positive and unable to be safely screened within target<br>3 patients received a delayed screening as the Stroke ward were not asked to complete the swallow screen in another GRH location | **Director of Unscheduled Care and Deputy Chief Operating Officer** |
| **% stillbirths as percentage of all pregnancies > 24 weeks**<br><br>**Standard: <0.52%** |  | The 3 stillbirths will be reviewed at the Maternity Risk Meeting on 16th April 2021 | **Divisional Chief Nurse and Director of Midwifery** |
| **Hospital standardised mortality ratio (HSMR)**<br><br>**Standard: Dr Foster** |  | HSMR remains "higher than expected" due to COVID. When the COVID codes are removed, actual indicator falls to within expected range and Peer review shows we are in line with COVID Peers determined by Dr Foster | **Medical Division Audit and M&M Lead** |

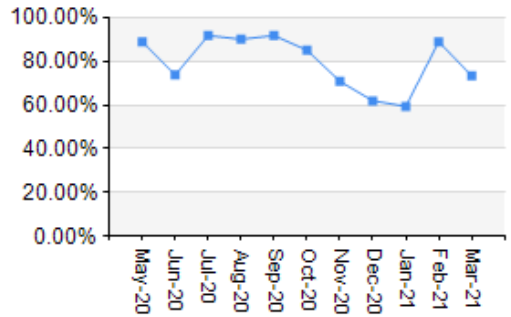
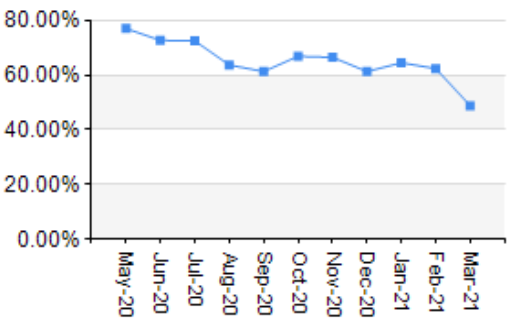
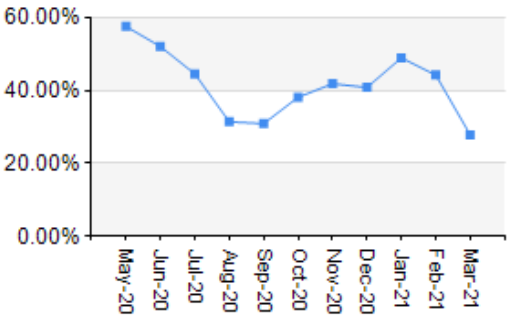
# Exception Reports - Caring (1)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **% of PALS concerns closed in 5 days**<br><br>**Standard: >=95%** |  | The % of PALS concerns closed in 5 days is currently sitting at 83.4%, against a target of 95%. In March, 2 ftc posts were introduced to support the team in managing the increased workload, and the data for March reflects not only a continued increase in the number of cases being received in PALS, but the new starters are still settling in to the role. We have continued to see an increase in the number of cases received, and the complexity of these cases, and so will be putting in a VCP to continue the 2 FTC posts for an additional 3 months, to cover the anticipated continuing increase in concerns (echoing the trends we saw coming out of the first wave of Covid). This will continue to be monitored closely and on enhanced surveillance at QDG. | **Head of Quality** |
| **ED % positive**<br><br>**Standard: >=84%** |  | In March, we reviewed all the FFT thresholds, to realign them with our performance over the last 12 months. In some cases this led to us decreasing the targets on specific surveys, to provide a greater sense of assurance around the trends, as previously the scores were only showing as red which didnt enable us to track any progress or deterioration in the reported experience.<br><br>Our ED score overall is rated at 77.5% positive experience, which is a decrease from the previous month. The team have a local patient experience improvement plan, and have also this month received the embargoed headlines from the National Urgent and Emergency Care Survey. This will be reviewed alongside the FFT data, and the plan refreshed and brought to QDG in May for review and discussion. | **Head of Quality** |
| **Maternity % positive**<br><br>**Standard: >=97%** |  | In March, we reviewed all the FFT thresholds, to realign them with our performance over the last 12 months. In some cases this led to us decreasing the targets on specific surveys, to provide a greater sense of assurance around the trends, as previously the scores were only showing as red which didn't enable us to track any progress or deterioration in the reported experience.<br><br>The 92.6% positive score from Maternity services is a decrease from the previous month. The team are working with Maternity Voices Partnership (MVP) and the Patient Experience team to review FFT data, feedback and experiences of women through MVP and data from national surveys to inform a patient experience improvement programme, with support from the QI team. | **Head of Quality** |

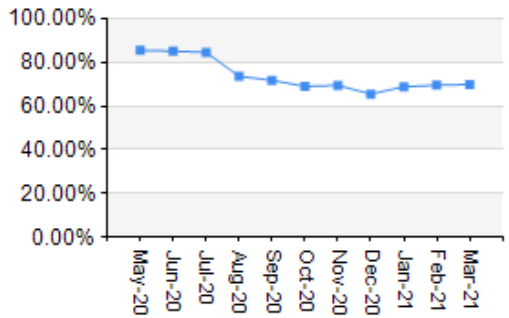
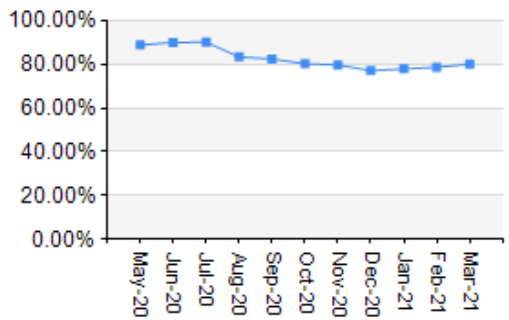
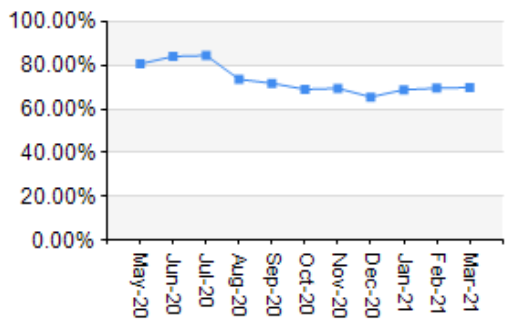
# Exception Reports - Responsive (1)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **% of ambulance handovers that are over 30 minutes**<br><br>**Standard: <=2.96%** |  | Ambulance handover delays has increased in March compared to February. A number of actions have been put in place at the beginning of April to reduce the handover delays. Pit stop staffing and physical environment has increased to meet demand. The challenge we still face is when multiple ambulance arrive at one time. SWAST are being encouraged to use Cinapsis to allow direct admissions to GPAU. | **Director of Unscheduled Care and Deputy Chief Operating Officer** |
| **% of ambulance handovers that are over 60 minutes**<br><br>**Standard: <=1%** |  | Ambulance handover delays has increased in March compared to February. A number of actions have been put in place at the beginning of April to reduce the handover delays. Pit stop staffing and physical environment has increased to meet demand. The challenge we still face is when multiple ambulance arrive at one time. SWAST are being encouraged to use Cinapsis to allow direct admissions to GPAU. | **Director of Unscheduled Care and Deputy Chief Operating Officer** |
| **Cancelled operations re-admitted within 28 days**<br><br>**Standard: >=95%** |  | Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In February just 1 patient was cancelled on the day that could not be rescheduled within 28 days. This was a Cardiology patient who was cancelled due to emergency and IP pressures. | **Deputy Chief Operating Officer** |

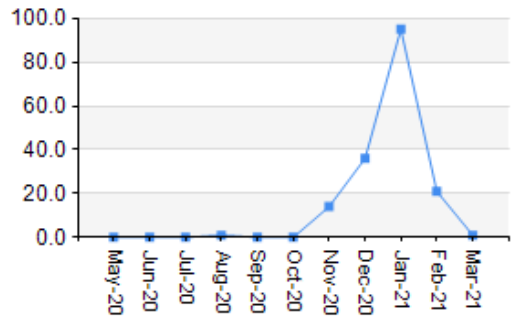
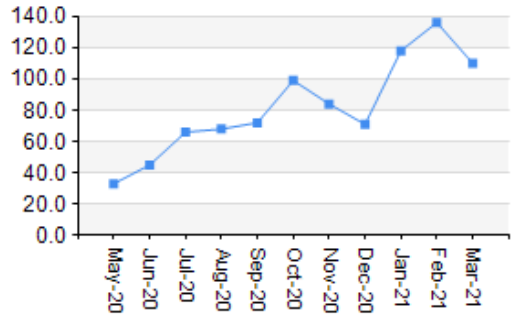
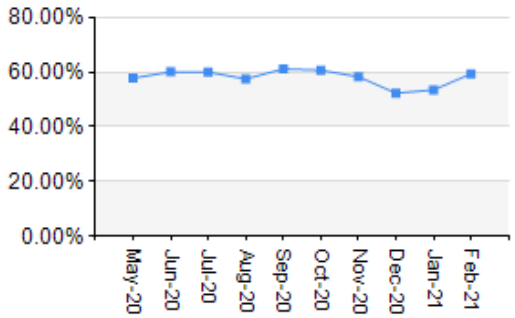
# Exception Reports - Responsive (2)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **Cancer 62 day referral to treatment (upgrades)**<br><br>**Standard: >=90%** |  | 62 day upgrades performance (unvalidated)= 73.30%<br>target = n/a<br>National performance = 78.8%<br><br>15 treatments<br>4 breaches<br><br>Urology 2.5 Lung 1 Gynae 0.5 | **Director of Planned Care and Deputy Chief Operating Officer** |
| **ED: % of time to initial assessment – under 15 minutes**<br><br>**Standard: >=95%** |  | Time to initial assessment or triage has been a focus in the last 2 weeks. It has been useful to also split the data out to walk in activity and ambulance arrivals. Enhanced pit stop staffing has improved time to initial assessment.<br>A SOP to escalate when triage for walk in patients is increased is now in place to allow flexing staff as when the demand dictates. | **Director of Unscheduled Care and Deputy Chief Operating Officer** |
| **ED: % of time to start of treatment – under 60 minutes**<br><br>**Standard: >=90%** |  | Time to initial assessment has increased in month. This is related to the increase in activity, but particularly walk in activity. Enhanced pit stop staffing and triage staffing will mitigate this in April. | **Director of Unscheduled Care and Deputy Chief Operating Officer** |

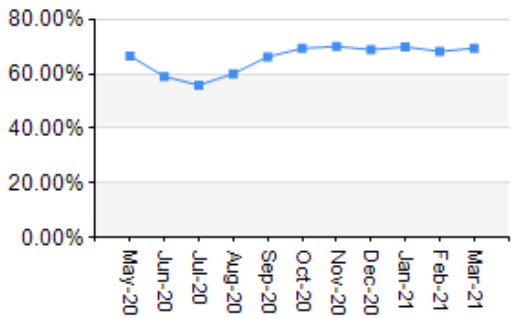
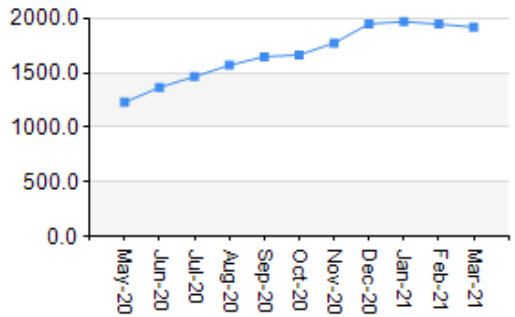
# Exception Reports - Responsive (3)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **ED: % total time in department – under 4 hours (type 1)**<br><br>**Standard: >=95%** |  | 4-hour performance has improved this month from 69.50% in February to 69.77% in March. The average total waiting in ED has reduced from 219.8 minutes in February to 212.1 minutes in March. | **Director of Unscheduled Care and Deputy Chief Operating Officer** |
| **ED: % total time in department – under 4 hours (types 1 & 3)**<br><br>**Standard: >=95%** |  | 4-hour performance has improved this month from 78.62% in February to 80.00% in March. The average total waiting in ED has reduced from 219.8 minutes in February to 212.1 minutes in March. | **Director of Unscheduled Care and Deputy Chief Operating Officer** |
| **ED: % total time in department – under 4 hours GRH**<br><br>**Standard: >=95%** |  | 4-hour performance has improved this month from 69.50% in February to 69.77% in March. The average total waiting in ED has reduced from 219.8 minutes in February to 212.1 minutes in March. | **Director of Unscheduled Care and Deputy Chief Operating Officer** |

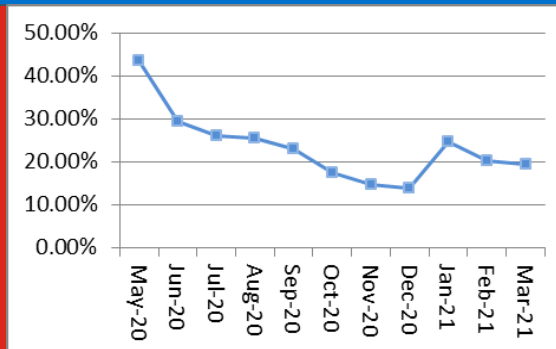
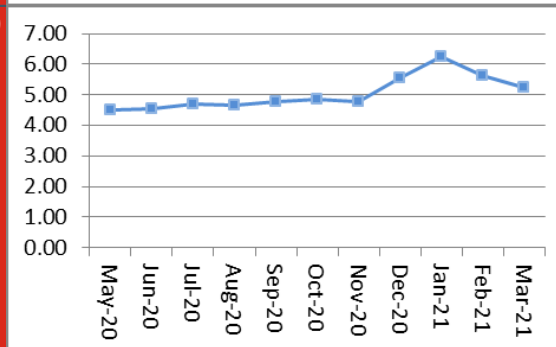
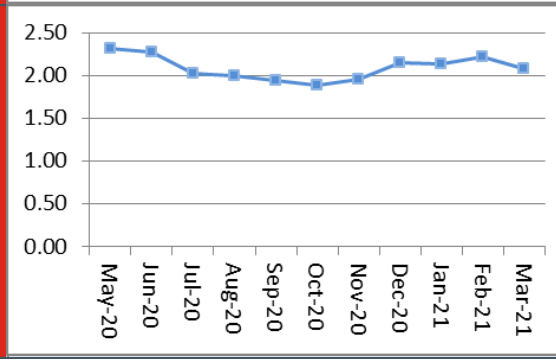
# Exception Reports - Responsive (4)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)**<br><br>**Standard: Zero** |  | Significant decrease in the 12 hour DTA breaches this month reducing from 21 in February to one in March. This one breach was a clinical breach as the patient was too unwell to move out of resus despite a bed being available. | **Director of Unscheduled Care and Deputy Chief Operating Officer** |
| **Number of patients stable for discharge**<br><br>**Standard: <=70** |  | Large numbers of MOFD patients identified as part of system 30 day ECIST work streams. Worked planned to review and focus efforts on reducing delays within specific pathways which make up the larger numbers of patients waiting for onward care. | **Head of Therapy & OCT** |
| **Patient discharge summaries sent to GP within 24 hours**<br><br>**Standard: >=88%** |  | Performance remains poor, it continues to be monitored at Executive reviews but realistically is unlikely to be significantly improved until discharge summaries are done on Sunrise, however additional focus has been provided by the work on system flow 30 day plan. | **Medical Director** |

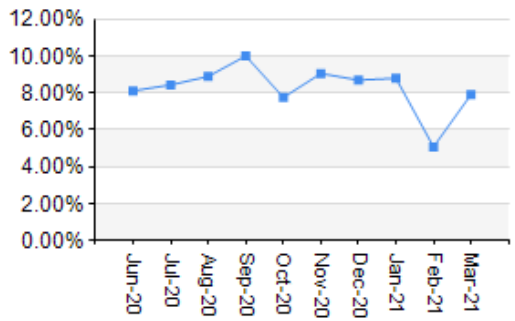
# Exception Reports - Responsive (5)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **Referral to treatment ongoing pathways under 18 weeks (%)**<br><br>**Standard: >=92%** |  | See Planned Care Exception report for full details. Restoration and recovery was still hampered during March due to the scale of the second surge, with both inpatient and outpatient services affected. Outpatient clinic activity has gradually increased with theatre availability still reduced and normal timetables resuming on 12th April. Performance remains relatively consistent with previous months and in line with many other Trusts nationally, with a part validated position for March being 69.4% and anticipated to be 69.5% at submission. 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**<br><br>**Standard: <=600** |  | There has been an improvement of performance (27) in March following February's performance of 1946. The service has reformulated the planned surveillance recovery plan following ongoing performance improvement of the 2ww and 6ww Diagnostic pathways which has delivered recovery over 2000 patients recovered in 2020-21.<br><br>The service is carving out 4x planned surveillance lists each month that guarantees a monthly improvement of 80 patients in the backlog to deliver 260 patient reduction by mid-July 2021. Recovery will be ongoing but will flex according to the 2ww and 6ww demands on the service.<br><br>Patients are being validated at a clinical level on a monthly basis and the service are collaborating with the Endoscopy Management System company (Medilogik) to create a specific panel within the IT system to complete clinical harm reviews of patients as part of good governance practices. | **Medical Director** |

# Exception Reports - Responsive (6)

| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **% waiting for diagnostics 6 week wait and over (15 key tests)**<br><br>**Standard: <=1%** |  | Diagnostic performance remains impacted post C-19, for delivery. Key areas are cardiology and endoscopy for which there are clear recovery plans in place, this is alongside recovery of all services and with appropriate support for workforce. | **Deputy Chief Operating Officer** |
| **Average length of stay (spell)**<br><br>**Standard: <=5.06** |  | Continue to monitor and measure LOS, various schemes detailed in the unscheduled care report support this. | **Deputy Chief Operating Officer** |
| **Outpatient new to follow up ratio's**<br><br>**Standard: <=1.9** |  | This will continue to be monitored, noting we have significant changes to our outpatient programme including the provision of mixed clinics through face to face and virtual supporting social distancing measures. We continue to deliver the standard virtual % for outpatients. This is within the operating context of a recovery period. | **Deputy Chief Operating Officer** |

# Exception Reports - Well Led (1)

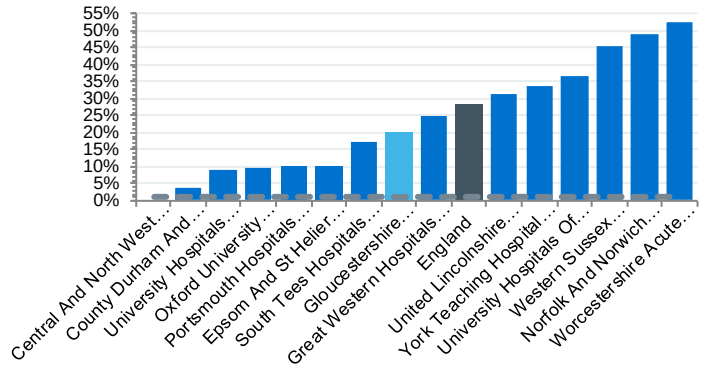
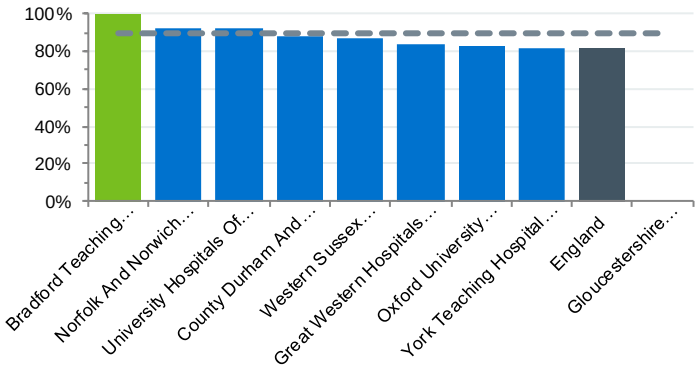
| Metric Name & Standard | Trend Chart | Exception Notes | Owner |
|---|---|---|---|
| **% vacancy rate for registered nurses**<br><br>**Standard: <=5%** |  | The Registered Nurse vacancy position has increased slightly however remains under 8%. The Trust has secured additional funding from NHSIE to increase our International Recruitment activity to 102 planned arrivals during this financial year. All other recruitment pathways will continue to be developed to reduce this vacancy position further. | **Director of Human Resources and Operational Development** |

# Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

**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

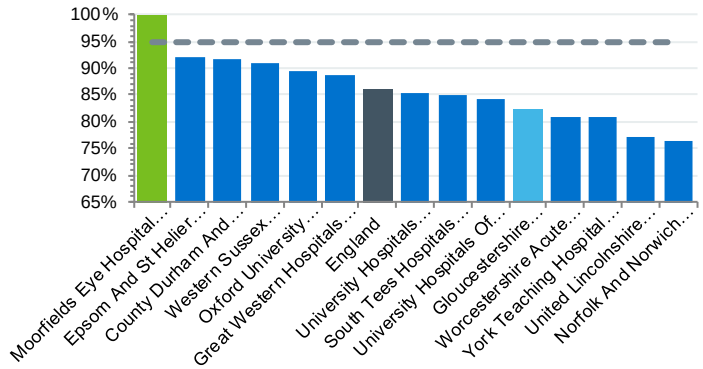
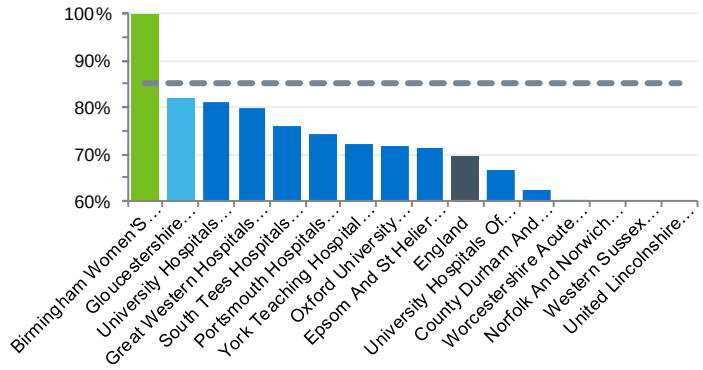
| Metric | Period | Peer Group | Rank | Quartile |
|---|---|---|---|---|
| **Diagnostics** | February-21 |  | 75 / 159 | 2nd |
| **Dementia** | February-20 |  | 82 / 82 | 4th |

# Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

**Standard** **England** **Other providers**
**GHT** **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

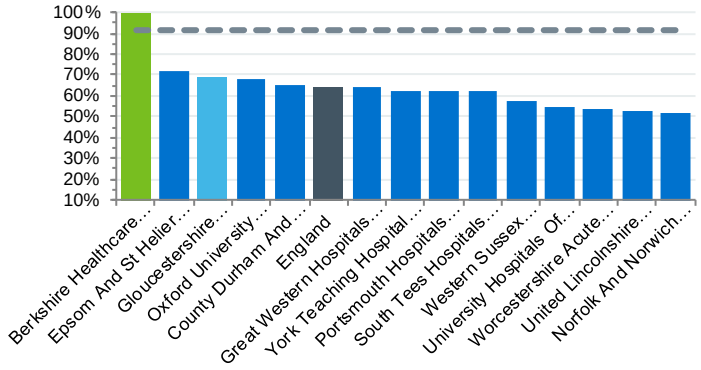
| Metric | Period | Peer Group | Rank | Quartile |
|---|---|---|---|---|
| **ED 4 Hour (Type 1 & Type 3)** | March-21 |  | 85 / 114 | 3rd |
| **Cancer 62 Days GP Referrals** | February-21 |  | 24 / 137 | 1st |

# Benchmarking (3)

Gloucestershire Hospitals NHS Foundation Trust

**Standard** **England** **Other providers**
**GHT** **Best in class***

*Where there is more than one top performing provider, the first in alphabetical order is reported here

| Metric | Period | Peer Group | Rank | Quartile |
|---|---|---|---|---|
| **RTT** | February-21 |  | 65 / 155 | 2nd |

NHS
Gloucestershire Hospitals
NHS Foundation Trust

# Quality and Performance Report Statistical Process Control Reporting

## Reporting Period March 2021

***Presented at April 2021 Q&P and May 2021 Trust Board***

# Contents

Gloucestershire Hospitals NHS Foundation Trust

# Guidance

Gloucestershire Hospitals NHS Foundation Trust

| 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

# Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we move forward with restoration and recovery of services. 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. 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.

The Trust is phasing in the support for increasing elective activity within April and currently meets the gateway targets for elective activity.

During March, 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 March was 69.77%, against the STP trajectory of 85.79%. The system did not meet the delivery of 90% for the system in March, at 80.00%.

The Trust did not meet the diagnostics standard for March at 19.48%. 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 97.0% in March but did not meet the standard for 62 day cancer waits at 83.1%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.40% (un-validated) in March, work continues to ensure that the performance is stabilised. Similar to other acute Trusts we have a significant number of patients waiting on our elective lists the number of patients waiting more than 52 weeks was 3,075 in March. 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. A recovery and restoration group has commenced in April to support all Divisional services.

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.

# Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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 | | |
|---|---|---|---|---|---|
| Consistently hit target | Hit and miss target subject to random | Consistently fail target | Special Cause Concerning variation | Common Cause | Special Cause Improving variation |

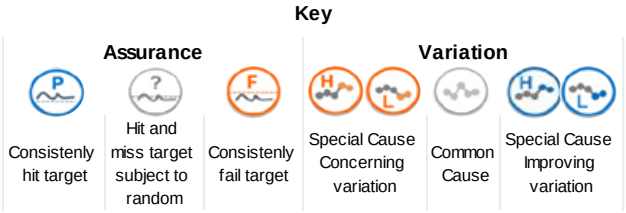
| MetricTopic | MetricNameAlias | Target & Assurance | | Latest Performance & Variance | | |
|---|---|---|---|---|---|---|
| Cancer | Cancer – 28 day FDS two week wait | No target | | Mar-21 | 78.0% | |
| Cancer | Cancer – 28 day FDS breast symptom two week wait | No target | | Mar-21 | 100.0% | |
| Cancer | Cancer – 28 day FDS screening referral | No target | | Mar-21 | 86.5% | |
| Cancer | Cancer – urgent referrals seen in under 2 weeks from GP | >=93% | | Mar-21 | 97.0% | |
| Cancer | 2 week wait breast symptomatic referrals | >=93% | | Mar-21 | 99.0% | |
| Cancer | Cancer – 31 day diagnosis to treatment (first treatments) | >=96% | | Mar-21 | 98.6% | |
| Cancer | Cancer – 31 day diagnosis to treatment (subsequent – drug) | >=98% | | Mar-21 | 99.3% | |
| Cancer | Cancer – 31 day diagnosis to treatment (subsequent – surgery) | >=94% | | Mar-21 | 93.6% | |
| Cancer | Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) | >=94% | | Mar-21 | 95.2% | |
| Cancer | Cancer 62 day referral to treatment (urgent GP referral) | >=85% | | Mar-21 | 83.1% | |
| Cancer | Cancer 62 day referral to treatment (screenings) | >=90% | | Mar-21 | 89.5% | |
| Cancer | Cancer 62 day referral to treatment (upgrades) | >=90% | | Mar-21 | 73.3% | |
| Cancer | Number of patients waiting over 104 days with a TCI date | Zero | | Mar-21 | 0 | |
| Cancer | Number of patients waiting over 104 days without a TCI date | <=24 | | Mar-21 | 12 | |
| Diagnostics | % waiting for diagnostics 6 week wait and over (15 key tests) | <=1% | | Mar-21 | 19.48% | |
| Diagnostics | The number of planned / surveillance endoscopy patients waiting at month end | <=600 | | Mar-21 | 1,919 | |
| Discharge | Patient discharge summaries sent to GP within 24 hours | >=88% | | Feb-21 | 59.4% | |
| Emergency Department | ED: % total time in department – under 4 hours (type 1) | >=95% | | Mar-21 | 69.77% | |
| Emergency Department | ED: % total time in department – under 4 hours (types 1 & 3) | >=95% | | Mar-21 | 80.00% | |
| Emergency Department | ED: % total time in department – under 4 hours CGH | >=95% | | Mar-21 | 99.52% | |
| Emergency Department | ED: % total time in department – under 4 hours GRH | >=95% | | Mar-21 | 69.77% | |

| 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 | | Mar-21 | 1 | |
| Emergency Department | ED: % of time to initial assessment – under 15 minutes | >=95% | | Mar-21 | 48.8% | |
| Emergency Department | ED: % of time to start of treatment – under 60 minutes | >=90% | | Mar-21 | 27.8% | |
| Emergency Department | % of ambulance handovers that are over 30 minutes | <=2.96% | | Mar-21 | 9.82% | |
| Emergency Department | % of ambulance handovers that are over 60 minutes | <=1% | | Mar-21 | 10.36% | |
| Maternity | % of women booked by 12 weeks gestation | >90% | | Mar-21 | 93.6% | |
| Operational Efficiency | Number of patients stable for discharge | <=70 | | Mar-21 | 110 | |
| Operational Efficiency | Number of stranded patients with a length of stay of greater than 7 days | <=380 | | Mar-21 | 366 | |
| Operational Efficiency | Average length of stay (spell) | <=5.06 | | Mar-21 | 5.26 | |
| Operational Efficiency | Length of stay for general and acute non-elective (occupied bed days) spells | <=5.65 | | Mar-21 | 5.59 | |
| Operational Efficiency | Length of stay for general and acute elective spells (occupied bed days) | <=3.4 | | Mar-21 | 2.9 | |
| Operational Efficiency | % day cases of all electives | >80% | | Mar-21 | 87.7% | |
| Operational Efficiency | Intra-session theatre utilisation rate | >85% | | Mar-21 | 88.3% | |
| Operational Efficiency | Cancelled operations re-admitted within 28 days | >=95% | | Mar-21 | 92.3% | |
| Operational Efficiency | Urgent cancelled operations | No target | | Mar-21 | 3 | |
| Outpatient | Outpatient new to follow up ratio's | <=1.9 | | Mar-21 | 2.08 | |
| Outpatient | Did not attend (DNA) rates | <=7.6% | | Mar-21 | 5.7% | |
| Readmissions | Emergency re-admissions within 30 days following an elective or emergency spell | <8.25% | | Feb-21 | 8.2% | |
| Research | Research accruals | No target | | Mar-21 | 220 | |

# Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

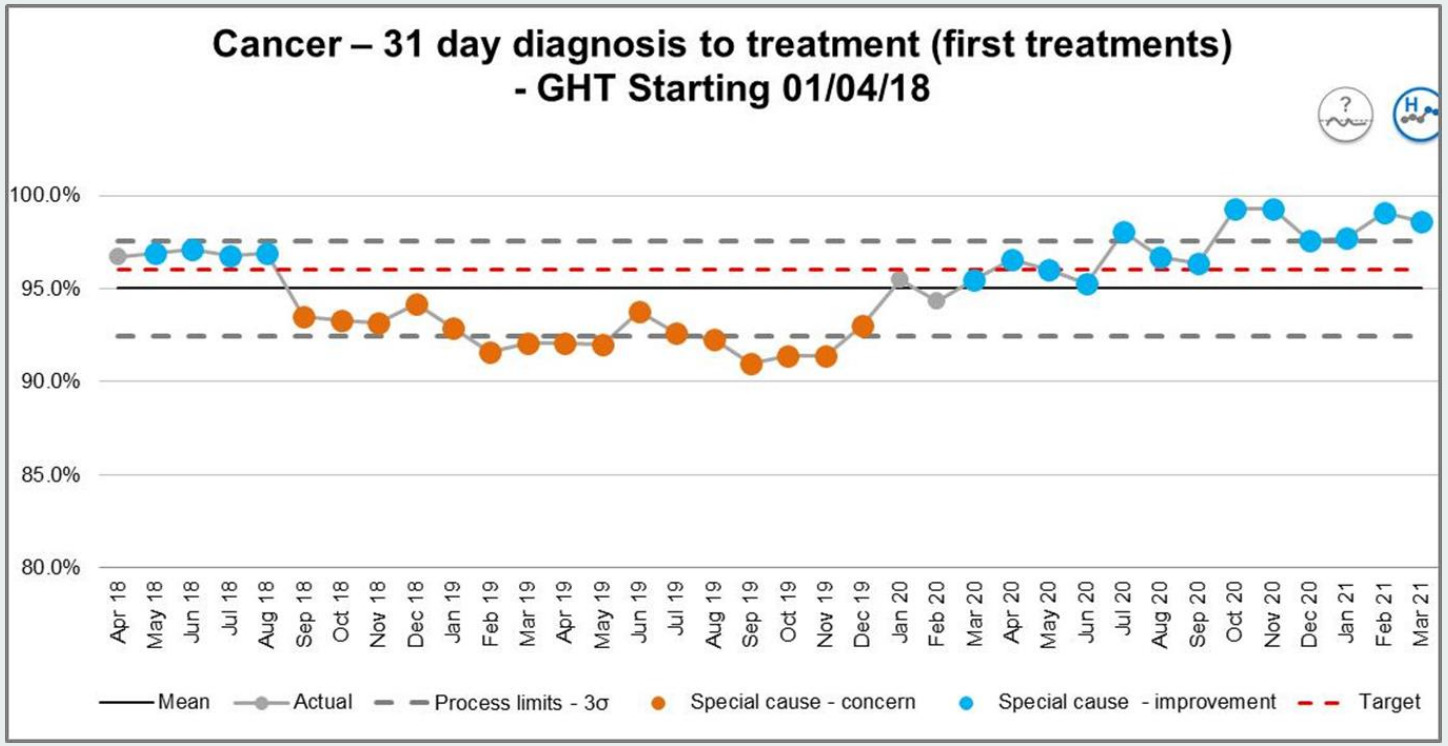
This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.




| MetricTopic | MetricNameAlias | Target & Assurance | | Latest Performance & Variance | | |
|---|---|---|---|---|---|---|
| RTT | Referral to treatment ongoing pathways under 18 weeks (%) | >=92% | | Mar-21 | 69.40% | |
| RTT | Referral to treatment ongoing pathways 35+ Weeks (number) | No target | | Mar-21 | 6,511 | |
| RTT | Referral to treatment ongoing pathways 45+ Weeks (number) | No target | | Mar-21 | 3,763 | |
| RTT | Referral to treatment ongoing pathways over 52 weeks (number) | Zero | | Mar-21 | 3,075 | |
| RTT | Referral to treatment ongoing pathways 70+ Weeks (number) | No target | | Mar-21 | 462 | |
| Stroke Care | Stroke care: percentage of patients receiving brain imaging within 1 hour | >=43% | | Mar-21 | 54.4% | |
| Stroke Care | Stroke care: percentage of patients spending 90%+ time on stroke unit | >=85% | | Feb-21 | 88.4% | |
| Stroke Care | % of patients admitted directly to the stroke unit in 4 hours | >=75% | | Mar-21 | 49.2% | |
| Stroke Care | % patients receiving a swallow screen within 4 hours of arrival | >=75% | | Mar-21 | 60.7% | |
| SUS | Percentage of records submitted nationally with valid GP code | >=99% | | Aug-20 | 100.00% | |
| 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% | | Mar-21 | 64.10% | |
| Trauma & Orthopaedics | % fractured neck of femur patients meeting best practice criteria | >=65% | | Mar-21 | 64.1% | |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

31 day new performance (unvalidated) = 98.7%
Target = 96%
National performance = 94.7%

Currently 97.9% for annual performance 20/21.

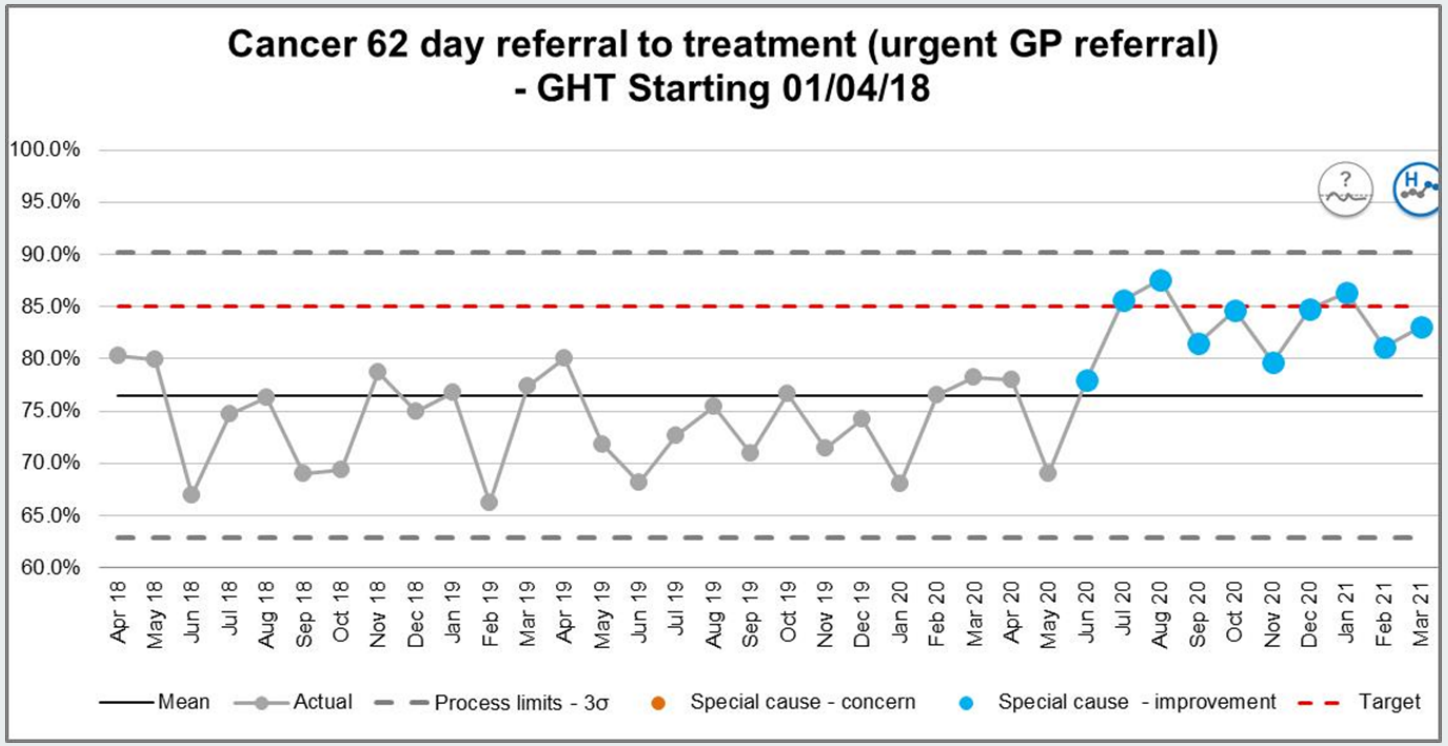
**- Director of Planned Care and Deputy Chief Operating Officer**

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 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. |
| 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

62 day GP performance (unvalidated) = 83.6% Target = 85% National performance = 69.7%
198 treatments; 32.5 breaches: Urology 12.5 LGI 8 H&N 4
There is a focus currently on improving the Urology performance which will be worked through the re-initiation of the Bladder and Renal Project group.
Annual performance 83.6%

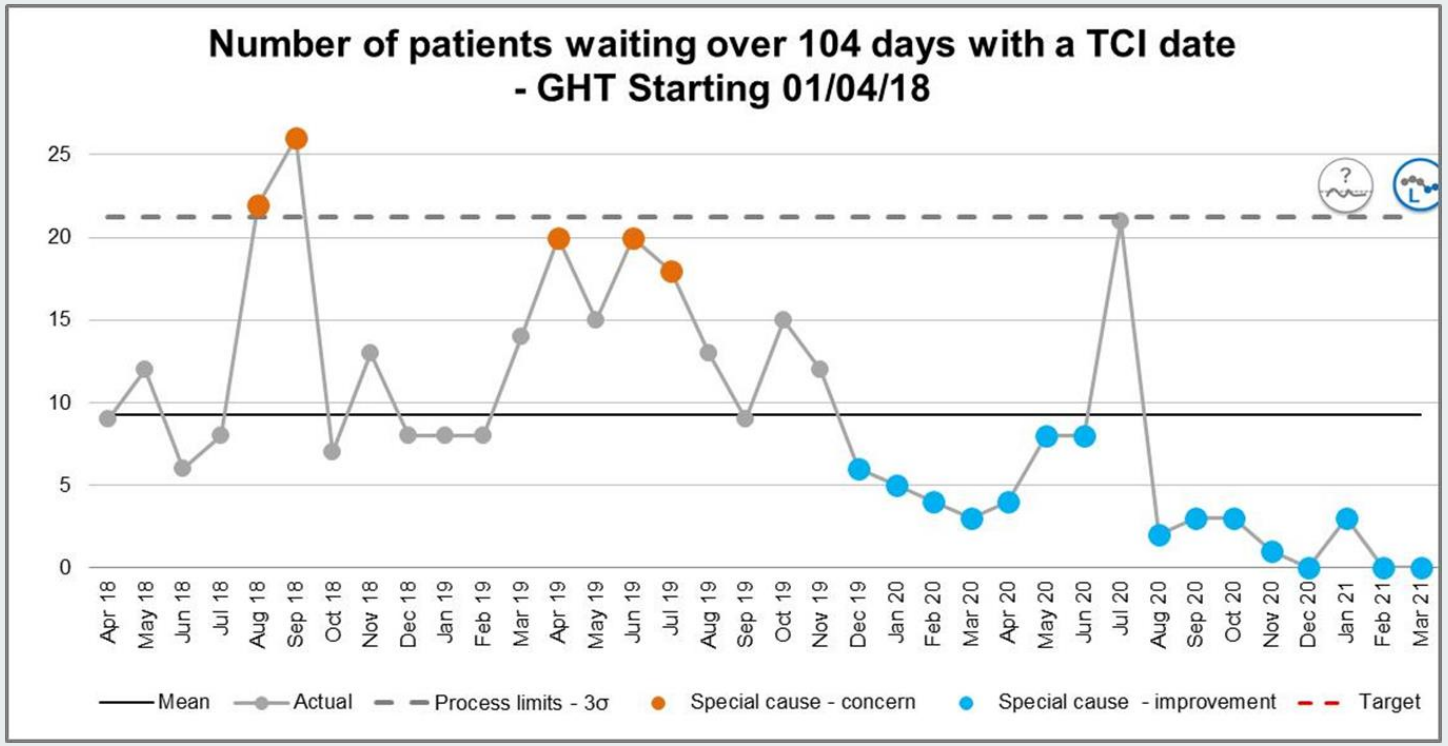
**- Director of Planned Care and Deputy Chief Operating Officer**

## Data Observations

| | |
|---|---|
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Specialty TCI recorded
Urological 1
Gynaecological 1
Grand Total 2

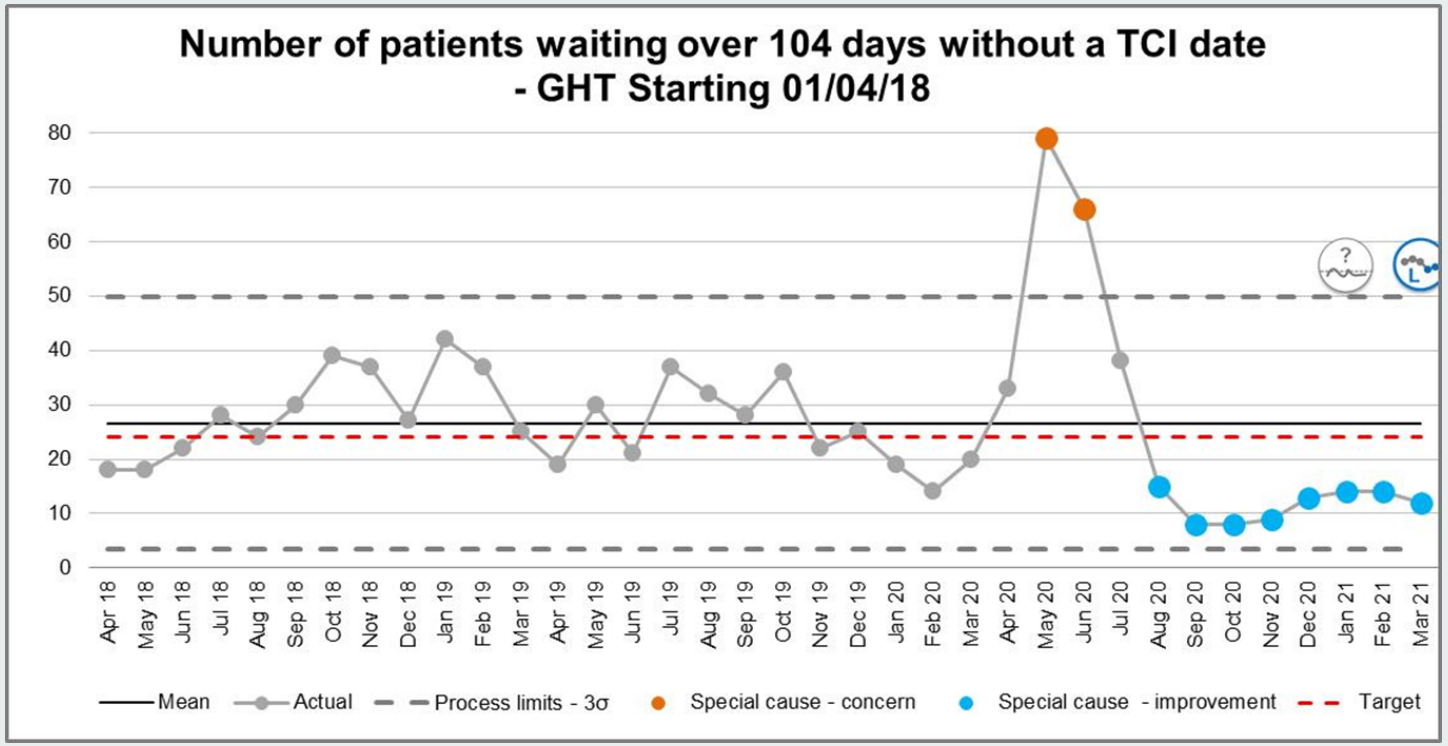
**- Director of Planned Care and Deputy Chief Operating Officer**

## Data Observations

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

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

| | | | |
|---|---|---|---|
| Specialty No TCI: | Lower GI 7 | Urological 5 | Upper GI 2 |
| | Haematological 1 | Head & neck 1 | Lung 1 |

Grand Total 17

Higher number of complex patients requiring additional tests. >62 day numbers still remain very low compared to pre pandemic.

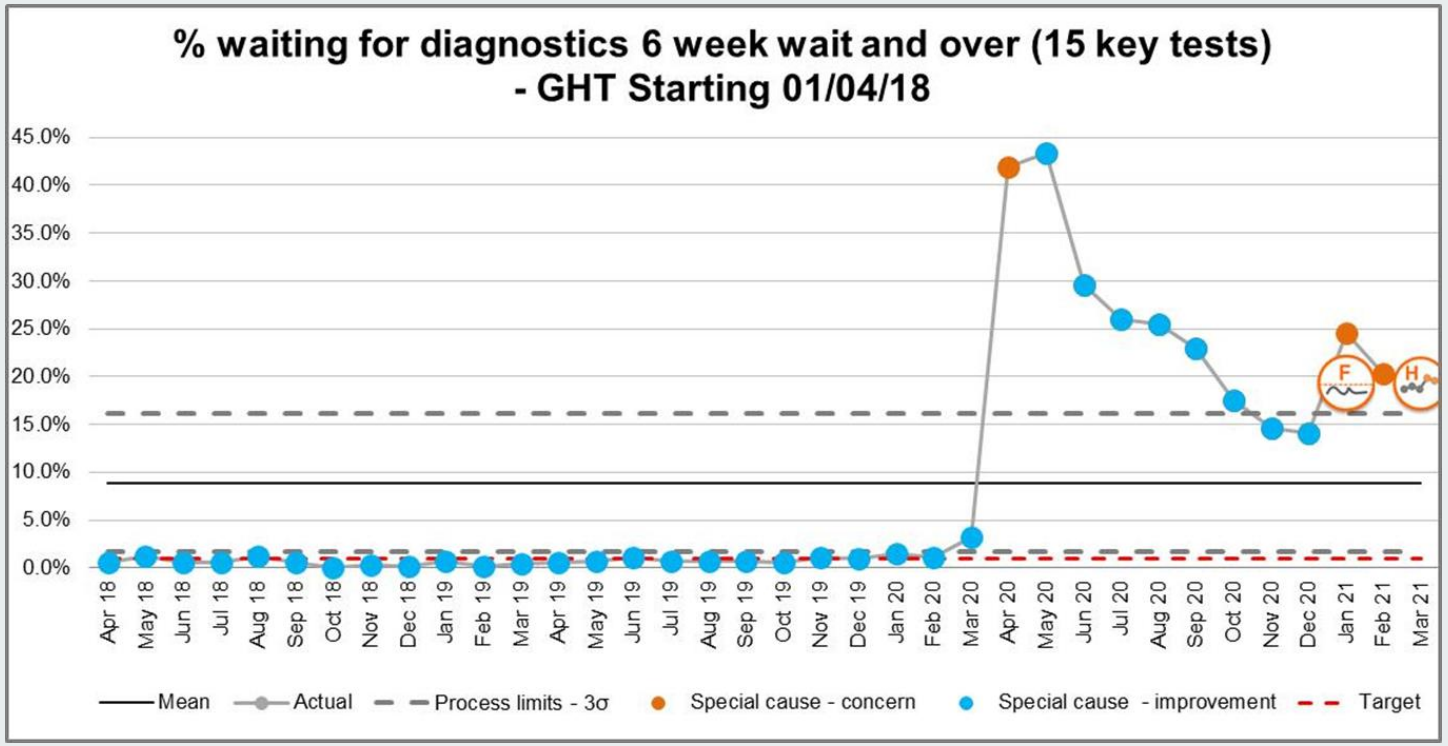
**- Director of Planned Care and Deputy Chief Operating Officer**

## Data Observations

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

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Diagnostic performance remains impacted post C-19, for delivery. Key areas are cardiology and endoscopy for which there are clear recovery plans in place, this is alongside recovery of all services and with appropriate support for workforce.

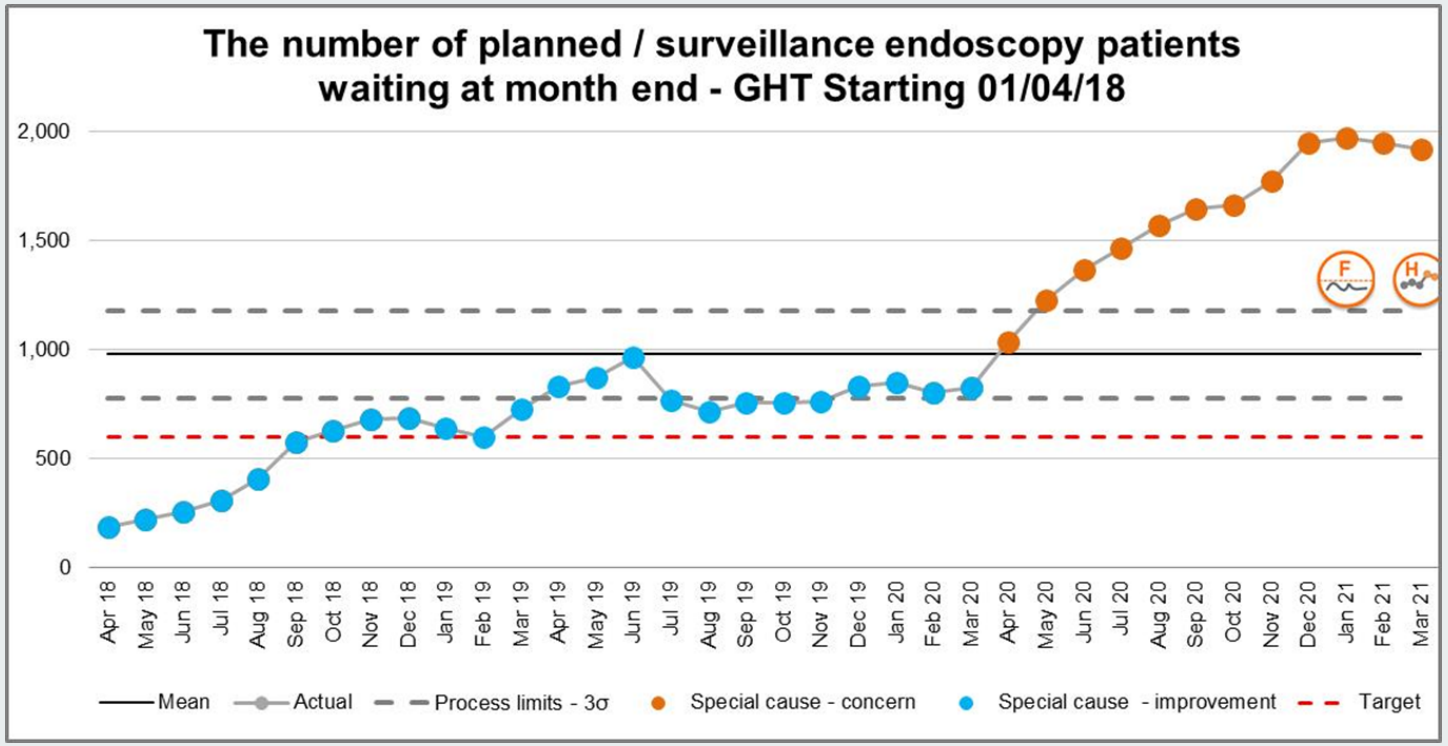
**- Director of Unscheduled Care and Deputy Chief Operating Officer**

## 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 10 data points which are above the line. There are 23 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

There has been an improvement of performance (27) in March following February's performance of 1946. The service has reformulated the planned surveillance recovery plan following ongoing performance improvement of the 2ww and 6ww Diagnostic pathways which has delivered recovery over 2000 patients recovered in 2020-21.

The service is carving out 4x planned surveillance lists each month that guarantees a monthly improvement of 80 patients in the backlog to deliver 260 patient reduction by mid-July 2021. Recovery will be ongoing but will flex according to the 2ww and 6ww demands on the service.

Patients are being validated at a clinical level on a monthly basis and the service are collaborating with the Endoscopy Management System company (Medilogik) to create a specific panel within the IT system to complete clinical harm reviews of patients as part of good governance practices.

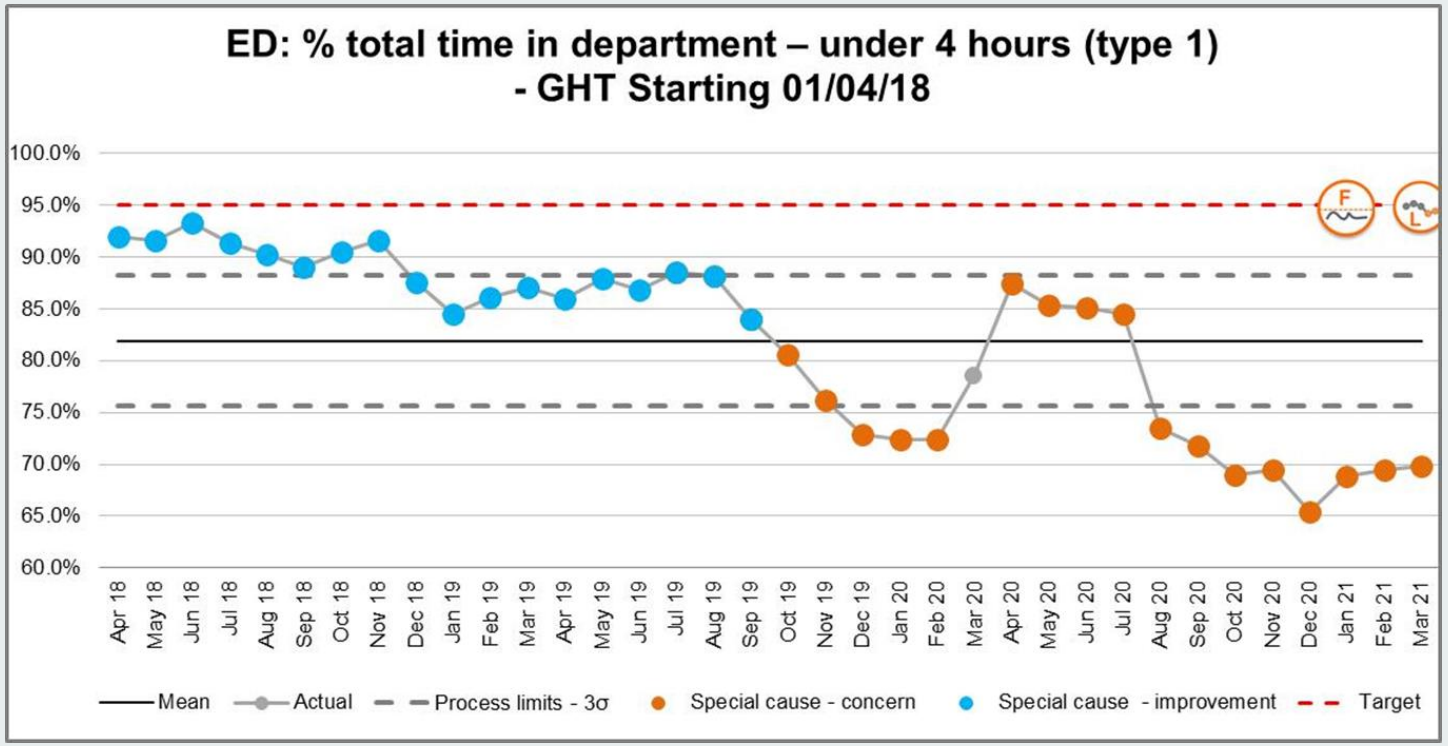
**- Medical Director**

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 17 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

4-hour performance has improved this month from 69.50% in February to 69.77% in March. The average total waiting in ED has reduced from 219.8 minutes in February to 212.1 minutes in March.

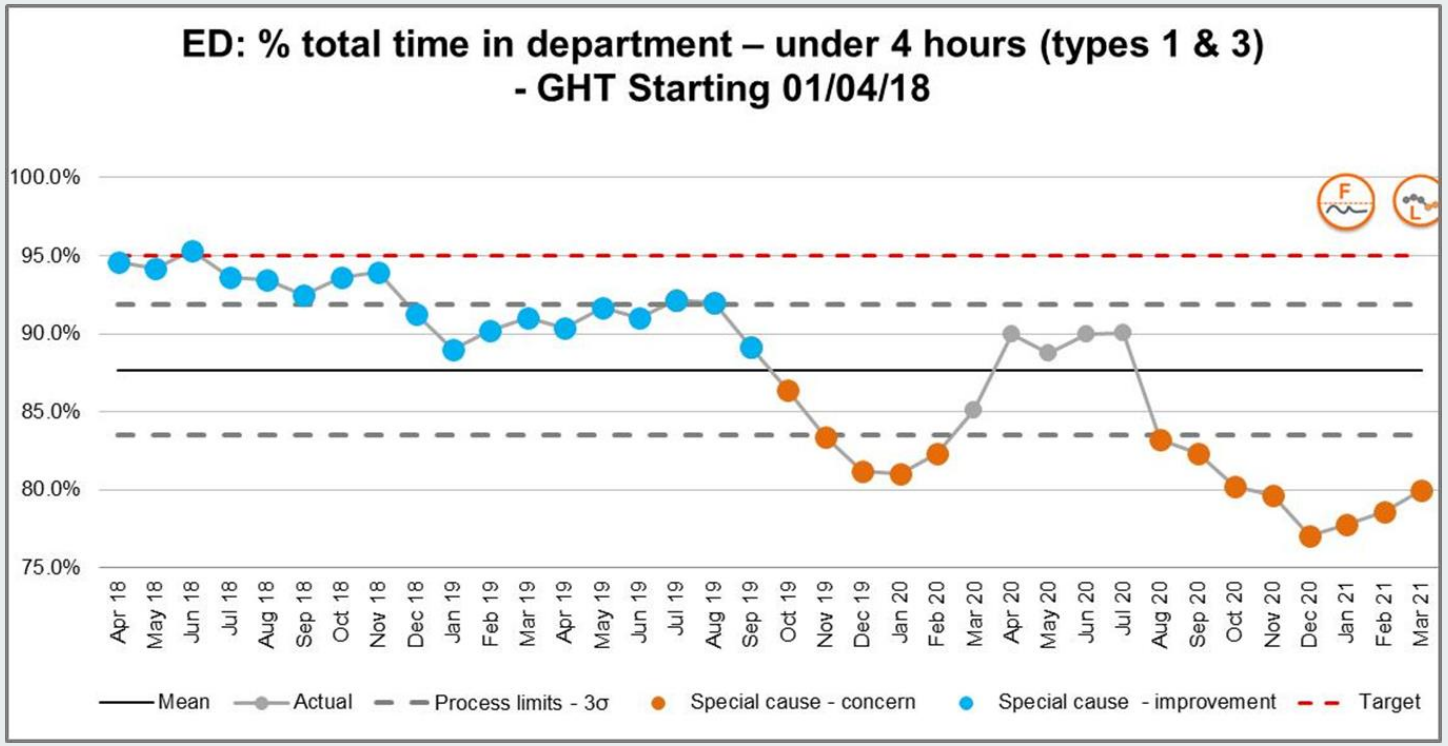
**- Director of Unscheduled Care and Deputy Chief Operating Officer**

## 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 9 data points which are above the line. There are 11 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

4-hour performance has improved this month from 78.62% in February to 80.00% in March. The average total waiting in ED has reduced from 219.8 minutes in February to 212.1 minutes in March.

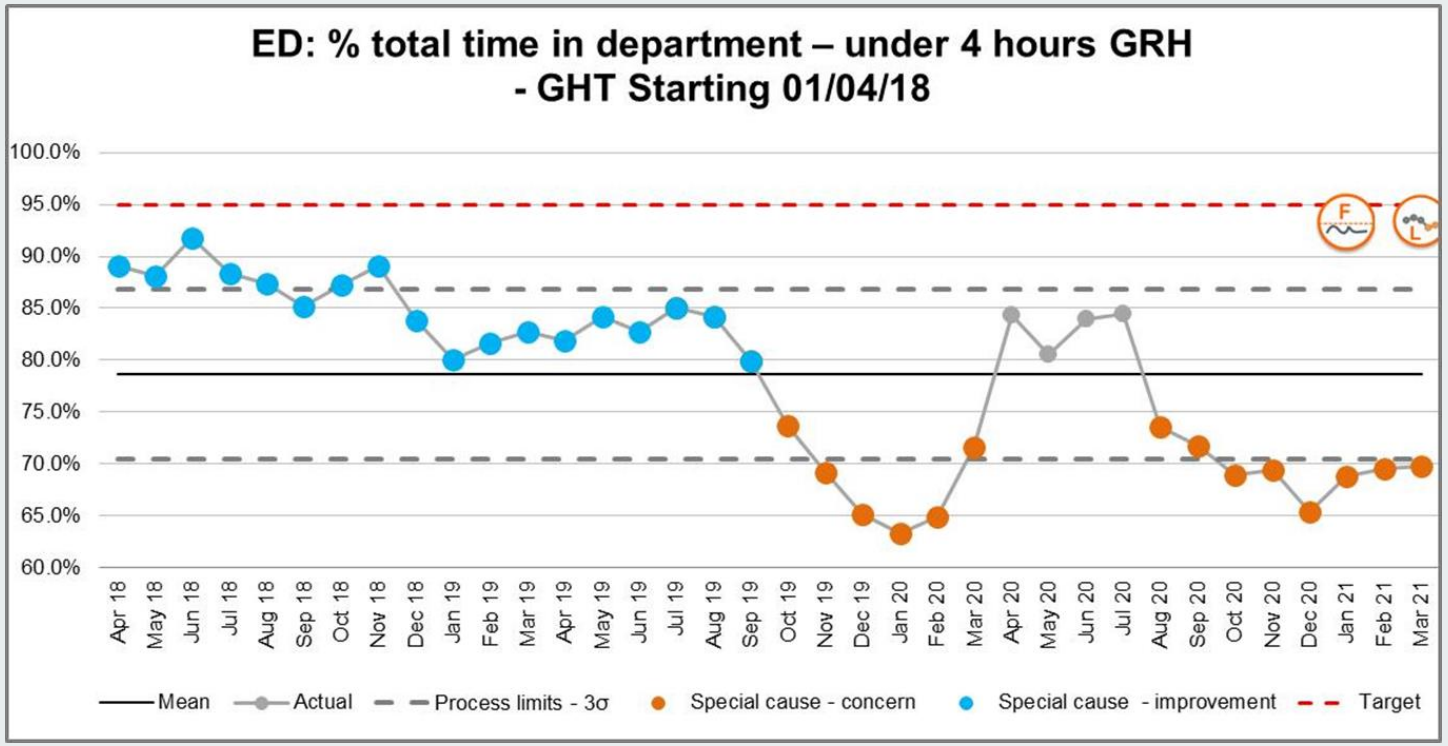
**- Director of Unscheduled Care and Deputy Chief Operating Officer**

## 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 10 data points which are above the line. There are 12 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

4-hour performance has improved this month from 69.50% in February to 69.77% in March. The average total waiting in ED has reduced from 219.8 minutes in February to 212.1 minutes in March.

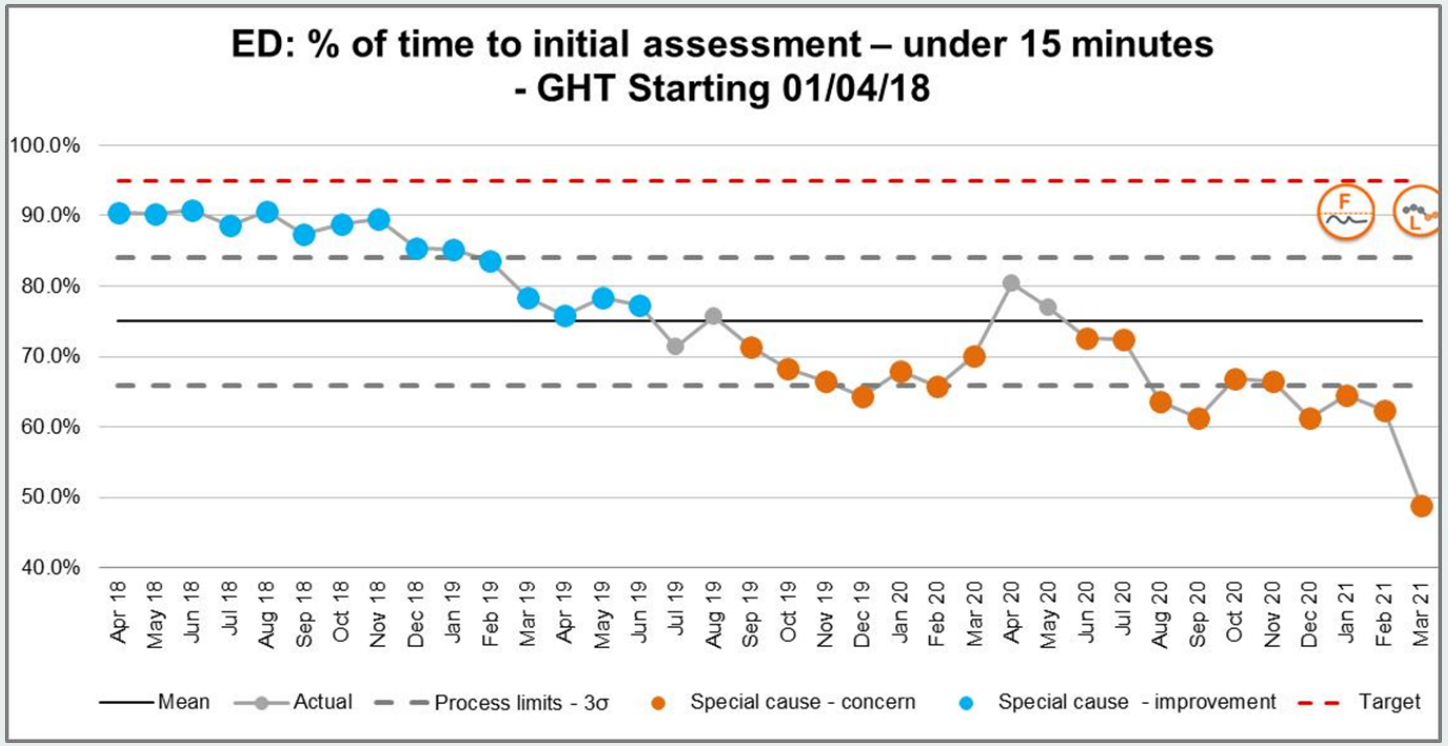
**- Director of Unscheduled Care and Deputy Chief Operating Officer**

## 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 7 data points which are above the line. There are 10 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Time to initial assessment or triage has been a focus in the last 2 weeks. It has been useful to also split the data out to walk in activity and ambulance arrivals. Enhanced pit stop staffing has improved time to initial assessment.
A SOP to escalate when triage for walk in patients is increased is now in place to allow flexing staff as when the demand dictates.

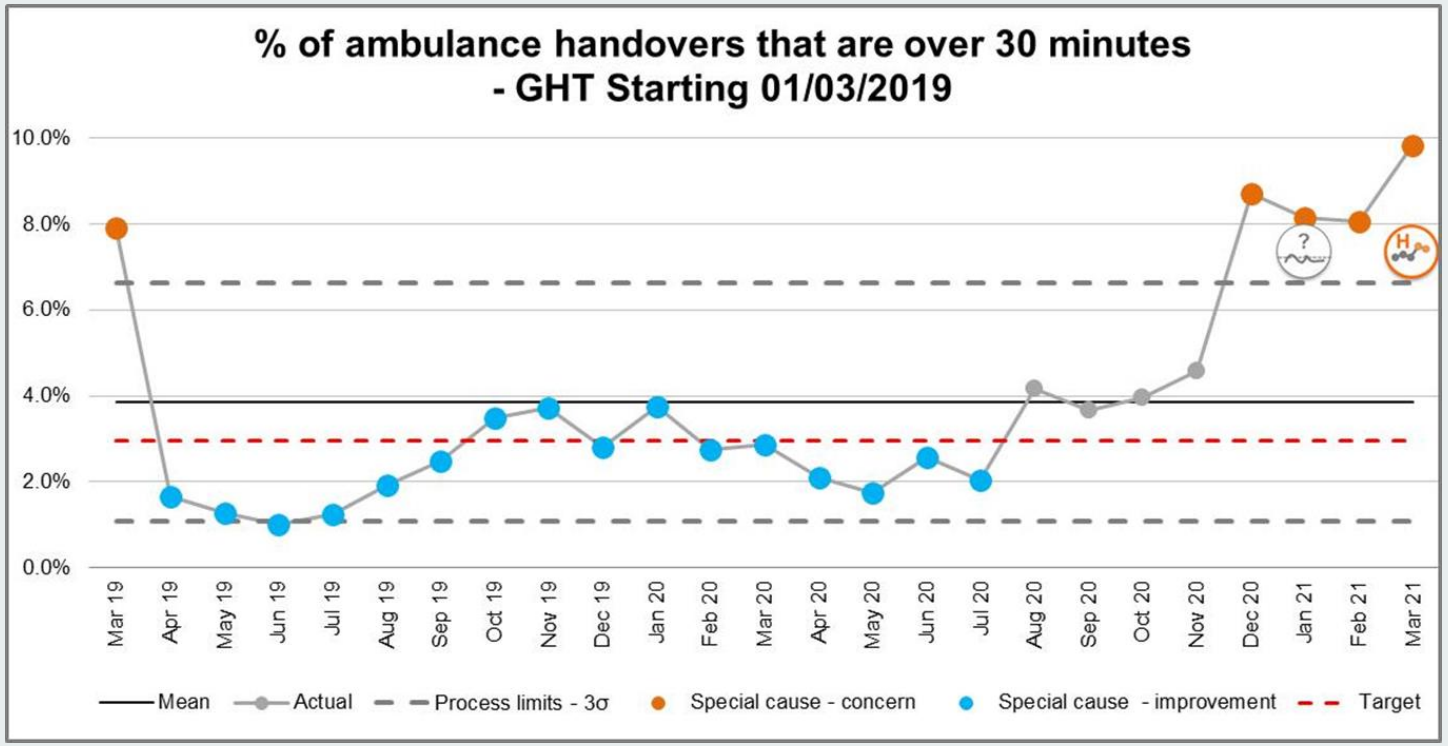
**- Director of Unscheduled Care and Deputy Chief Operating Officer**

## 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 10 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. |
| 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Ambulance handover delays has increased in March compared to February. A number of actions have been put in place at the beginning of April to reduce the handover delays. Pit stop staffing and physical environment has increased to meet demand. The challenge we still face is when multiple ambulance arrive at one time. SWAST are being encouraged to use Cinapsis to allow direct admissions to GPAU.

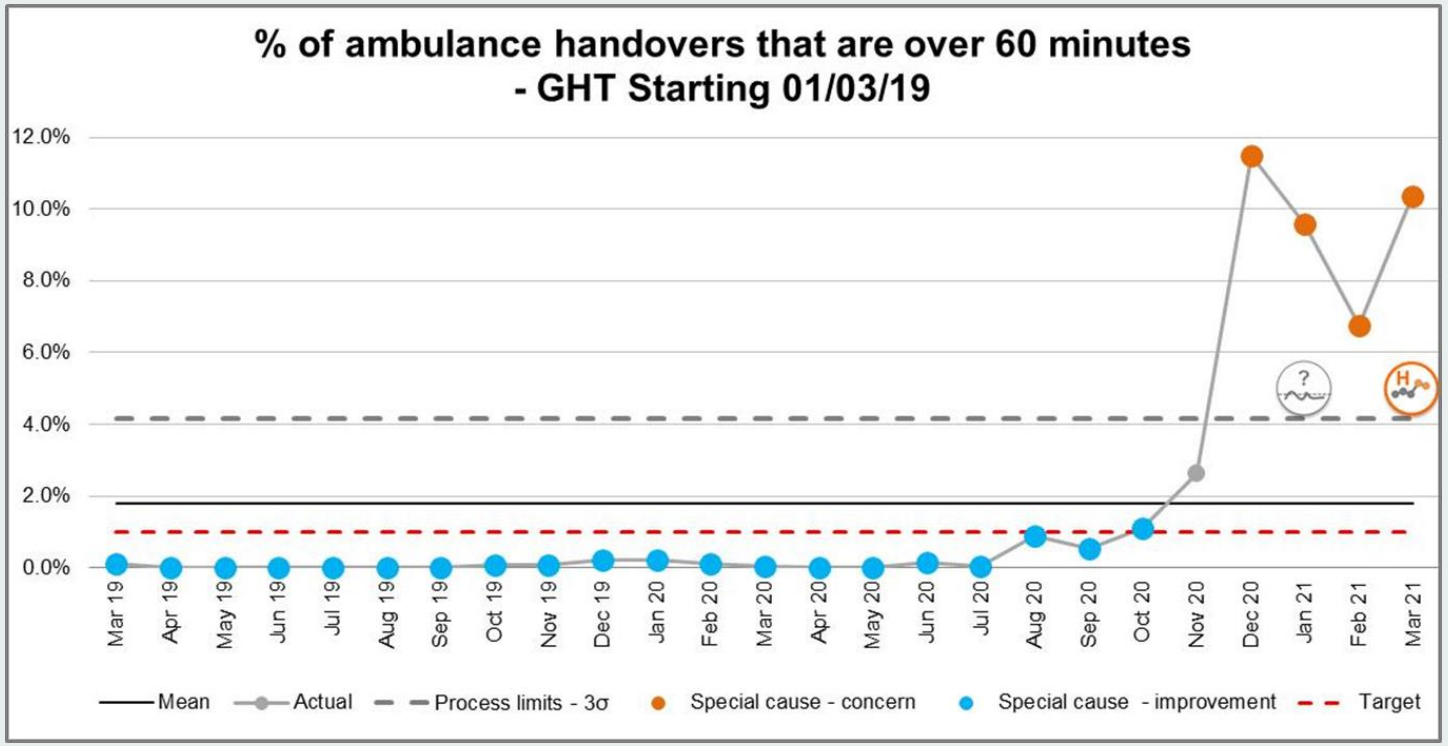
**- Director of Unscheduled Care and Deputy Chief Operating Officer**

## 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 5 data points which are above the line. There is 1 data point(s) below the line |
| 2 of 3 | When 2 out of 3 points lie near the LPL this is a warning that the process may be changing |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Ambulance handover delays has increased in March compared to February. A number of actions have been put in place at the beginning of April to reduce the handover delays. Pit stop staffing and physical environment has increased to meet demand. The challenge we still face is when multiple ambulance arrive at one time. SWAST are being encouraged to use Cinapsis to allow direct admissions to GPAU.

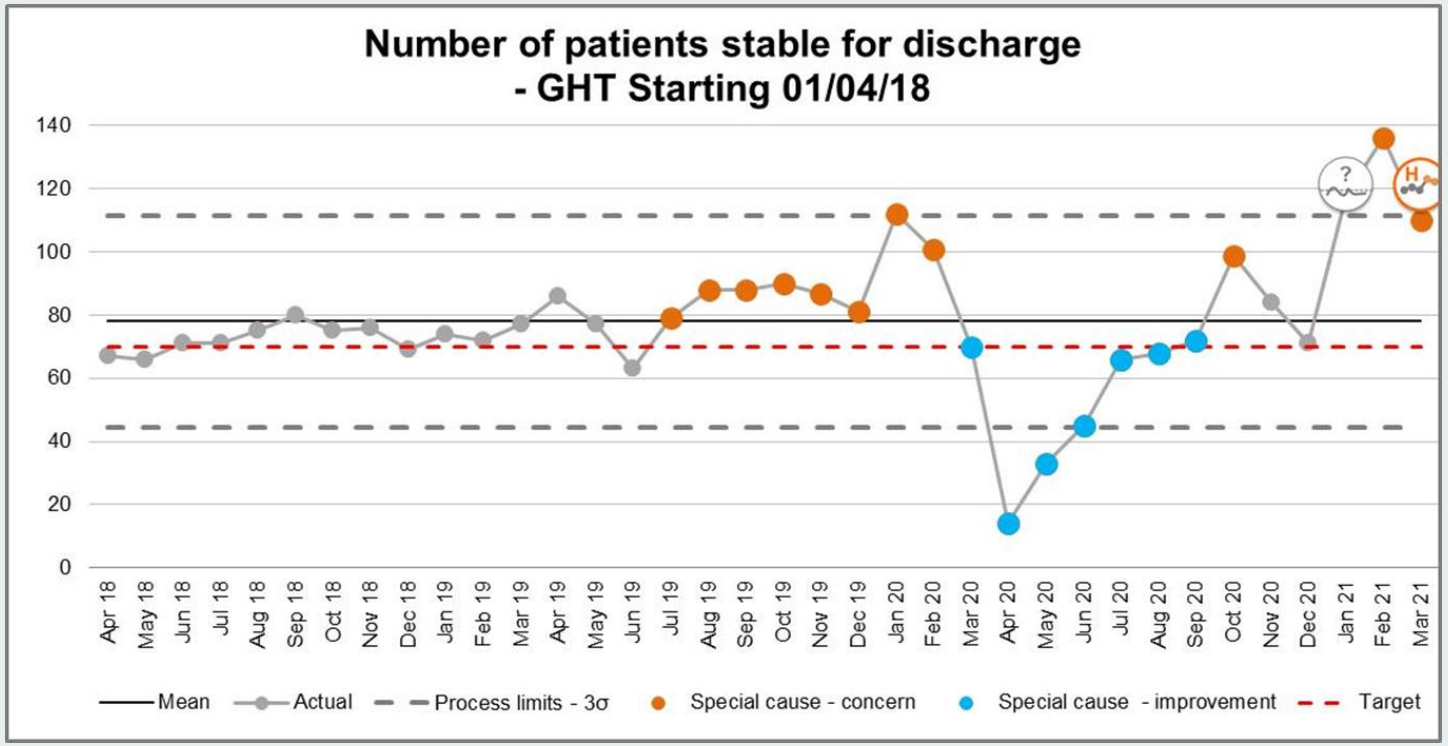
**- Director of Unscheduled Care and Deputy Chief Operating Officer**

## 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. |
| 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Large numbers of MOFD patients identified as part of system 30 day ECIST work streams. Worked planned to review and focus efforts on reducing delays within specific pathways which make up the larger numbers of patients waiting for onward care.

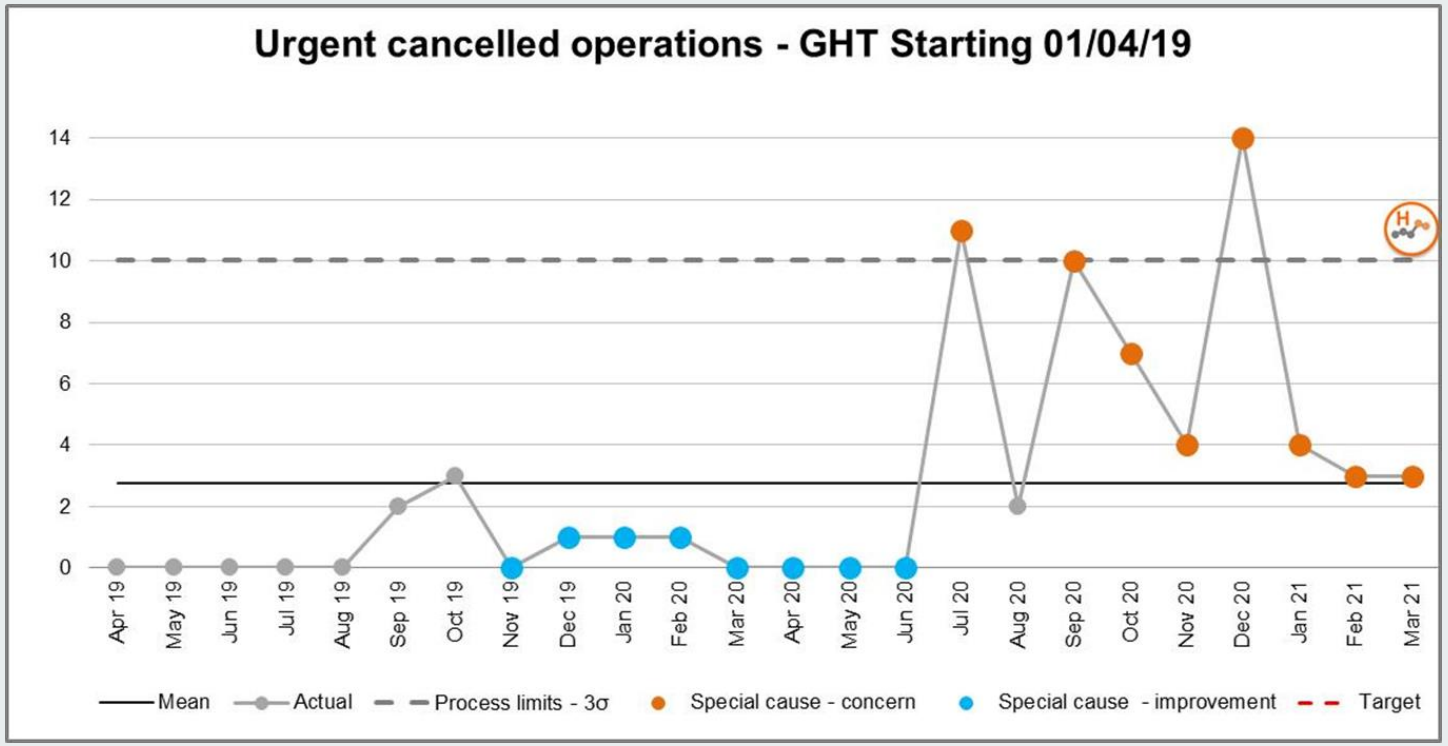
**- Head of Therapy & OCT**

## 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 3 data point which is above the line. There are 2 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Under Review

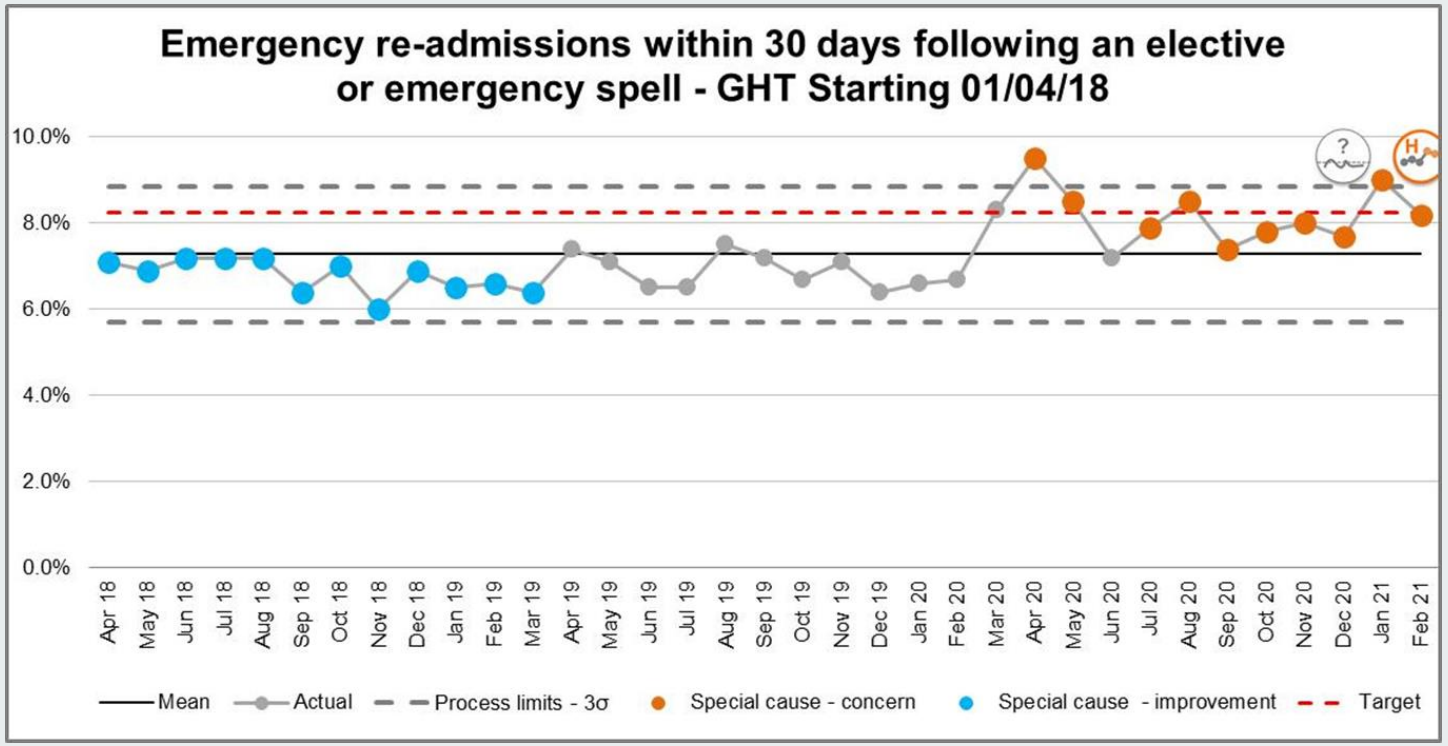
**- Director of Operations - Surgery**

## 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 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 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

This metric is now green and has improved on the previous month which reflects the impact of the second surge has had as described previously.

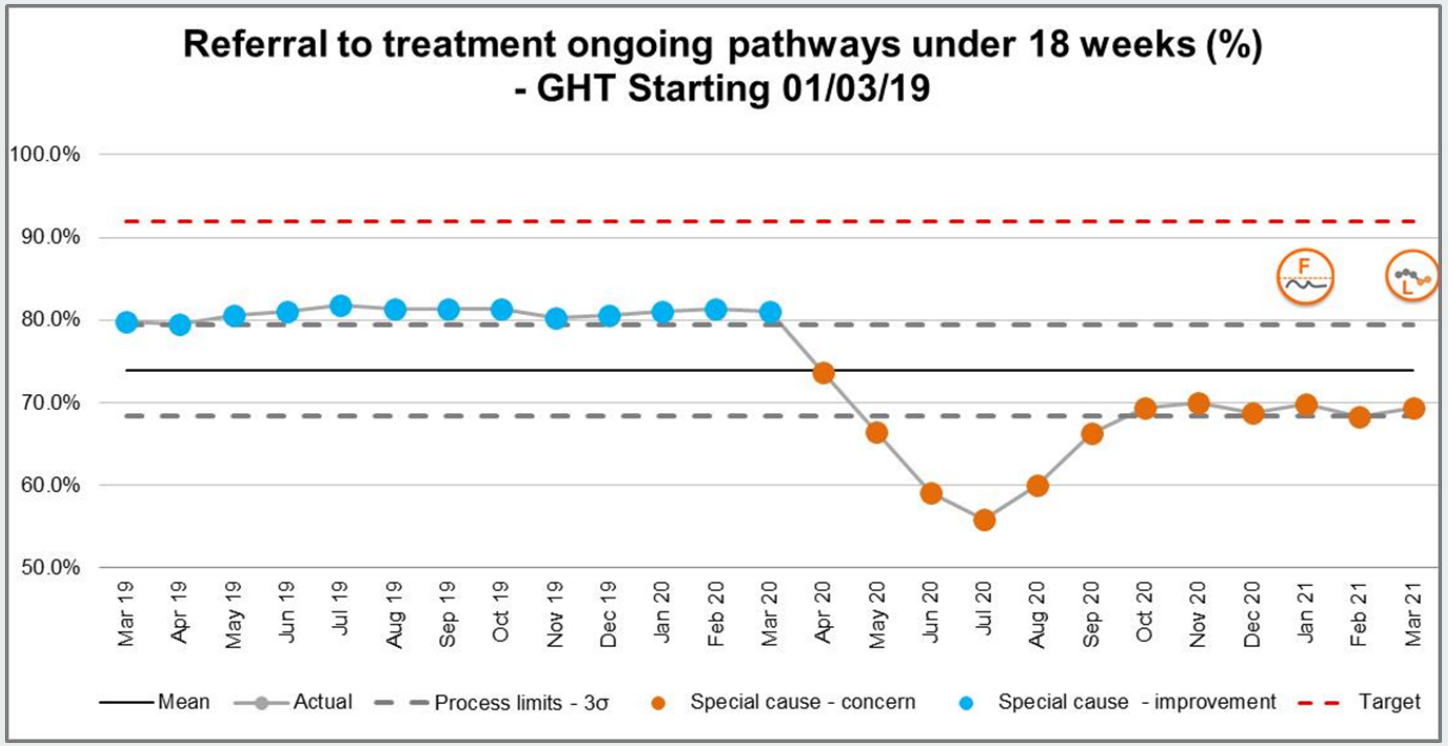
**- Deputy Medical Director**

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. |
| 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

See Planned Care Exception report for full details. Restoration and recovery was still hampered during March due to the scale of the second surge, with both inpatient and outpatient services affected. Outpatient clinic activity has gradually increased with theatre availability still reduced and normal timetables resuming on 12th April. Performance remains relatively consistent with previous months and in line with many other Trusts nationally, with a part validated position for March being 69.4% and anticipated to be 69.5% at submission. As indicated in other metrics the long waiting cohort of patients has risen in recent months.

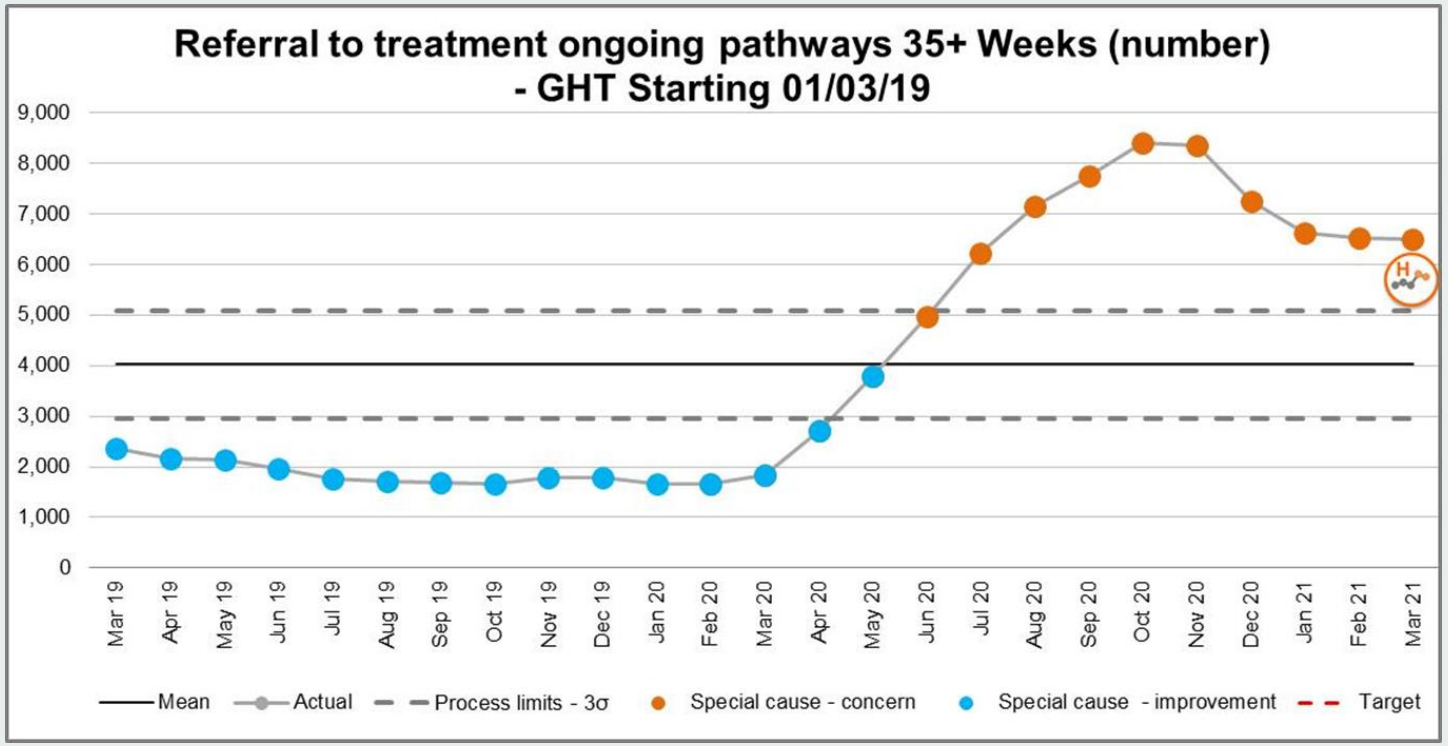
**- Deputy Chief Operating Officer**

## 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 12 data points which are above the line. There are 6 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Restoration and recovery was still hampered during March with both inpatient and outpatient services affected. Outpatient clinic activity has gradually increased with theatre availability still reduced and normal timetables resuming on 12th April. The cohort of patients over 35+ weeks has reduced again for the fourth consecutive month, although longer waiting patients have increased in March.

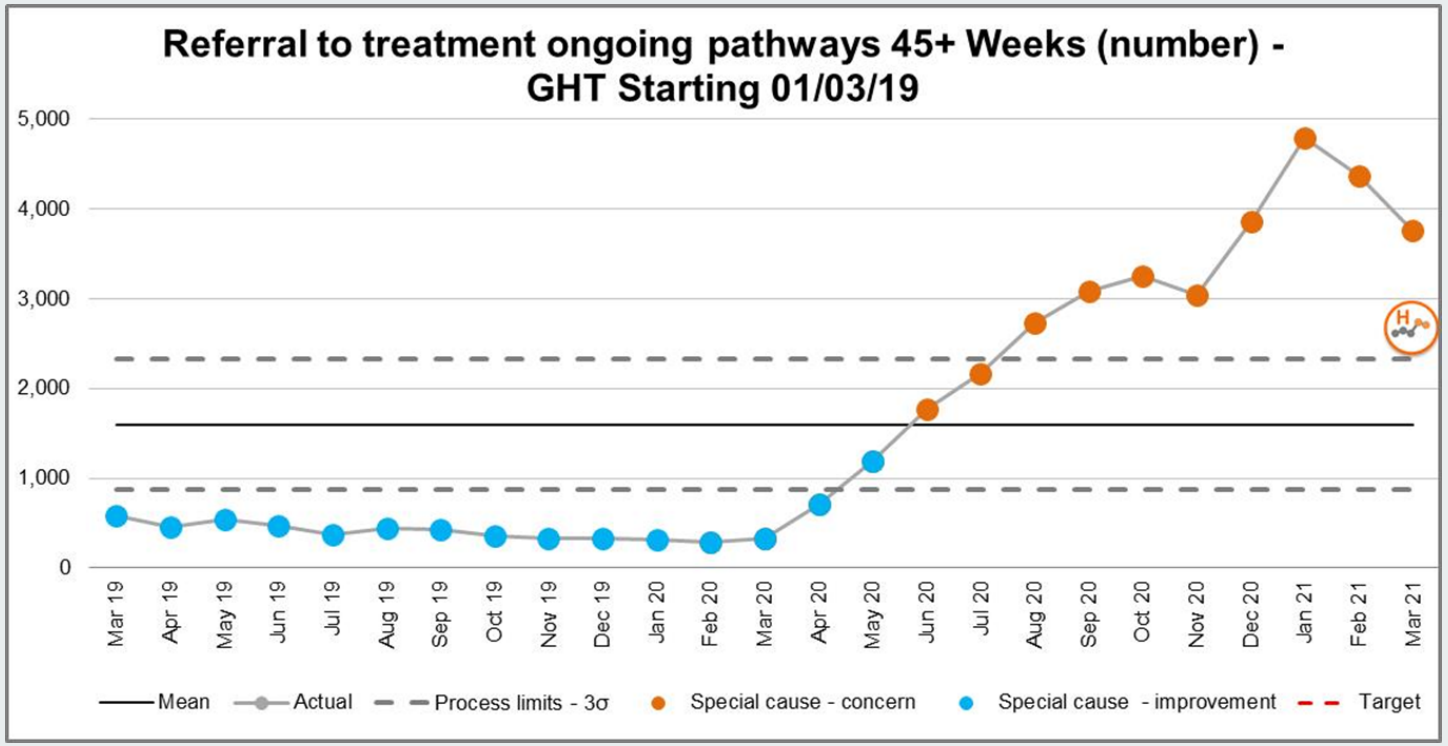
**- Deputy Chief Operating Officer**

## 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 9 data points which are above the line. There are 14 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Restoration and recovery was still hampered during March with both inpatient and outpatient services affected. Outpatient clinic activity has gradually increased with theatre availability still reduced and normal timetables resuming on 12th April. Similar to the 35+ weeks, a decrease in the number of patients in this cohort has been seen in month (~600).

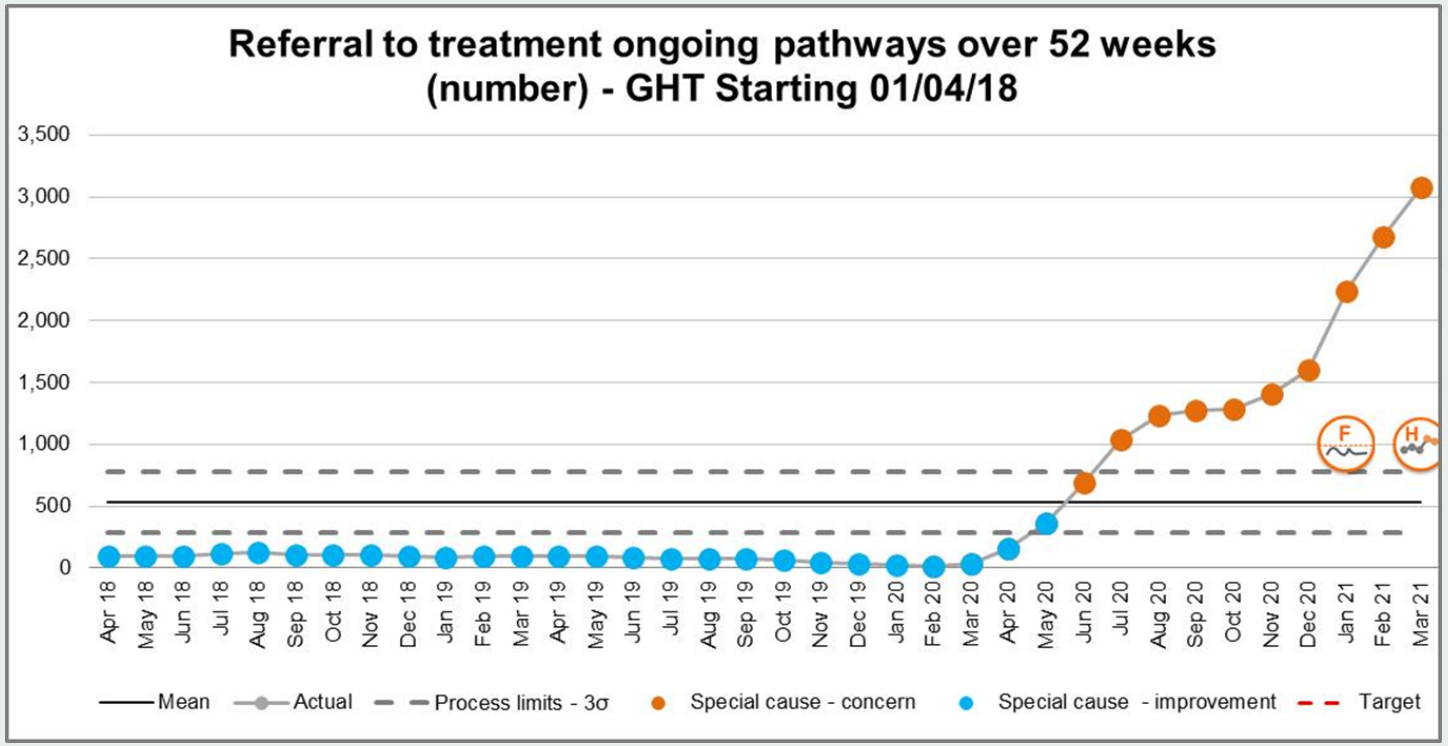
**- Deputy Chief Operating Officer**

## 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 14 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

See Planned Care Exception report for full details. Restoration and recovery was still hampered during March due to the scale of the second surge, with both inpatient and outpatient services affected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Consequently the cohort of long waiting patients has increased in March.

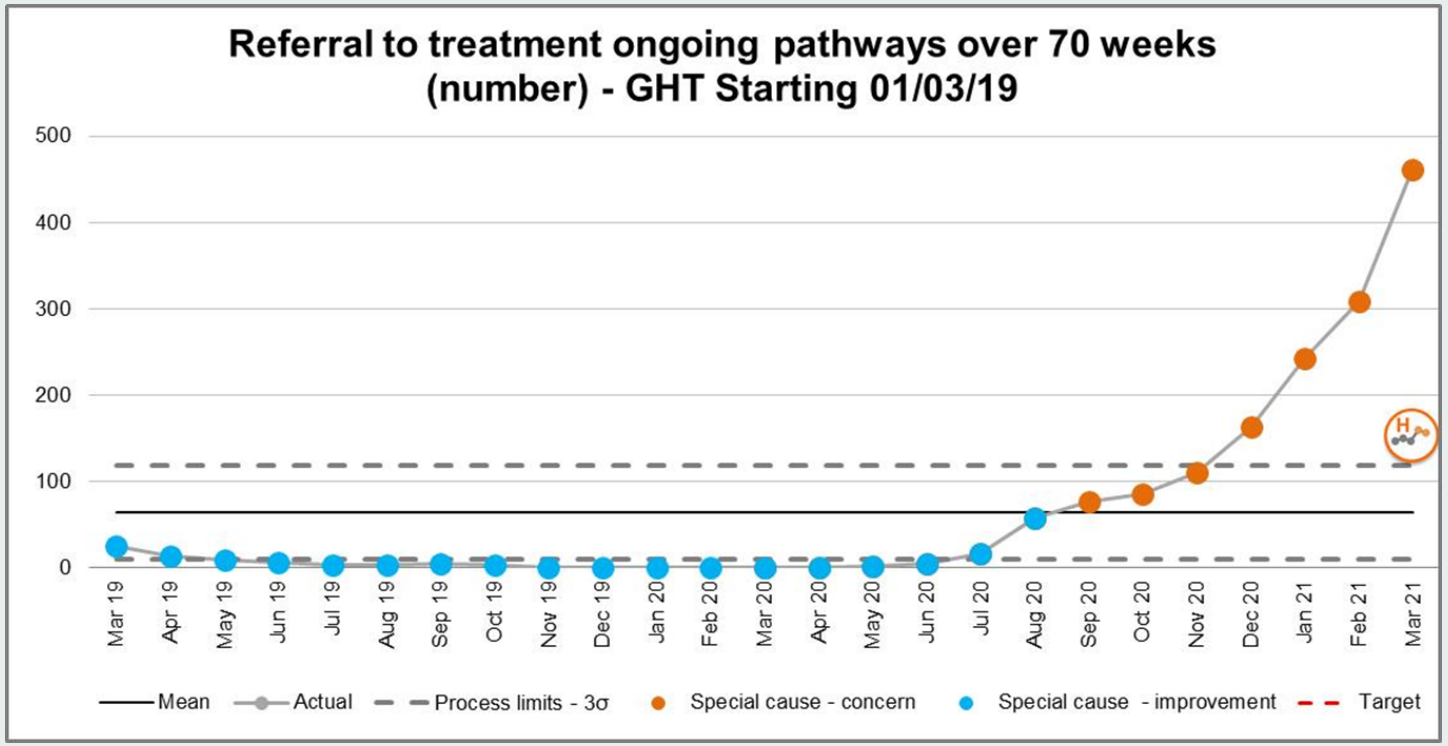
**- Deputy Chief Operating Officer**

## 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 9 data points which are above the line. There are 25 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 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Restoration and recovery was still hampered during March due to the scale of the second surge, with both inpatient and outpatient services effected. Cancellation of inpatients and reduction of outpatient clinics has resulted in a deterioration of performance. Consequently the cohort of long waiting patients has increased in March. P1 and P2 patients continue to be the focus. Those patients over 70 weeks are primarily P3 or P4 patients, and any patients prioritised as P2 (quite often through re-review) are expedited.

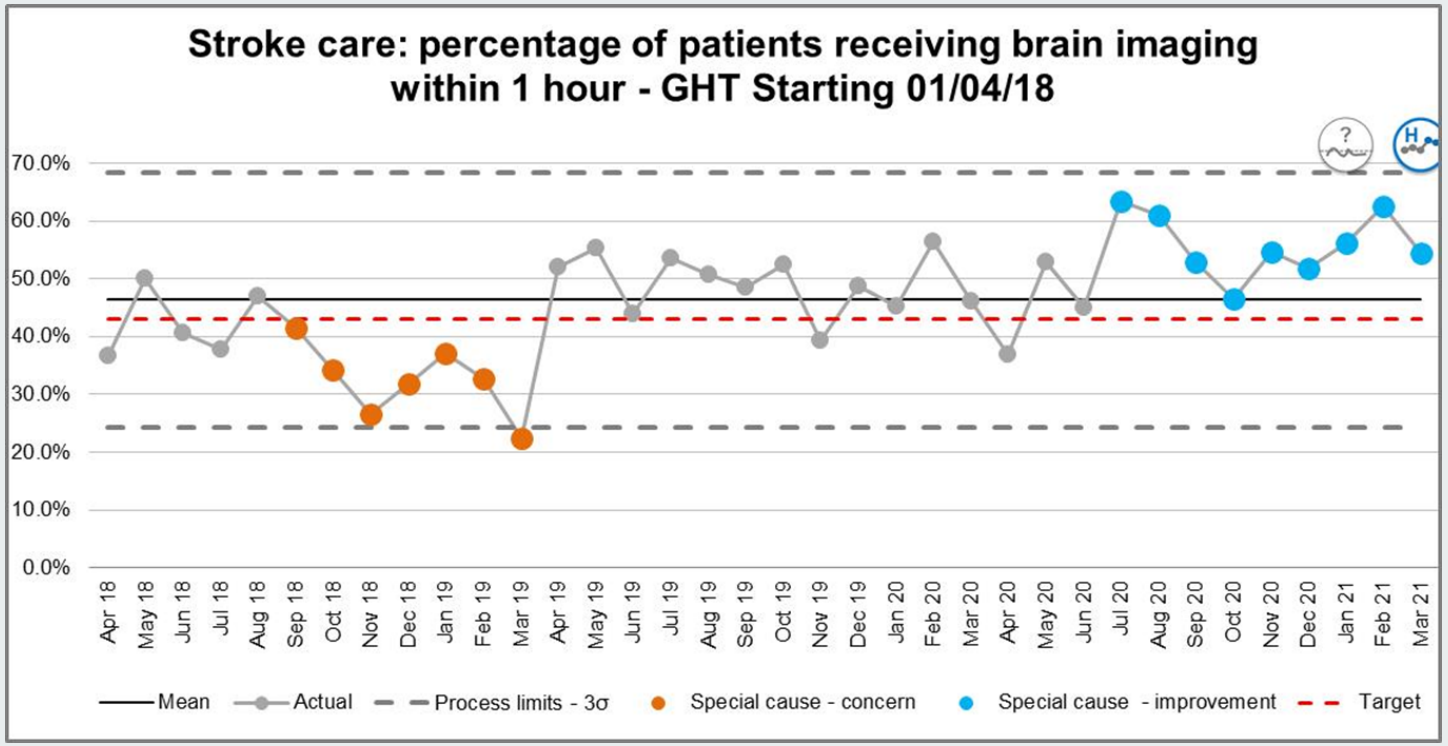
**- Deputy Chief Operating Officer**

## 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 14 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points 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 |

# Access:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

The metric for time to CT head has deteriorated in performance on the month of February (deterioration of 8.10%) but is still within target. The ED service continues to work with the Stroke team on the early identification of stroke patients who should have their radiology request completed quickly on arrival. This performance reduction is linked to ambulance off-load delays which were significant in March. A recovery plan is already in place to improve these delays from April 2021 onward.

**- Director of Unscheduled Care and Deputy Chief Operating Officer**

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point(s) below the line |
| 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 |

# 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**

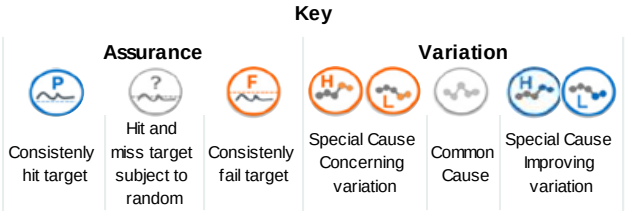

| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & Variance | | |
|---|---|---|---|---|---|
| Dementia Screening | % of patients who have been screened for dementia (within 72 hours) | >=90% | Mar-21 | 70% | |
| Friends & Family Test | Inpatients % positive | >=90% | Mar-21 | 89.6% | |
| Friends & Family Test | ED % positive | >=84% | Mar-21 | 77.5% | |
| Friends & Family Test | Maternity % positive | >=97% | Mar-21 | 92.6% | |
| Friends & Family Test | Outpatients % positive | >=94.5% | Mar-21 | 94.5% | |
| Friends & Family Test | Total % positive | >=93% | Mar-21 | 92.1% | |
| PALS | Number of PALS concerns logged | No Target | Mar-21 | 262 | |
| PALS | % of PALS concerns closed in 5 days | >=95% | Mar-21 | 83% | |
| Infection Control | Number of trust apportioned MRSA bacteraemia | Zero | Mar-21 | 0 | |
| Infection Control | MRSA bacteraemia – infection rate per 100,000 bed days | Zero | Mar-21 | 0 | |
| Infection Control | Number of trust apportioned Clostridium difficile cases per month | 2019/20: 114 | Mar-21 | 8 | |
| Infection Control | Number of community-onset healthcare-associated Clostridioides difficile cases per month | <=5 | Mar-21 | 5 | |
| Infection Control | Number of hospital-onset healthcare-associated Clostridioides difficile cases per month | <=5 | Mar-21 | 3 | |
| Infection Control | Clostridium difficile – infection rate per 100,000 bed days | <30.2 | Mar-21 | 30.9 | |
| Infection Control | Number of MSSA bacteraemia cases | <=8 | Mar-21 | 3 | |
| Infection Control | MSSA – infection rate per 100,000 bed days | <=12.7 | Mar-21 | 11.6 | |
| Infection Control | Number of ecoli cases | No target | Mar-21 | 2 | |
| Infection Control | Number of pseudomona cases | No target | Mar-21 | 1 | |
| Infection Control | Number of klebsiella cases | No target | Mar-21 | 2 | |
| Infection Control | Number of bed days lost due to infection control outbreaks | <10 | Oct-20 | 5 | |
| Infection Control | COVID-19 community-onset – First positive specimen <=2 days after admission | No target | Mar-21 | 29 | |

| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & Variance | | |
|---|---|---|---|---|---|
| Infection Control | COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission | No target | Mar-21 | 3 | |
| Infection Control | COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission | No target | Mar-21 | 1 | |
| Infection Control | COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission | No target | Mar-21 | 2 | |
| Maternity | % C-section rate (planned and emergency) | <=27% | Mar-21 | 0 | |
| Maternity | % emergency C-section rate | No target | Mar-21 | 17.7% | |
| Maternity | % of women smoking at delivery | <=14.5% | Mar-21 | 0 | |
| Maternity | % of women that have an induced labour | <=30% | Mar-21 | 30.6% | |
| Maternity | % stillbirths as percentage of all pregnancies > 24 weeks | <0.52% | Mar-21 | 0.62% | |
| Maternity | % of women on a Continuity of Carer pathway | No target | Mar-21 | 0.00% | |
| Maternity | % breastfeeding (initiation) | >=81% | Mar-21 | 82.4% | |
| Maternity | % Massive PPH >1.5 litres | <=4% | Mar-21 | 5.2% | |
| Maternity | Number of births less than 27 weeks | NULL | Mar-21 | 3 | |
| Maternity | Number of births less than 34 weeks | NULL | Mar-21 | 10 | |
| Maternity | Number of births less than 37 weeks | NULL | Mar-21 | 29 | |
| Maternity | Number of maternal deaths | NULL | Mar-21 | 1 | |
| Maternity | Total births | NULL | Mar-21 | 483 | |
| Maternity | Percentage of babies <3rd centile born > 37+6 weeks | NULL | Mar-21 | 1.04% | |
| Maternity | % breastfeeding (discharge to CMW) | NULL | Mar-21 | 56.7% | |
| Mortality | Summary hospital mortality indicator (SHMI) – national data | NHS Digital | Nov-20 | 1 | |
| Mortality | Hospital standardised mortality ratio (HSMR) | Dr Foster | Dec-20 | 108.2 | |
| Mortality | Hospital standardised mortality ratio (HSMR) – weekend | Dr Foster | Dec-20 | 109.8 | |

# Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

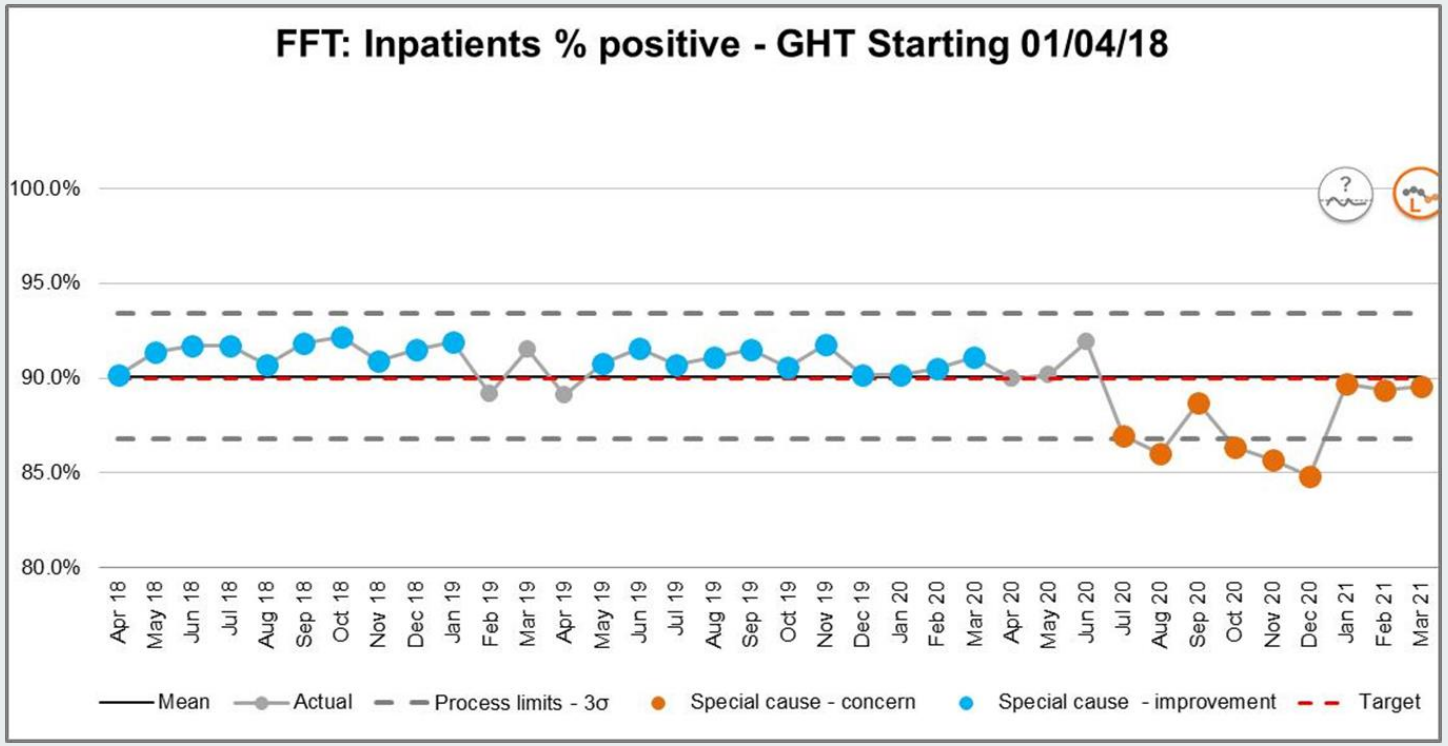
This dashboard shows the most recent performance of metrics in the Quality category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.




| MetricTopic | MetricNameAlias | Target & Assurance | Latest Performance & Variance | | |
|---|---|---|---|---|---|
| Mortality | Number of inpatient deaths | No target | Mar-21 | 129 | |
| Mortality | Number of deaths of patients with a learning disability | No target | Mar-21 | 0 | |
| MSA | Number of breaches of mixed sex accommodation | <=10 | Mar-21 | 1 | |
| Patient Safety Incidents | Number of patient safety alerts outstanding | Zero | Mar-21 | 0 | |
| Patient Safety Incidents | Number of falls per 1,000 bed days | <=6 | Mar-21 | 6.6 | |
| Patient Safety Incidents | Number of falls resulting in harm (moderate/severe) | <=3 | Mar-21 | 6 | |
| Patient Safety Incidents | Number of patient safety incidents – severe harm (major/death) | No target | Mar-21 | 10 | |
| Patient Safety Incidents | Medication error resulting in severe harm | No target | Mar-21 | 0 | |
| Patient Safety Incidents | Medication error resulting in moderate harm | No target | Mar-21 | 4 | |
| Patient Safety Incidents | Medication error resulting in low harm | No target | Mar-21 | 11 | |
| Patient Safety Incidents | Number of category 2 pressure ulcers acquired as in-patient | <=30 | Mar-21 | 29 | |
| Patient Safety Incidents | Number of category 3 pressure ulcers acquired as in-patient | <=5 | Mar-21 | 1 | |
| Patient Safety Incidents | Number of category 4 pressure ulcers acquired as in-patient | Zero | Mar-21 | 0 | |
| Patient Safety Incidents | Number of unstagable pressure ulcers acquired as in-patient | <=3 | Mar-21 | 1 | |
| Patient Safety Incidents | Number of deep tissue injury pressure ulcers acquired as in-patient | <=5 | Mar-21 | 4 | |
| Sepsis Identification | Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis | >=90% | Dec-20 | 67% | |
| RIDDOR | Number of RIDDOR | SPC | Mar-21 | 4 | |
| Safety Thermometer | Safety thermometer – % of new harms | >96% | Mar-20 | 97.8% | |
| Serious Incidents | Number of never events reported | Zero | Mar-21 | 0 | |
| Serious Incidents | Number of serious incidents reported | No target | Mar-21 | 4 | |
| Serious Incidents | Serious incidents – 72 hour report completed within contract timescale | >90% | Mar-21 | 100.0% | |
| Serious Incidents | Percentage of serious incident investigations completed within contract timescale | >80% | Mar-21 | 100% | |

# Quality:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

In March, we reviewed all the FFT thresholds, to realign them with our performance over the last 12 months. In some cases this led to us decreasing the targets on specific surveys, to provide a greater sense of assurance around the trends, as previously the scores were only showing as red which didnt enable us to track any progress or deterioration in the reported experience.

Our inpatient FFT score in March is at 89.6%, which is rated Amber in the new thresholds, and has been stable for the last few months following a period of instability during Covid. The national reporting will resume shortly, and we will be able to see how this compares with peer organisations. Additionally, we are expecting the results of the National Adult Inpatient Survey soon, the results of which can be triangulated with the FFT feedback to support a Trustwide improvement plan for adult inpatient areas.

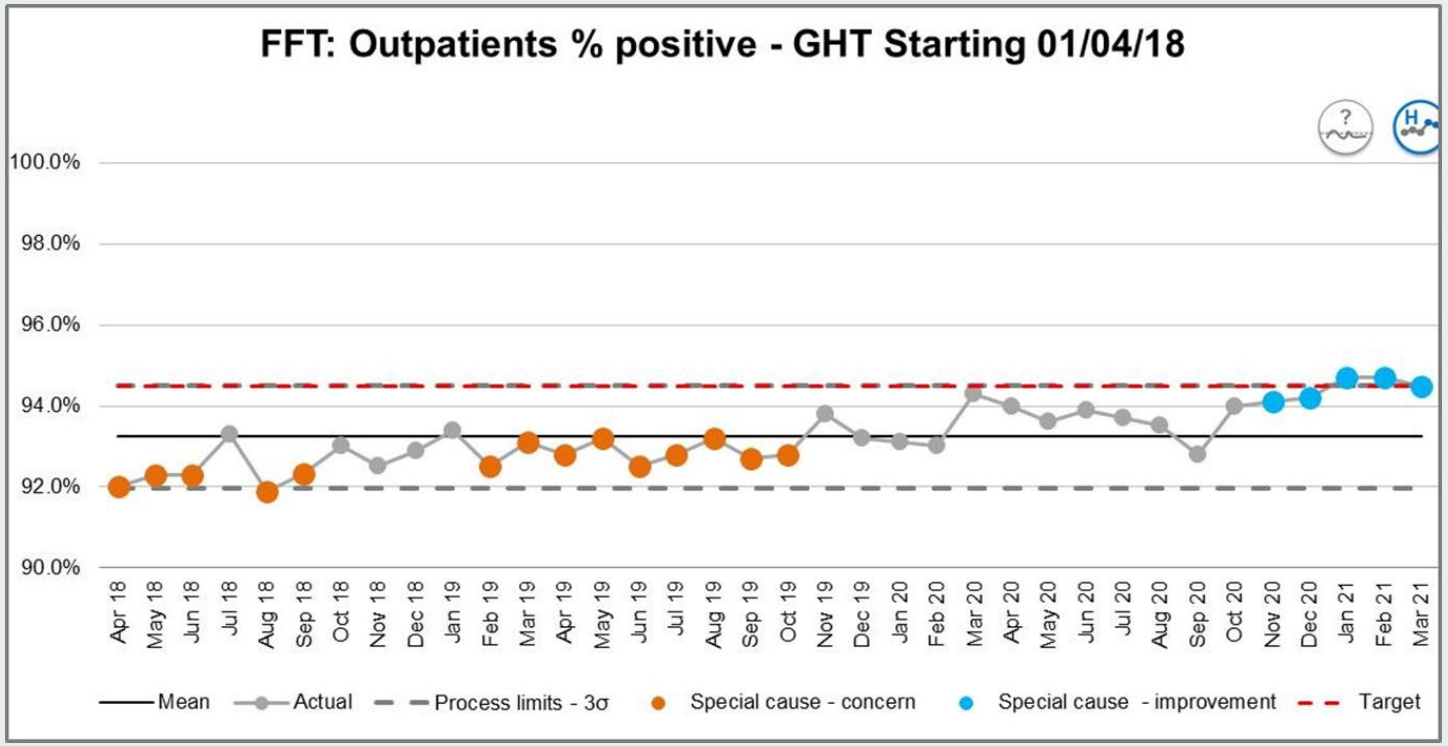
**- Head of Quality**

## Data Observations

| | |
|---|---|
| Single point | Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| 2 of 3 | When 2 out of 3 points lie near the LPL this is a warning that the process may be changing |

# Quality:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

In March, we reviewed all the FFT thresholds, to realign them with our performance over the last 12 months. In some cases this led to us decreasing the targets on specific surveys, to provide a greater sense of assurance around the trends, as previously the scores were only showing as red which didnt enable us to track any progress or deterioration in the reported experience.

Outpatients FFT has remained consistently positive throughout the Covid period, feedback which is reflected through the FFT feedback and also the feedback collated by the Attend Anywhere project team, with patients reporting a consistently positive experience.

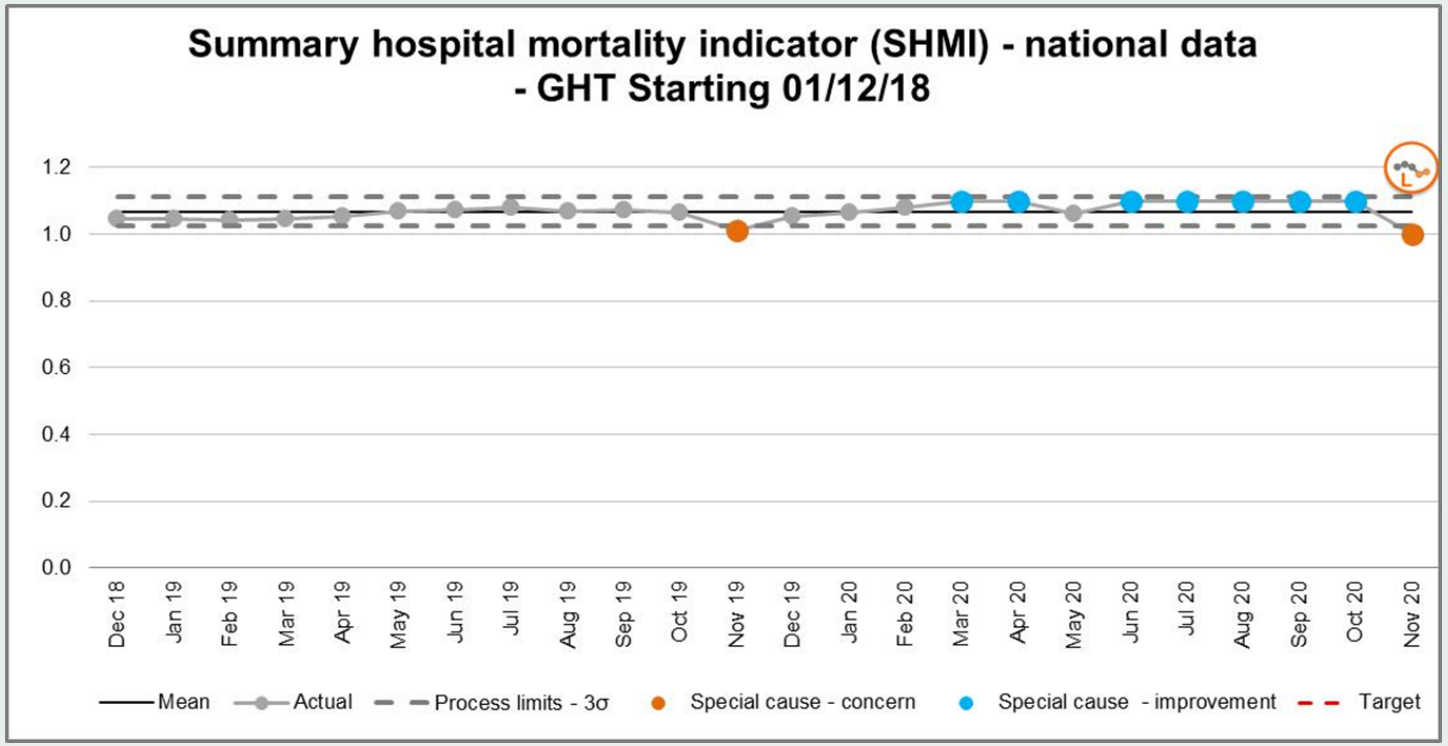
**- Head of Quality**

## Data Observations

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

# Quality:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

SHMI remains within expected levels.

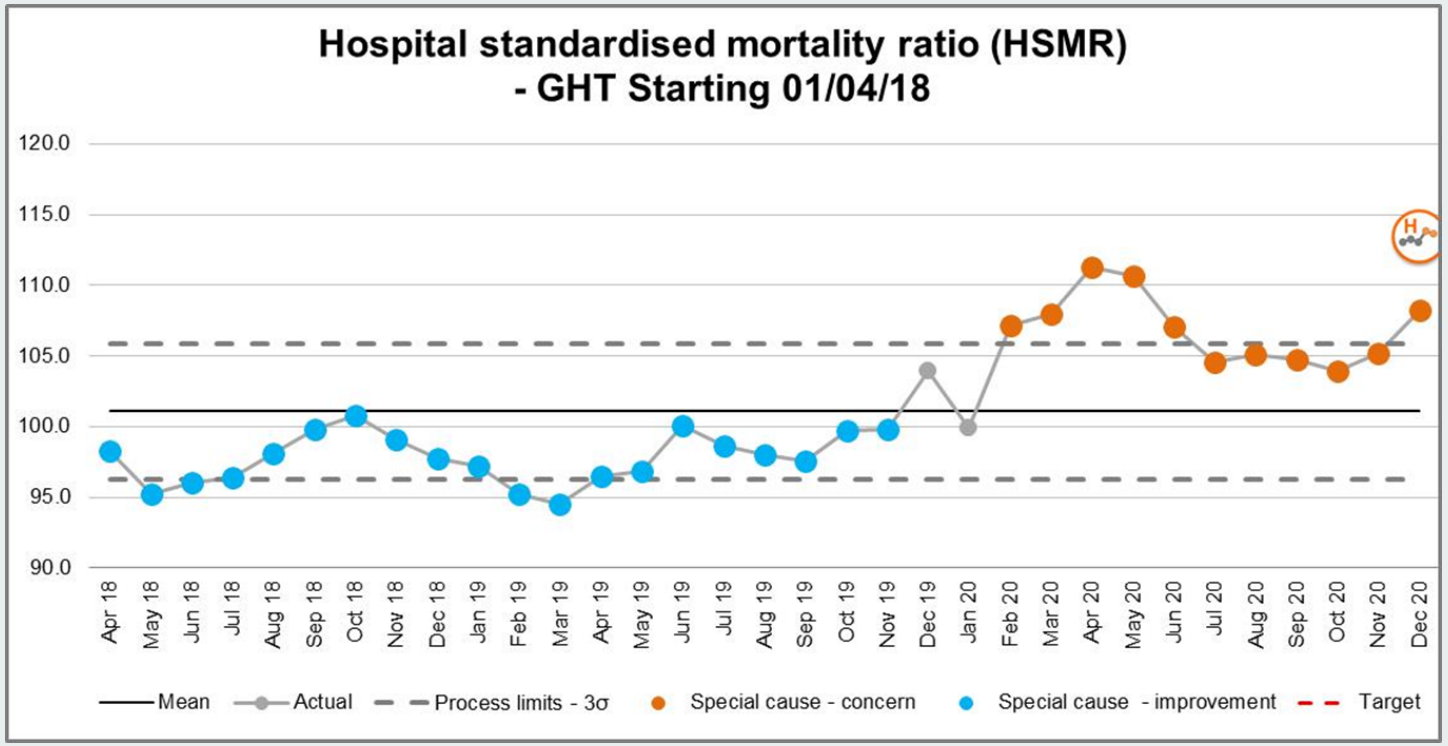
**- Medical Division Audit and M&M Lead**

## 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 2 data point(s) below the line |
| 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 |

# Quality:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

HSMR remains "higher than expected" due to COVID. When the COVID codes are removed, actual indicator falls to within expected range and Peer review shows we are in line with COVID Peers determined by Dr Foster.

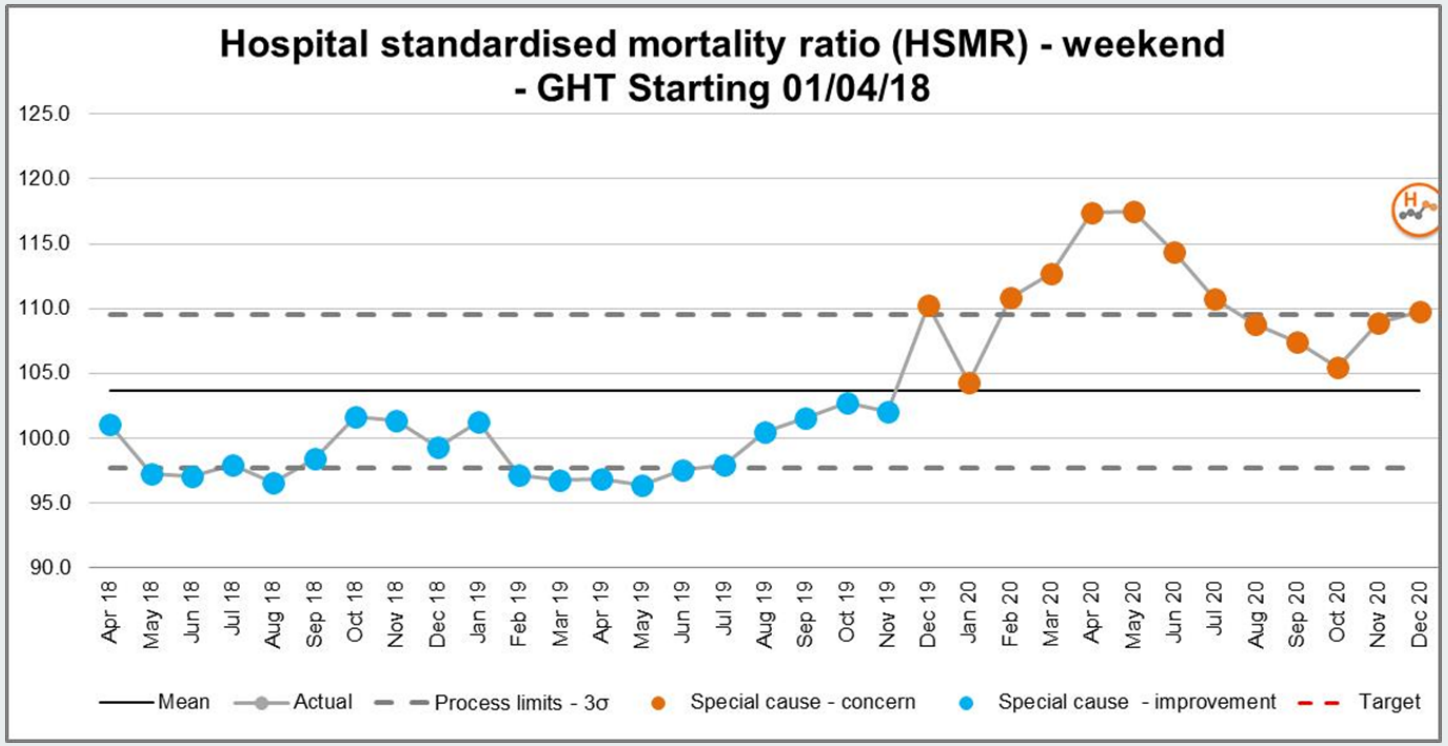
**- Medical Division Audit and M&M Lead**

## 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 6 data points which are above the line. There are 4 data point(s) below the line |
| Shift | When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean. |
| 2 of 3 | When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing |

# Quality:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

HSMR remains "higher than expected" due to COVID. When the COVID codes are removed, actual indicator falls to within expected range and Peer review shows we are in line with COVID Peers determined by Dr Foster.

**- 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 8 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. |
| 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 |

# Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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**

- Consistenly hit target
- Hit and miss target subject to random
- Consistenly fail target

**Variation**

- 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 |

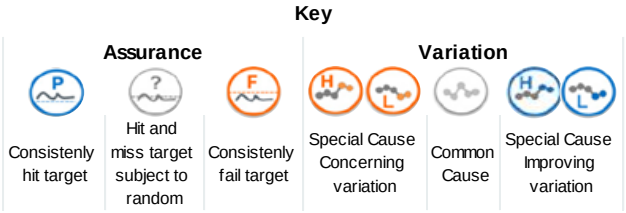


*Please note that the finance metrics have no data available due to COVID-19*

# People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

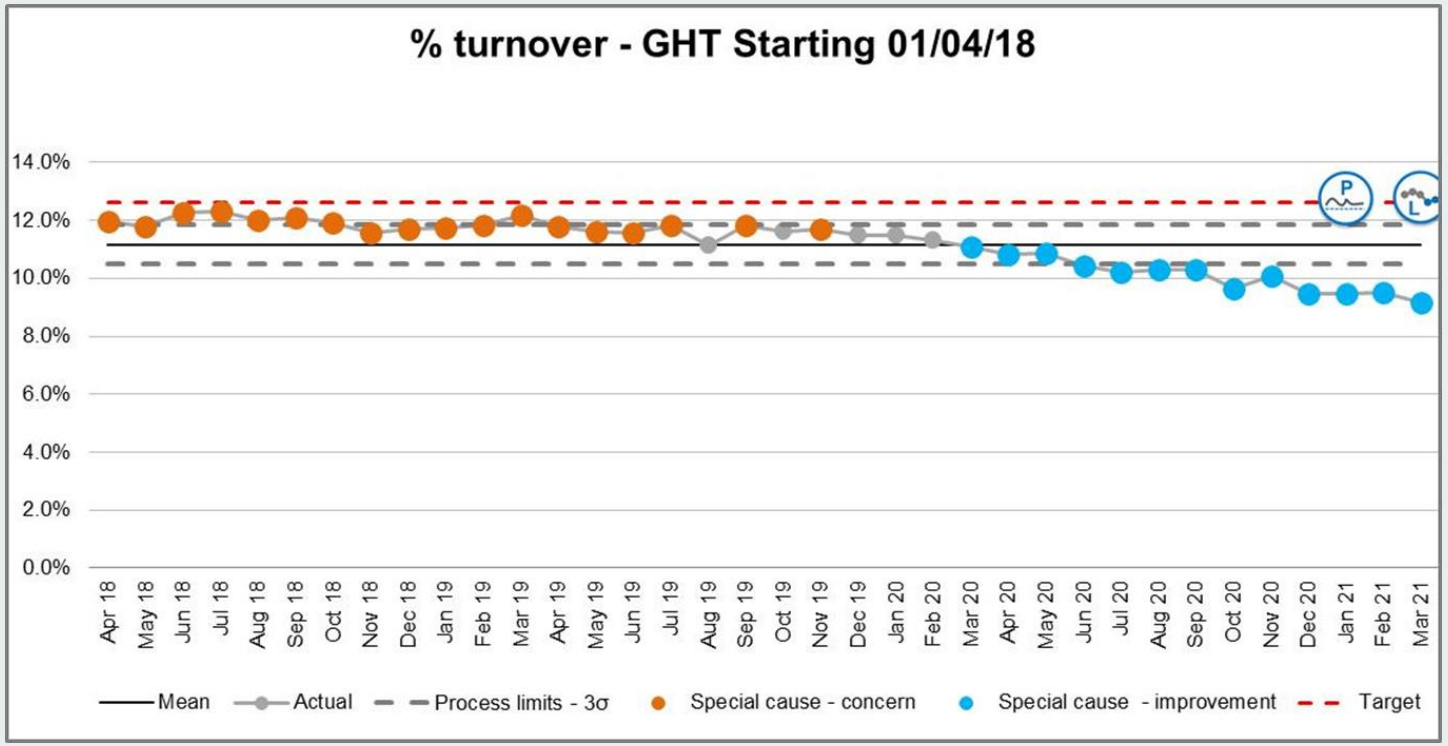
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.




| MetricTopic | MetricNameAlias | Target & Assurance | | Latest Performance & Variance | | |
|---|---|---|---|---|---|---|
| Appraisal and Mandatory | Trust total % overall appraisal completion | >=90% | F | Mar-21 | 83.0% | |
| Appraisal and Mandatory | Trust total % mandatory training compliance | >=90% | ? | Mar-21 | 90% | |
| Safe Nurse Staffing | Overall % of nursing shifts filled with substantive staff | >=75% | P | Mar-21 | 93.1% | |
| Safe Nurse Staffing | % registered nurse day | >=90% | ? | Mar-21 | 90.7% | L |
| Safe Nurse Staffing | % unregistered care staff day | >=90% | P | Mar-21 | 101.3% | |
| Safe Nurse Staffing | % registered nurse night | >=90% | ? | Mar-21 | 97.3% | |
| Safe Nurse Staffing | % unregistered care staff night | >=90% | P | Mar-21 | 108.9% | |
| Safe Nurse Staffing | Care hours per patient day RN | >=5 | | Mar-21 | 5.9 | |
| Safe Nurse Staffing | Care hours per patient day HCA | >=3 | ? | Mar-21 | 3.8 | H |
| Safe nurse staffing | Care hours per patient day total | >=8 | | Mar-21 | 9.7 | |
| Vacancy and WTE | Staff in post FTE | No target | | Mar-21 | 6653.99 | |
| Vacancy and WTE | Vacancy FTE | No target | | Mar-21 | 330.61 | L |
| Vacancy and WTE | Starters FTE | No target | | Mar-21 | 67.2 | |
| Vacancy and WTE | Leavers FTE | No target | | Mar-21 | 45.79 | |
| Vacancy and WTE | % total vacancy rate | <=11.5% | P | Mar-21 | 4.75% | L |
| Vacancy and WTE | % vacancy rate for doctors | <=5% | ? | Mar-21 | 0.73% | L |
| Vacancy and WTE | % vacancy rate for registered nurses | <=5% | F | Mar-21 | 7.92% | |
| Workforce Expenditure | % turnover | <=12.6% | P | Mar-21 | 9.2% | L |
| Workforce Expenditure | % turnover rate for nursing | <=12.6% | P | Mar-21 | 9.9% | L |
| Workforce Expenditure | % sickness rate | <=4.05% | P | Mar-21 | 3.6% | L |

# People & OD:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Trust rolling annual turnover continues to show a gradual decrease since 2019, placing our Trust in the top quartile of peers for workforce stability (model hospital).

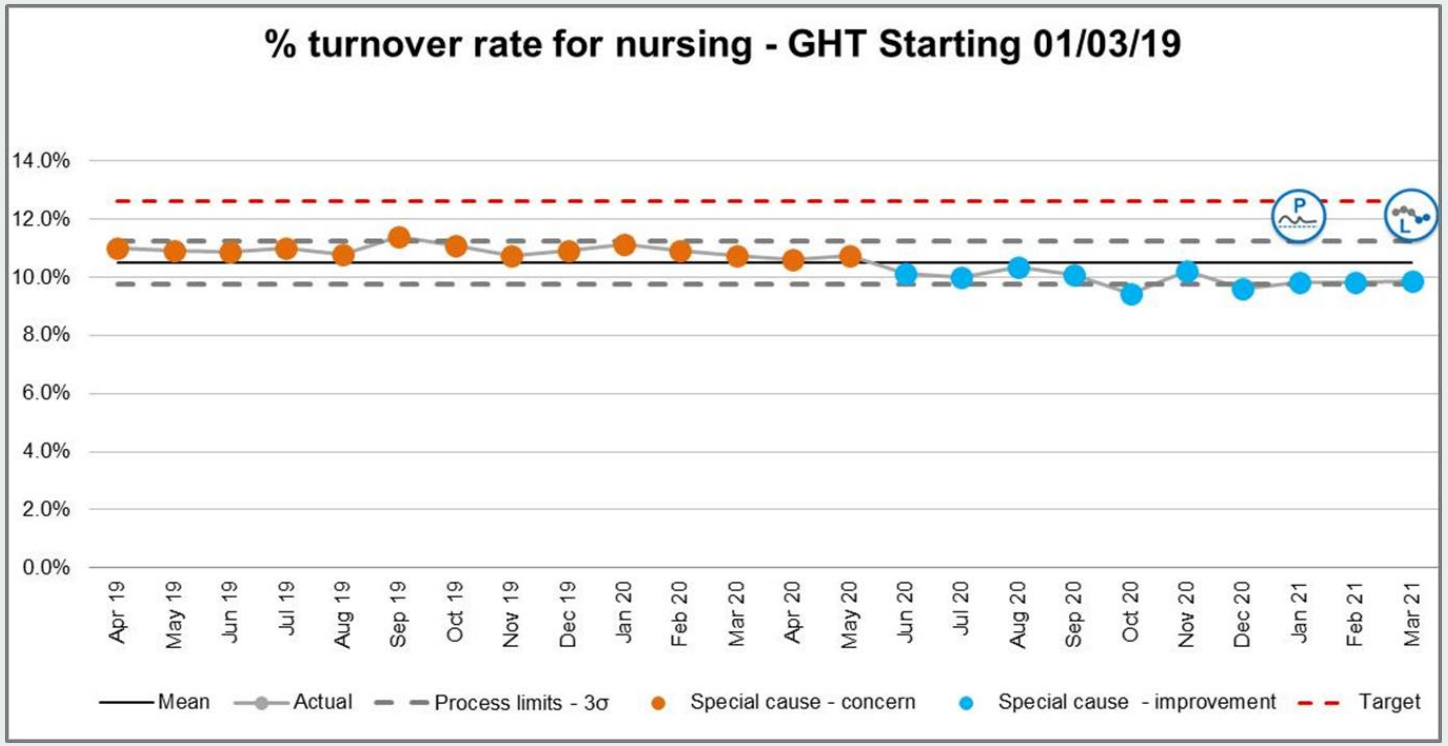
- **Director of Human Resources and Operational Development**

## 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 9 data points which are above the line. There are 10 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 |

# People & OD:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Trust rolling annual turnover continues to show a gradual decrease since 2019, placing our Trust in the top quartile of peers for workforce stability (model hospital).

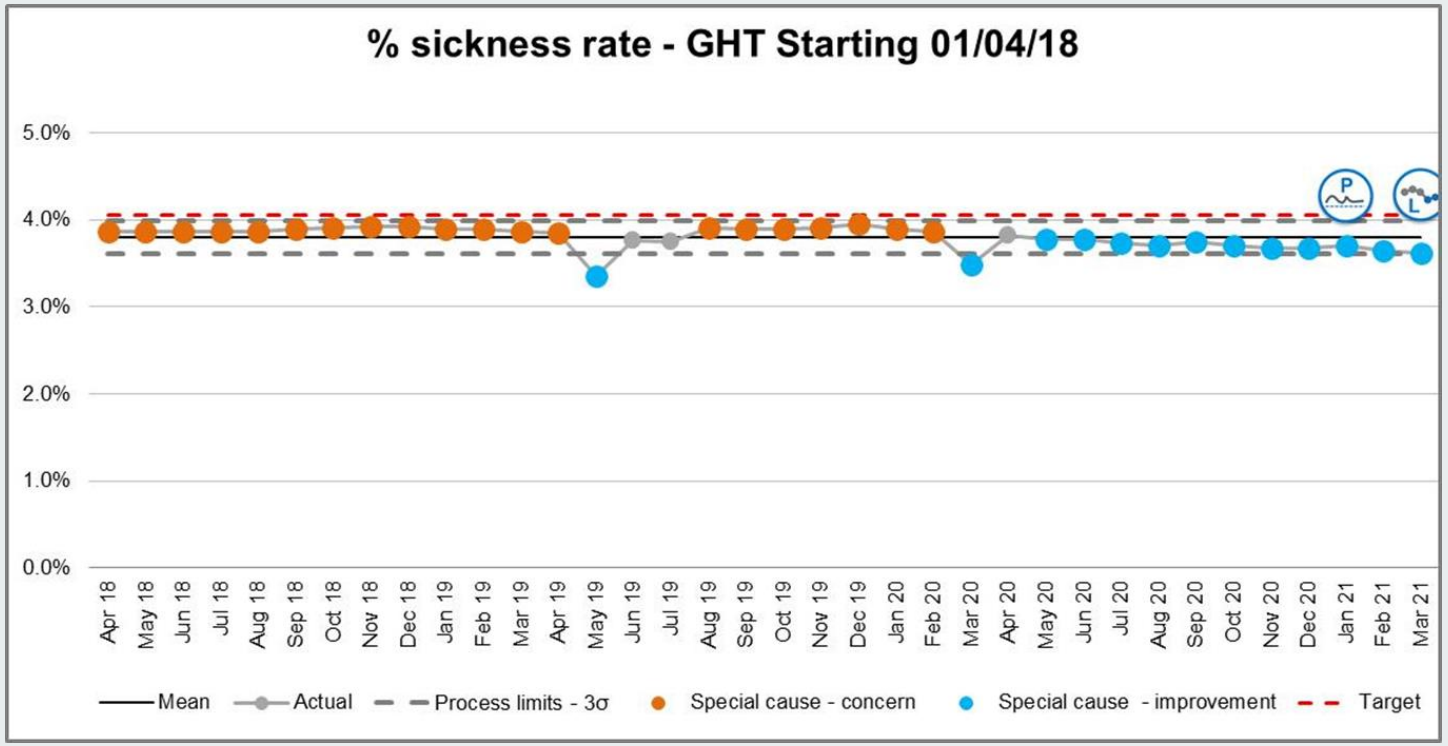
- **Director of Human Resources and Operational Development**

## Data Observations

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

# People & OD:
# SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust




## Commentary

Trust sickness absence remains low, however whilst other sickness absence has reduced, we recognise a continued trend in sickness absence related to Mental Health. In response to this anticipated trend, the People and OD teams have ensured there are a wide variety of health and wellbeing support mechanisms in place.

- **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 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 sigificant 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 |

Gloucestershire Hospitals
NHS Foundation Trust

**REPORT TO TRUST BOARD – MAY 2020**

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

This report describes the business conducted at the Quality and Performance Committee held on 28 April 2021, 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 |
|---|---|---|---|---|
| Review of Red rated Indicators | Update report on indicators which had been red rated for a period of time. ( previous report received un Sept 2020) All indicators have an executive owner and agreed delivery group. Four indicators require realignment of structured plan and improvement activities.<br>Sepsis and antibiotics within 1 hour, VTE risk assessment, patient discharge summaries to GP within 24 hours and outpatients to follow up ratios. Further indicators need review to ensure improved performance. | Where do the indicators feature which do not currently have a RAG rating? | Assurance given that these indicators will also be reviewed. | |
| | | New to follow up ratios is a surprise, what is the CQC lens? can the | Will confirm | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | | indicator be reviewed and amount of virtual appointments included | | |
| | | Is there a deadline for reviewing CQC domains? Can you make it automatic? | New software in due course will enable this, currently a manual application | |
| Medical Review Project | Annual report on progress against the 7 day medical standards following medical review audit carried out pre and during Covid. Two standards were not being met previously ( standard 2- time to first consultant review and standard 8 – ongoing patient review) | ? | Report and detail of audit welcomed and commended. | Agreed to update report to return to committee later in calendar year |
| | | What are the implications of being under a Consultant who no longer works for the Trust | Consultant allocation of patients key and linked to sunrise roll out. Progress has been made in last 12 months with more to do. | |
| | | Improvements seen with both standards during the Covid model in place, are they sustainable? | Re audit will be needed and reported into committee. | |
| Quarterly Executive Review | Summary of the quarterly Chief Executive led review meeting with clinical Divisions, underpinned by the approved Performance | As there had been a gap of the Chief Executive led reviews of 6 months due to Covid, were there any surprises or | Assurance given that the monthly executive review process had continued through the last 6 months, so sighted on the main | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | and Accountability Framework. Assurance also received of clinical divisional progress against the Trust objectives. All reviews noted to be successful with securing assurance on areas of concern, agreeing future priorities, addressing matters for escalation and any additional support needs. | anything unexpected? | issues. | |
| | | At P and OD Committee, some corporate divisional metrics seen to be worse than clinical divisions, but noted that not an equivalent process for corporate division in place | Process is in place but was deferred for practical reasons, will be recommencing now. | |
| Serious Incidents | Report updating on numbers of serious incident actions plans closed in month, new serious incidents identified (x5), New Maternity Healthcare Safety Investigation Branch – (HSIB) Investigation, nil Never Events reported in this period. | The 72 hour reports are helpful to see and comprehensively completed, what assurance do you have that the immediate actions identified to be taken, have in fact been taken? | In one case, national guidance circulated for staff with direct and multiple personal communications form the Medical Director | |
| | | Specific example, what insights and internal controls do you have | Regular audits noted to be in place but not enough in this situation, will be | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | | from the errors noted in one serious incident example? What had progress been from January to date? | reviewed. | |
| | Update received on progress against the wheelchair accident investigation and CQC formal interest. | | | Further briefings as required to committee and Trust Board |
| | | What happens if an assessment is missed in RIDDOR reporting and what is in place to ensure that doesn't happen again? | Links to ePR noted and reported that % of assessments undertaken and improved to 80% with work ongoing. | |
| Quality and Performance Report – Quality Delivery Group (QDG) | Review of the current QPR undertaken prior to new version in Autumn, will continue to evolve. Detail included on several areas including falls with links to risk assessment completed, importance of ratio of Registered /Nurses to Health care Assistants and ongoing recruitment campaign ( links to P and OD Committee agenda)<br>Data of young people who deliberate self-harm noted, with partnership work in | Using the falls lens, how well does QDG function and what balance between analysis, encouragement, support, direction and compliance? | Assurance given that the executive review process is to hold to account, the QDG works in the improvement space and felt to be a balanced approach | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | progress. | | | |
| | | With the maternity safeguarding concerns, was there confidence with the skills, workforce and overall support? | Stated that the maternity approach has been robust, flexing resource if additional demands noted. Continuity of Carer development is important to help in this area. | |
| | | In addition to maternity, the DOLs applications being lower reflecting a lack of appreciation from staff is a concern | Reported that the dedicated safeguarding team have resumed team visits in clinical areas to raise awareness and support. | |
| | Published CQC visit concerning Infection, Prevention and Control. Very positive report with several examples of outstanding practice, leadership and focus. Three areas of 'should dos' which will be incorporated into future quarterly reporting to committee. | | Substantial and heartening assurance of cultural approach, communications and practical application of best practice in matters of IPC.<br>Always relevant and especially so considering the last 14 months and ongoing pressures. | |
| Cancer Delivery Group | Reporting seven of eight cancer standards being met, eighth standard above national average. Continued management actions noted to improve and sustain | | Current performance commended, good assurance of operational knowledge of detail and individual patients progress through the | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | performance. | | system. | |
| Planned Care Delivery Group | Range of planned care metrics shared. Formal reporting of RTT and over 52 week waiting patients continue to be reported to NHSE/I, current position noted, comparable RTT performance, Over 52 weeks anticipated increase. National prioritisation processes being used.<br>Good performance in diagnostics of MRI and CT noted.<br>Terms of reference for new Restoration and Recovery Group shared. | How comfortable are you with the progress and speed on the communications front with patients? | Verbal update given that national, regional and local discussions continue and work internally progressing as planned. | Written update on communications to future committee. |
| | | Will reporting into committee change with the recovery plans prioritisation? | Question noted, prioritisation status included in report. | |
| Emergency Care Delivery Group | Care Quality Commission (CQC) unannounced visit to EDs on 30th March. No written report received yet, verbal feedback noted pressures, overcrowding with risks in meeting standards for ambulance handover, triage and use of escalation areas. | What if any impact is the 30 day system recovery plan having? | Evidence of strong and positive organisational response to the visit. 30 day plan in progress, some pathway and data improvements noted internally. Numbers of Patients who are medically stable for discharge is lower, but still remains | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | | | high and reliant on system working.<br>Reported that this 30 day plan should be followed by continuous 30 day system improvement plan cycles for best effect. | |
| | Verbal update following visit show improvements and significant changes across unscheduled care internally. | Noting the issues re violence and aggression on staff, are you confident with what is in place to support? | New governance structure noted to be in place and confidence this will help. | |
| Maternity Delivery Group | Exception report noting new governance and assurance arrangements to oversee improvements.<br>Leadership structure and some roles changed.<br>New maternity dashboard to May/June meeting. | Noting the previous development of a single action plan to ensure a coherent approach to improvement, what will Committee see to be assured of progress against the plan? | Quarterly reports to Committee. Strengthening of governance and leadership roles noted. | |
| Planning Guidance and Recovery of Services | Latest guidance, scenarios used and implications, current operational position. Scenario 2 the main focus of work. | How have you satisfied yourselves that the assumptions are credible in the divisions where needed to work? | Assurance that engagement and internal governance processes being used including Directors Operational Assurance Group, Restoration and Recovery Group, Trust Leadership Team, before sign off at Finance and Digital Committee. Joint working with partners noted and | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / Gaps in Controls or Assurance |
|---|---|---|---|---|
| | | | dynamic. | |
| | | Where is it weakest and how would the scenarios be stress tested? | Early assumptions on primary care and community demand, targets being developed. Assurance that stress testing an important feature of the plans, noting a number of unknowns | |
| | | If the most at risk groups are to be seen first, how is this being progressed? | Internally, patients reviewed by clinicians, ICS issue with unknown patients and drop off of referrals, noted that Public Health colleagues are working on this, remains an outstanding issue. | |

**Alison Moon**
**Chair of Quality and Performance Committee**
**28th April 2021**

Gloucestershire Hospitals
NHS Foundation Trust

# MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 17 FEBRUARY 2021 AT 14:30

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

| **PRESENT:** | | |
|---|---|---|
| Alan Thomas | AT | Public Governor, Cheltenham (Lead) |
| Matt Babbage | MB | Appointed Governor, Gloucestershire County Council |
| Liz Berragan | LB | Public Governor, Gloucester |
| Hilary Bowen | HB | Public Governor, Forest of Dean |
| Geoff Cave | GCa | Public Governor, Tewkesbury |
| Carolyne Claydon | CC | Staff Governor, Other and Non-Clinical |
| Debbie Cleaveley | DC | Public Governor, Stroud |
| Graham Coughlin | GCo | Public Governor, Gloucester |
| Anne Davies | AD | Public Governor, Cotswold |
| Pat Eagle | PE | Public Governor, Stroud |
| Colin Greaves | CG | Appointed Governor, Clinical Commissioning Group (CCG) |
| Pat Le Rolland | PLR | Appointed Governor, Age UK Gloucestershire |
| Sarah Mather | SM | Staff Governor, Nursing and Midwifery *(from 006/21)* |
| Russell Peek | RP | Staff Governor, Medical and Dental |
| Maggie Powell | MPo | Appointed Governor, Healthwatch |
| Julia Preston | JP | Staff Governor, Nursing and Midwifery |
| Nick Price | NP | Public Governor, Out of County |
| **IN ATTENDANCE:** | | |
| Peter Lachecki | PL | Trust 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 |
| Marie-Annick Gournet | MAG | Associate Non-Executive Director |
| Balvinder Heran | BH | Non-Executive Director |
| Natashia Judge | NJ | Corporate Governance Manager (Minutes) |
| Alison Moon | AM | Non-Executive Director |
| Mike Napier | MN | Non-Executive Director |
| Katie Parker-Roberts | KPR | Head of Quality |
| Rebecca Pritchard | RP | Associate Non-Executive Director |
| Elaine Warwicker | EWa | Non-Executive Director |
| **MEMBERS OF THE PUBLIC/PRESS/STAFF** | | |
| There were no members of the public present. | | |
| **APOLOGIES:** | | |
| Kate Atkinson | KA | Public Governor, Cotswold |
| Tim Callaghan | TC | Public Governor, Cheltenham |
| Fiona Marfleet | FM | Staff Governor, Allied Health Professional |

**ACTION**

## 001/21 DECLARATIONS OF INTEREST

There were none.

## 002/21 MINUTES FROM THE PREVIOUS MEETING

**RESOLVED:** Minutes APPROVED as an accurate record.

**ACTION**

**003/21 MATTERS ARISING**

**RESOLVED:** The Committee APPROVED the closed items.

**004/21 CHAIR'S UPDATE**

The Chair reminded the Council that virtual meetings would continue until at least the end of March, reflecting that this had not held the Trust back and that all participants had embraced the digital opportunities over the last few months, with more participants than had been achieved when meetings had been face to face. The Chair also explained that Non-Executive Directors would continue to work from home, despite longing to be on site, as it was the right thing to do.

The recent government white paper regarding NHS integration and innovation was noted, with the Chair anticipating change ahead. The April Council of Governors meeting would include a significant agenda item to discuss. **NJ**

**RESOLVED:** The Council NOTED the update.

**005/21 REPORT OF THE CHIEF EXECUTIVE OFFICER**

DL presented her report to the Council and provided a contemporary update on:

- COVID-19: current inpatient levels, the reduction in community transmission and the extension of the shielding deadline
- The ongoing success of the Trust's COVID-19 vaccination programme and high vaccine uptake rates
- The increased focus on improving care and experiences for patients with mental health conditions
- The recent successful bid for £20k to take forward a partnership arts programme
- The Trust's recent award of Digital Aspirant Status and related funding
- The finalisation of the Strategic Site Business Case and submission to NHS England/ Improvement
- The Hospital Charity's new project, the Green Spaces Appeal, to build a garden of commemoration for those who had died from COVID-19

PLR asked whether the additional care home designated by Gloucestershire County Council was a physical or virtual care home. DL explained that it was physical, with 15 beds, and was based in Cheltenham.

PLR also noted the recent announcement of an internal critical incident, despite a reduction in COVID-19 positive patients. DL explained that this was due to an increase in non COVID-19 patients, as well as the pressure imported on the organisation due to the reduced bed base required to ensure wards were COVID-19 secure. In addition, the high number of medically stable for discharge patients (120) was compounding the situation.

**RESOLVED:** The Council NOTED the CEO's report.

## 006/21 QUALITY ACCOUNT PRIORITIES

KPR gave a presentation to the Council which explained:

- What the Quality Account was, including the annual statutory requirement to produce
- The delays and changes to Quality Account submission due to COVID-19
- The Governors' Indicator and the usual process of establishing, noting that this did not occur in 2019/20 and there was no mandate to undertake this in 2020/21
- Quality and Delivery Group's (QDG) proposed Quality Indicators for 2020/21, with governors asked for their thoughts on what they felt the QDG should prioritise

DL reminded governors of the importance of distinguishing between the governor indicator, which served to review quality of data, and areas of interest for QDG's indicators, due to potential concerns regarding quality of service.

The Chair said that he understood that there may be some audit time to undertake review of the data quality of a governor indicator, even though it was not mandated. AT added that this was discussed at the Governor pre-meeting, and two areas of interest were identified by the governors that attended: these were maternity services and Patient Advice and Liaison Team (PALS) data.

The Chair asked whether there was a firm commitment from the Audit and Assurance Committee regarding the governors' indicator and CF answered that while not included in the guidance, there was an appetite if the Council wanted to take forward. AT expressed that governors would appreciate this, as a reminder of normal governor obligations, but was conscious of capacity. DL explained that PALS was data rich but subjective with no national data set, and therefore suggested a maternity indicator may be more helpful. This would be discussed with KPR and AT outside of the meeting. **KPR / AT**

The Committee supported the priorities for the Quality Delivery Group but also suggested additional areas:

- GC posed missed diagnosis and delays to cancer treatment
- DC raised the impact of repeated bed moves on patient quality of care.
- AT echoed this, in particular for patients with dementia with greater falls risks

**RESOLVED:** The Council NOTED the presentation for information and confirmed that they would like to select one data quality indicator.

## 007/21 CHAIRS' REPORTS

The Chair encouraged Committee observers to contribute to the Chair's

reports should they wish and reminded the Council that comprehensive reports, for each area, were available within the Trust's public Board papers.

Finance and Digital Committee

RG presented the Chair's report from the January 2021 meeting, highlighting that due to operational pressures the Committee had a reduced agenda. The finance section of the meeting was noted to have focused on analysis of the Trust's current financial position, approval of additional capital and the Trust's ability to spend allocations, review of the admin and governance behind the Public Sector Decarbonisation Scheme and budget setting within the current climate. The digital section of the Committee was noted to have focused on the extension of the electronic patient record (EPR) into additional areas, the progress of other projects via a Red Amber Green (RAG) status report, and the wellbeing and robustness of the busy digital team.

AT asked where decisions were made regarding capital programme prioritisation and it was confirmed that these were made at the Infrastructure Delivery Group (IDG), which was a forum for operational and senior leaders to discuss scheme priority. The group was noted to be accountable to the Trust Leadership Team.

Estates and Facilities Committee

MN presented the Chair's report from the January 2021 meeting. As with the Finance and Digital Committee, the meeting had operated on a reduced agenda. Key topics highlighted at the Committee included the resilience of staff and access to 2020 Hub and other support services, Gloucestershire Managed Services (GMS) performance against key performance measures (KPIs) and the approval of Trust's strategic site development (SSD) programme business case.

People and Organisational Development Committee

BH presented the Chair's report from the December 2020 meeting. Key topics highlighted at the Committee included improving retention, increased funding to improve nursing establishments, appraisal performance, development and wellbeing, the effectiveness of virtual face to face training, positive agency/bank staff trends and corporate HR capacity.

AT felt the health and wellbeing reporting suggested issues with staff connecting with psychological link workers and asked whether this was due to support only being available within office hours. BH responded that psychological link worker resource was for two days a week and issues related to this resource being quite limited as well as finding time for staff to be released from duties. As a result, national charity funding was being sought to enable greater resource. DL added that the Trust was moving to a new model using TRiM (Trauma Risk Management) Practitioners which, with 40 trained practitioners, would have a much greater reach.

AT expressed discomfort at the comment that red progress against the People and OD Strategy was not on a risk register as the team did not wish to publically highlight. BH explained that the nuance of the

conversation had been difficult to capture and PL said that the team did not want to highlight this issue for their area only, as it was a broader issue. DL added that this had been debated at length and had referred to the suggestion of a distinct risk related to the Executive Team (ET); The ET felt that the aggregate risk was sufficient and did not want to single themselves out given there were other staff groups who had been impacted more significantly.

PLR asked whether the Committee were assured that they were receiving sufficient information on the Freedom to Speak Up (FTSU) processes and whether this was working effectively. BH answered that they were, and that FTSU was working well and improving on an ongoing basis. It was agreed that it would be helpful to discuss at a future governor meeting. GC asked whether there were any emerging themes that governors should be aware of and DL answered that themes were triangulated through other routes, such as the staff experience report, and related largely to poor team culture and concerns around patient care. **NJ**

MB noted that there were issues with recruitment and retention with the emergency departments (ED) and asked what was being done to address. BH answered that this was part of a wider piece of work being undertaken in the medical division. DL answered that this was a historic issue and added that vacancies within the ED nursing team had actually reduced, with close to full recruitment on both sites and new staff now employed to the service as a whole (as opposed to under a specific site). Middle grade medical staffing remained an issue locally and nationally.

Quality and Performance Committee
AM presented the Chair's report from the January 2021 meeting. Key topics highlighted at the Committee included the current challenges within the organisation and the use of escalation areas; increasing waiting lists and clinical prioritisation processes; and the recently published Ockendon report and the Trust's own maternity services.

Audit and Assurance Committee
CF presented the Chair's report from the reduced agenda January 2021 meeting. Key topics highlighted at the Committee included the quality of risk management arrangements, external auditors (Deloitte) progress and transmission plans, a letter from the Trust's former external auditors detailing that they had ceased to hold office, and an internal audit report regarding violence and aggression towards staff.

**RESOLVED**: The Council NOTED the assurance reports from the Committee Chairs.

**008/21 GOVERNOR'S LOG**

The Governors' Log and the process behind it were noted, with further guidance and standard operating procedure noted to be available within the Governor Handbook. NJ highlighted that the only outstanding query had since been resolved and that the response would be available on Admin Control and within the next Council of Governors' meeting public

| | | ACTION |
|---|---|---|
| | papers. | |
| | AD reinforced the importance of her question related to support for staff who were hard of hearing and felt recently introduced badges could be considered demeaning. She also encouraged the Trust to consider greater use of loop systems as part of Fit for the Future. DL clarified that the Trust was adopting badges that were nationally advocated and clarified some confusion regarding badges for children with cochlear implants which were the Teddy Bear ones that AD referred to. DL would relay the comments regarding loop systems to the Strategic Site Development Team. | **DL** |
| | GC noted that the number of individuals who had received Mental Health First Aid Training was very low. DL explained that nurse training was orientated towards the care of a "whole" person with enhanced training on communication skills but noted the Director of Quality and Chief Nurse would be taking the topic further as part of the Trust's Mental Health Strategy. In addition, AD also clarified the origins of her query related to mental health training. | |
| | JP said that she felt the response she received to a query she submitted did not answer her questions. DL said that the initial question had been answered but that she considered the supplementary questions to be of a level of detail not applicable to the Log. The joint Director of Quality and Chief Nurse (DQCN) would be reminded to liaise directly with JP as advised previously. | |
| | **RESOLVED:** The Council NOTED the Governor's Log. | |
| **009/21** | **ANY OTHER BUSINESS** | |
| | There were no items of any other business. | |
| | **DATE AND TIME OF THE NEXT MEETING** | |
| | The next meeting of the Council of Governors will take place at 14:30 on Wednesday 21 April 2021. | |

Signed as a true and accurate record:

**Chair**
**21 April 2021**