Gloucestershire Hospitals
NHS Foundation Trust

AGENDA

Meeting: **Public Trust Board meeting**

Date/Time: Thursday 10 June 2021 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies (EW, MN, RG, RdC, MH)	Chair		12:30	
1.	Declarations of interest	Chair			
2	Patient story	Katie Parker-Roberts	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	Deborah Lee	Approval	13:15	YES
7.	Compassionate culture follow up: setting an Ambition.	Deborah Lee	Approval	13:25	YES
	AUDIT AND ASSURANCE				
8.	Board Assurance Framework (BAF)	Sim Foreman	Approval	13:35	YES
9.	Modern Slavery Statement	Sim Foreman	Approval		YES
10.	Application of the Trust Seal report	Sim Foreman	Assurance		YES
11.	Assurance Report of the Chair of the Audit and Assurance Committee	Claire Feehily	Assurance	13:45	YES
	ESTATES AND FACILITIES				
12.	Assurance Report of the Chair of the Estates and Facilities Committee	Elaine Warwicker	Assurance	13:55	YES
	BREAK			14:05	

	QUALITY AND PERFORMANCE				
13.	Quality and Performance report	Steve Hams / Felicity Taylor-Drewe / Mark Pietroni	Assurance	14:15	YES
14.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	14:25	YES
	FINANCE AND DIGITAL				
15.	Finance report	Karen Johnson	Assurance	14:35	YES
16.	Capital Report	Karen Johnson	Assurance		YES
17.	Digital report	Mark Hutchinson	Assurance	14:50	YES
18.	Assurance report of the Chair of the Finance and Digital Committee	Balvinder Heran	Assurance	15:00	YES
	ADDITIONAL ITEMS				
19.	Learning from patient stories	Steve Hams / KPR	Assurance	15:10	YES
	STANDING ITEMS				
20.	Governor questions and comments	Chair		15:20	
21.	New risks identified	Chair			
22.	Any other business	Chair			
CLOSE				15:30	

Date of the next meeting: Thursday 08 July 2021 at 12:30

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

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

Board Members	
Peter Lachecki, Chair	

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

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MICROSOFT TEAMS THURSDAY 13 MAY 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
Mark Hutchinson	MH	Chief Digital and Information Officer
Marie-Annick Gournet	MAG	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	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
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
IN ATTENDANCE:		
James Brown	JB	Director of Engagement, Involvement & Communications
Sim Foreman	SF	Trust Secretary
Jamie Inch	JI	Phlebotomy (staff story)
Kimberley Legge	KL	Nurse - Ward 2B (staff story)
Tom Mitchell	TM	Emergency Department Consultant (staff story)
Rebecca Pritchard	RP	Associate Non-Executive Director
Roy Shubhabrata	RS	Associate Non-Executive Director
APOLOGIES:		
None		
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were four Governors, two members of the public and six members of staff present.		

ACTION

076/21 DECLARATIONS OF INTEREST

There were none.

077/21 STAFF STORY

MH introduced KL, TM and JI and invited them to share their experiences of the difference that the digital work within the Trust, in particular the Electronic Patient Record (EPR), had made to them, their teams and the patients they care for.

The Board heard that Ward 2B was the first area to go live with EPR and KL advised that before this, nursing staff spent a lot of time chasing up

departments and people for notes and other paperwork; she said that she was amazed at how far things had progressed with clear processes and fast, easy access to records. KL shared that her vision for the future was that all paperwork would be electronic.

JI advised the main differences in phlebotomy were increased accuracy of samples, eradication of hand written labels and increased ability to locate patients more quickly and feedback problems easily. Each aspect had positively impacted department productivity. The Board heard that the department had been excited about the new process but there was degree of hesitancy about IT literacy and competence. This was eased by the work the EPR team had undertaken and the ability that staff had to have a say in the development of the system. JI's personal favourite change was the ability to audit patient numbers at the click of a button: a task that would have previously been manual and taken a considerable amount of time.

TM introduced himself and advised he worked across both Emergency Departments (ED) as a Consultant and was the ED lead for EPR. TM explained that whereas colleagues had struggled to write up discharge summaries, EPR had changed this and made things easier through scanning everything back into the system. TM recognised that it had taken a long time to develop a flexible and efficient system but the benefits of this were now being seen. As noted by JI, TM explained there had been reluctance and trepidation about the new system as many staff felt scarred from the previous experience of implementation of TrakCare. However, like phlebotomy colleagues, they were pleased at how smoothly things were working and that the approach and support was unrecognisable from the prior go-live. TM recognised that with such a change, there would always be an element of some refusing to adopt the technology, or simply preferring what they had before, but the ability to provide every patient with a copy of their discharge summary and to mitigate patients dropping out of pathways was transformational in changing perceptions. TM also reflected on the benefits of being able to configure the system ourselves and what a huge difference this had made in respect of a system that met the needs of the teams but also in securing engagement from clinical colleagues.

RG explained his role as chair of the Finance and Digital Committee (FDC) and the immense assurance their stories of front line experience of EPR, had provided him with.

MN endorsed this and referenced that all three presenters had mentioned a lack of IT skills or literacy as a potential barrier, asking to what extend this was down to inability or lack of experience. JI felt that within phlebotomy it was a matter of confidence and within 6 to 12 months this would be overcome.

CF recalled the previous system implementation described by TM and commended MH for the different style applied to project leadership – listening and switching as required. CF asked MH for his sense of confidence that the team could protect the short term gains and meet the longer term needs of the Trust. MH recognised the risk of being overtaken by desire and stressed the need to be realistic on priorities i.e.

the Trust might have received 140 requests for changes to the system, but only 38 could be delivered and so prioritisation was key to success.

AM thanked the presenters and welcomed the difference to outcomes, experience and safety of patients that were being made. AM continued that the Quality and Performance Committee (QPC) discussed discharge summaries regularly and asked what benefits were being seen and what feedback had been received from primary care partners. TM replied there were fewer query emails and that previously letters were not even sent on the day, with some sent a week to a month after the patient had been discharged. These were now sent electronically immediately, with patients provided with their own copy which was a huge improvement to both safety and communication.

RdC asked TM how his team had reflected on the implementation of EPR at Cheltenham General Hospital (CGH) and whether there had been any learning ahead of the rollout at Gloucestershire Royal Hospital (GRH). TM said that he had been unexpectedly surprised by the positivity and advised that the ability to rotate staff between sites would mean the GRH rollout would benefit from this approach. The challenge would arise from colleagues and specialists from other areas coming into the department and using the system but plans to support non-regular users were in hand.

BH was pleased to hear and see the enthusiasm from staff as well as the impact and benefits from the system and hoped that the Trust would exploit the funding opportunities for NHS digital benefits that had been mentioned in the Queen's speech (in order to further accelerate the work).

The Chair asked KL what she had learned was the best way to "support compliance inwards" when implementing the system. KL felt senior EPR link nurses being able to monitor compliance and identify improvements to delegate tasks was the key to success.

The Chair thanked MH and all presenters for their time and great stories.

078/21 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meeting held on Thursday 08 April 2021.

079/21 MATTERS ARISING

In relation to 057/21A DL advised that funding had been secured for a 18 month fixed-term post to ensure there was clarity on the benefits in order to make a case for recurrent system funding. The role would be delivered through a partnership between the Trust and Gloucestershire Health and Care NHS Foundation Trust (GHC) mental health service.

DL concluded saying that she felt this initiative had the potential to transform care for people who use drugs and present to A&E or end up being admitted to a ward.

RESOLVED: The Board APPROVED the CLOSED matters.

080/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL reported the next step out of lockdown on 17 May 2021 posed the biggest potential risk of increase in community transmission rates and whilst it was hoped this would not translate into hospitalisations (due to the vaccination programme) there was still a need for caution and adherence to other measures such as social distancing and mask wearing, due to the threat from emerging variants. On a positive note, DL was pleased that colleagues could meet in the Trust's restaurants in groups of up to six but signalled that they would not be open to the public until 21 June. Changes to visiting would positively mean that visitors could spend more time with patients each visit.

The number of Emergency Department (ED) patient attendances was noted to be high and of concern to DL and her team, given the impact of activity on waiting times and quality of care. She commended the department on the hugely positive improvements in eradicating corridor care, improving ambulance handover waiting times and improved time to triage and initial assessment. She noted however, her concern with respect to the four hour waiting time standard which was not improving at the rate other measures of quality were.

She described the narrative in the service having moved from one largely about system issues to one more reflective of internal issues and most notably medical staffing. She said that whilst the focus on the 30 day recovery plan would remain, work to look at what could be done to mitigate the impact and risks associated with staff shortages. She concluded by saying that the following day would see the announcement of the opening of ED and CGH in June.

DL explained that significant progress continued to be made in order to address the backlog of patients waiting for treatment but said that teams were seeking to go further, faster whilst remaining focussed on staff wellbeing and tempering any approach in respect of not impacting adversely on staff who were already fatigued.

Other highlights from the report included International Nurses Day and the importance of national awareness weeks for the end of life care and for mental health awareness. On the latter, the Trust had chosen a different theme to the national (outdoor spaces) to draw attention to the work of the ED Working Group and she thanked the governors for their focus on this important issue. DL highlighted Anne Davies, Public Governor for Cotswolds for her work to bring the voices of young people into the Trust.

AM expressed concerns about ED performance and noted the focus appeared to be on internal issues as opposed to previous emphasis on system actions. She asked if there were internal changes that could facilitate long term improvements. RdC acknowledged there were internal actions to be considered but some issues were outside of the Trust's control such as the highest number of ambulance transfers in

region and high activity levels (181% increase on last year). MP added there were multiple issues but felt there were still things the Trust could do, which albeit small, would make a difference.

DL asked if there was anything to explain the difference between day time and night time performance levels. MP explained that overnight staffing levels were lower than in the day but the surge of activity in the late afternoon/early evening impacted performance from 23:00 onwards. MP explained that the current consultant and middle grade vacancies alongside the Trust encouraging staff to take leave and tired staff being less likely to take on additional shifts, meant that there was reduced medical staffing overnight on a regular basis. RdC explained demand was exceeding supply and that some of the options available were not available out of hours but noted that three consultant appointments had recently been made.

The Chair followed up on AM's question to state some things were unpredictable but that others were; for example, it was known when peak attendance times were and he asked what else could be done to improve performance, and requested a more detailed discussion at QPC which RdC, MP and AM supported.

DL said the Executive team recognised the role of the NEDs in holding them to account and together with the Chair confirmed that there was a whole Board commitment to improving ED performance.

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

081/21 TRUST RISK REGISTER

EW presented the report and the Board heard there were NO new risks and two risks, related to cleaning standards, had reduced from 4 x 4 to 4 x 3. These had been discussed and reviewed at Estates and Facilities Committee (EFC), Infection Prevention and Control Committee (IPC) and the Risk Management Group (RMG).

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

082/21 DIGITAL REPORT

MH advised the Board that the earlier staff reflections were a great reminder of the digital project work to date but reminded the Board that there was still some huge challenges ahead. He advised that the EPR had been implemented in the Minor Injuries and Illness Unit (MIIU) at CGH and a new pharmacy stock control had launched on 7 April 2021. MH's team were continuing to progress projects ahead of a planned rest period over the summer months.

The Board heard that the NHSAI Skunkworks Project was a cross government initiative that the Trust were bidding to be a part of. This artificial intelligence would learn from risk factors resulting in patients staying over 21 days so that earlier interventions would hopefully reduce length of stay and improve overall care.

The doctors' handover notes digital solution had gone live the previous day with over 400 engagements on the first day. This would record the date of planned discharge and also build upon the patient's care record for the rest of the system.

The Chair asked when results were expected from the Skunkworks project and MH responded it was a 12 week project to test the concept and would begin once information governance requirements were all signed off. This was planned for the next day and work would start immediately.

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

083/21 FINANCE REPORT

KJ reported the pre-audit position was that the Trust had achieved a small surplus for 2020/21. The Month 10 (M10) position had been a £11.5m deficit which had been improved through additional non-recurrent national and regional funding.

She went on to say that the external auditors, Deloitte LLP, were carrying out the audit and had paid considerable attention to the VAT position with HMRC. The audit was expected to finish the following week.

KJ advised that the system revenue position had closed with £100k surplus with all organisations each having a small surplus.

KJ also reported that Trust colleagues had been able to spend and commit £16m of capital funding over a two week period and gave credit to the project leads and capital team who had all ensured the evidence was provided for accruals and overpayments. The capital position also closed with a small surplus due to technical adjustment meaning there was a slight underspend.

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

084/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

RG thanked KJ and her team for all their work to help the Trust deliver its control totals, particularly on capital. RG advised he had been concerned about the end of year spending but KJ's team had already reflected on future actions that would prevent future year-end surges and assured the Board that the Committee had given the matter detailed scrutiny.

The Committee had also considered overseas patients' charging procedures and received good assurance on the controls in place.

RG advised that the digital assurance had linked to the themes from the staff story and shown the multiplicity of projects that were underway and how some of these impacted on other systems. The Committee had been assured that MH and his team understood the position.

RG updated that a follow-up paper on cybersecurity threat had been requested by the Committee as this posed significant risk to the Trust and the Committee wanted to give it more attention than it had received previously.

The Chair invited KJ to provide an update on the latest 2021/22 planning position and the Board heard that the ICS had submitted a balanced plan for the first half of the year (H1) but there remained some uncertainty on the H2 position. The draft plan was submitted on 6 May 2021 with the final submission due in early June. This would be reviewed and approved at an extraordinary confidential board meeting. The performance, workforce and finance submission from the Trust would link with those of ICS partners. RG confirmed that there had been an extraordinary Finance and Digital Committee to review the draft submission with all NEDs invited to attend. The Committee were assured by the considerable detail provided.

KJ reminded the Board that the draft submission related to revenue as the capital plan had already been approved by the Board and submitted with the Trust hoping to receive feedback in June 2021.

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

085/21 PEOPLE AND ORGANISATIONAL DEVELOPMENT REPORT

EW presented the report which included additional details requested my MN at a previous meeting.

The operational/strategic dashboard showed most indicators were green and positively the Trust was reporting best in class performance for turnover, vacancy and stability rates amongst university hospital peers. However, EW advised that the Trust was struggling with appraisal compliance (particularly in the Corporate division) with targeted follow-ups to improve this. This reflected the preference for face to face appraisals which had reduced due to the degree of homeworking in corporate teams.

The staff survey results had been considered by the People and OD Committee and detailed data had been provided to divisions based on staff groups and demographics. The survey had seen a 22% increase in responses from those who reported themselves as from an ethnic minority background. The Trust results were below the targets set for all areas but the variance from best in class was between 0.5 – 0.8 points.

The number of staff recommending the Trust as a place to work had increased but the survey still highlighted bullying and harassment as a problem. EW provided details on measures to tackle this in the next year

which included the introduction of “Respectful Resolution” to redesign how complaints and issues were managed and to address poor behaviours. EW’s team would work with the Medicine Division to pilot this as they had been identified as one of the areas of greatest need.

The staff survey also identified issues related to violence and aggression. A new integrated group had been established that would look at how patients were managed and the staff response whilst developing measure of success. EW confirmed that Health and Safety objectives included indicators related to both Health and Wellbeing and Violence and Aggression.

EWa asked what respectful resolution would look like and how it would be delivered. EW summarised the approach which was about addressing concerns early on before they became escalated.

The Chair acknowledged it was good to look at comparators and peers but flagged that the Trust’s issues and context might be different and asked how this might be reflected. EW responded that conversations with colleagues in networks on the specific problems and issues were invaluable. EW added that the Board could be assured on the tools themselves as they had been developed nationally and were being rolled out across the NHS. The Trust also had the benefit of learning by not being one of the first to implement, instead being a fast follower.

RS commented that it was clear a lot of work had been invested into the staffing side as well as recruitment and asked about the risks of filling posts from staff outside the UK and if this was sustainable. The Board heard that international recruitment had continued throughout COVID-19 and the Trust was well-versed at this, connecting with international recruits and into local networks. EW felt the more pressing issue was ethical international recruitment and SH added that it is important to be able to recruit in a way that did not detrimentally effect the home country of the applicant i.e. recruitment of nursing staff from India had been stopped due to the crisis underway there. SH reminded the Board of success in other international recruitment exercises.

RP asked if there were any impediments to people getting involved in the respectful resolution work and measuring attendance. It was explained that the number of attendees at a workshop was recorded, individual names were not.

MN commended the report and thanked EW for the detail and assurance on the questions he had previously raised. He asked what EW had in mind for the “cultural barometer” in terms of metrics and monitoring frequency. EW advised this would look at greatest concerns across five themes with 15 areas under these to give a contemporary picture, The work would move away from the historic data sets to include different layers specific to the Trust so may take some time to develop.

MAG asked if there was a way to ensure voices were heard and reporting of bullying and harassment happened where individuals might not fit the prescribed definition. EW summarised the work underway to

support colleagues to feel safe to speak up.

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

086/21 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

AM presented the report as she had chaired the meeting on behalf of BH. It had been a full meeting with well-prepared papers on a themed approach. AM highlighted a number of key areas discussed.

It was noted that the Equality, Diversity and Inclusion (EDI) action plan would be presented as a full report to Board in July 2021.

The Committee had received an employee relations report and an update on cases which had shown a disproportionate number of Black, Asian and Minority Ethnic (BAME) colleagues going through disciplinary processes. This reflected the national picture and was of considerable concern.

A presentation on leadership in the Medical Division provided assurance that work was being embedded a divisional level.

There had also been discussion and recognition on the work of the 2020 Hub and Freedom To Speak Up (FTSU) guardians.

DL welcomed the focus on employee relations in support of the development of a compassionate culture and asked what assurance the Committee had received on the support provided to staff undergoing investigation. It was noted that each person going through the process had a normal link worker and a new group had been created to examine and consider if it was worth pursuing a case or whether this was disproportionate. Case length was noted to vary and most investigators were line managers supported by HR advisors. EW advised that everyone in the process would be contacted to check if they were okay and if not asked how her team could triage those needing support. EW continued that in addition, the Trust was still working on the Dido Harding serious harm recommendations. There was no guidance or assistance available to support this work therefore the Trust was using the Quality Improvement Academy to assess how the patient Never Event processes could be used. The 2020 Hub contacted everyone who was subject to investigation to ensure they knew how to access support.

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

087/21 GUARDIAN FOR SAFE WORKING QUARTERLY REPORT

MP presented the Guardian for Safe Working for junior doctors and dentists in training for the period January to March 2021. The Board heard that the current guardian, Dr Simon Pirie was stepping down from the role at the end of June and recruitment for a successor was underway. The Board formally noted thanks to Dr Pirie and commended the quality of the reports during his tenure, asking DL to confirm this in a letter. **DL**

There were 46 exceptions reports noted and no fines levied. Although three exception reports identified immediate safety concerns, following investigation by Dr Pirie it was confirmed there were none. MP advised the majority of the reports came from doctors working in the acute take and overall the situation was very good with the lack of exception reports suggesting that junior doctors were not being overworked.

RP observed that the system was reliant on junior doctors reporting and asked to what extent MP felt there was under or over reporting. MP acknowledged this was a fair concern and advised that rising numbers typically supported a positive and open reporting culture but that some junior doctors may feel under pressure not to report. There was ongoing focus to ensure they felt safe and supported to do so and from his conversations with SP and junior doctors he felt this was not an issue. The next report would see comparators against other Trusts.

BH left at 14:31.

It was reported that DL and CF, as executive and NED leads for Freedom to Speak Up were discussing how these reports could be shared with Board in a similar way to the Guardian report in the spirit of openness and transparency.

RESOLVED: The Board RECEIVED the contents of the report as assurance that the exception reporting process was robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly.

088/21 QUALITY AND PERFORMANCE REPORT

SH, MP and RdC presented the Quality and Performance Report (QPR).

SH advised that nosocomial transmissions of COVID-19 had fallen in line with community transmission levels but that there had been an increase in Clostridium Difficile cases over the last month in both hospitals and the community. It was believed this related to anti-microbial prescribing and cases were being reviewed.

SH also reported on an 18% reduction in falls thanks to risk assessments being completed for patients on admission. 82% of patients had risk assessments on admission and these were also being completed for those staying on.

MP highlighted that Hospital Standardised Mortality Rates (HSMR) were going down and were well within acceptable levels if mortality from

COVID19 was excluded. COVID-19 mortality rates were at the better end of the spectrum based on 12 month rolling average data set. The Board heard that all trusts had seen an increase in Dr Foster reported HSMR data due to COVID-19.

RdC highlighted continued good performance in relation to cancer and planned care as acknowledged in AM's chair's assurance report.

MN queried the removal of the indicator dials from the report and SH confirmed they had been removed as they were leading the Trust to the wrong conclusions. SH continued that a detailed review of the QPR was underway to remove the manual manipulation required to produce it. RG offered to act as sounding board for NEDs on this work if needed.

RESOLVED: The Board RECEIVED the report as assurance that the Executive team and Divisions fully understand the levels of non-delivery against performance standards and had action plans to improve this position.

089/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

AM presented the report and continuing from the previous item, advised there had been good discussion on the new QPR being introduced from September. AM added that the overall papers were high quality and that the Committee had covered the full agenda.

The Committee had looked at RED performance indicators and had requested a follow up report on those deemed most important.

There had been a presentation on the medical review project (also known as seven day services) from one of the Trust's Chief Registrars and progress against the two standards that had been historically shown as hard to meet; time to first consultant review and ongoing patient review.

The Committee had been greatly assured by the CQC report on Infection Prevention and Control.

It was noted that the quarterly divisional review process led by the CEO had reported to the Committee and there were no surprises or issues emerging from these.

A Maternity Delivery Group had been established to bring together multiple action plans with an update planned to the next meeting.

AM concluded her report by highlighting cancer standards achievements with seven of eight standards being delivered and felt that this should not go unnoticed.

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

090/21 COUNCIL OF GOVERNOR MINUTES

RESOLVED: The Board NOTED the minutes of the Council of Governors Meeting held on 17 February 2021.

091/21 GOVERNOR QUESTIONS AND COMMENTS

Alan Thomas (AT), Lead Governor and Public Governor for Cheltenham made three comments and asked three questions.

AT commented that the ED discussion was a great example of the NEDs holding the Executives to account, adding that governors also shared concerns on performance in this area.

He also supported the work to engage young voices in the Mental Health work championed by Anne Davies, Public Governor for Cotswolds and that "every patient matters" was at the forefront of the Trust's planned recovery work.

AT's questions related to the POD report. He asked how "Respectful Resolution" as part of the complaints process for bullying and harassment would identify informal issues and felt it was strange term to use. EW explained the title was from an overall package of components to resolve complaints and the Trust would be ensuring the language was adapted to its needs. The intention was to resolve concerns and issues more informally and faster.

AT advised that governors had attended a good Strategy and Engagement meeting which had alluded to a "cultural barometer" and asked how the Trust would define "fair weather" and if success would be determined by attaining this or measuring changes. EW explained the purpose of the barometer was to help managers understand how colleagues and employees felt and the aim was to achieve "best in class" performance amongst peers as measured by the staff survey indexes.

On violence and aggression, AT commented on targets reducing from 10% to 8% over three years and asked for these to be clarified. He felt any physical harm to staff was too much. EW confirmed the improvements and statistics came from research into levels of harm. EW also explained that the NHS was not recording centrally levels of Violence and Aggression and that the plan was for a falling trend of reported incidents of harm over the period.

092/21 NEW RISKS IDENTIFIED

There were none.

093/21 ANY OTHER BUSINESS

The Chair announced it would be RdC's last board meeting and expressed the thanks and gratitude of the Board to her. He stated that the Board had been delighted with RdC's credentials on appointment and not been disappointed with the NEDs in particular welcoming her clarity on assurance topics in her remit. The Chair also commended her

leadership throughout COVID-19 and stated she would be missed but wished her much success in her next role.

There were no 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 10 June 2021 via Microsoft Teams

[Meeting closed at 15:02]

Signed as a true and accurate record:

Chair
10 June 2021

Gloucestershire Hospitals
NHS Foundation Trust

Public Trust Board – Matters Arising – June 2021

Minute	Action	Owner	Target Date	Update	Status
MAY 2020					
087/21	**GUARDIAN FOR SAFE WORKING QUARTERLY REPORT**				
	Send letter of thanks to Dr Simon Pirie for his work as Guardian for Safe Working.	DL	June 2021	Letter sent.	**CLOSED**

PUBLIC BOARD – JUNE 2021
CHIEF EXECUTIVE OFFICER'S REPORT

1 Operational Context

1.1 Since my last report, we have taken another significant step out of lockdown with indoor gatherings and international travel now permitted. Whilst our local rates of community transmission remain low at just 7.7 per 100,000, the picture in a number of regions is much more concerning. Positively, there is good evidence that those who have had both of their vaccinations have significant protection against the prevailing Indian variant and we are making the most of this evidence in reinforcing the message locally regarding the importance of taking up the offer of vaccination.

1.2 Thankfully, COVID-19 cases in our hospitals remain minimal; however, all services have contingency plans in place in the event that we experience a third surge of COVID-19.

1.3 In Gloucestershire, we have now vaccinated 74% of the adult population with their first dose and second dose uptake remains high; a total of 627,986 vaccinations to date with 58,138 delivered by the hospital hub. 93% of those in the initial priority groups 1-9 have now had at least one vaccination. 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 a number of initiatives in hand to further improve uptake including an anonymous survey of all those who are unvaccinated with the aim of better understanding the reasons behind their decision.

1.4 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 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 and we continue in our endeavours to ensure that every patient's experience is a positive one. Despite the ongoing challenges, we have made very significant improvements with respect to ambulance handover delays and we have eliminated corridor care, alongside significant improvements in the timeliness of initial triage and medical assessment. The Trust has been commended by NHS Improvement (NHSI) for such significant improvements in these areas; however, significant challenges remain with respect to improved four hour waiting time performance. As always, the underlying causes of this poor performance are multifactorial but key issues include ongoing vacancies in medical and senior nurse staffing, access to beds in a timely way and high levels of demand. Positively, despite national shortages in accident and emergency physicians the Trust has just appointed three new consultants who will join us in the next few months; similarly, we have been fortunate in appointing an experienced Matron who will have responsibility for A&E services. 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. The high levels of activity, particularly in the minors service, reflects the pressure that primary care services are under who themselves are experiencing very high levels of demand; similarly, calls to ambulances are also up 41.5% on a year ago.

1.6 There are a number of work streams across the Integrated Care System (ICS) supporting system wide flow challenges. NHSI have flagged to us that we as an organisation that could improve our simple discharge; by ensuring that every patient's Expected Date of Discharge (EDD) is captured in real-time and updated every day. We are working to do this each day as part of doctors' handover so that multidisciplinary teams across the Trust can prioritise safe discharge as early as possible.

1.7 Working closely with clinical leads, we have launched additional functionality within Sunrise Electronic Patient Record (EPR) that will allow us to improve the quality of information collected and shared at ward handovers, and in so doing also meet national reporting requirements. Using a new doctor's handover document that is completed daily on EPR – as part of board and ward rounds - we can fully implement the Hospital Discharge Services (HDS) Policy and the recording of Medically Optimised For Discharge (MOFD) or 'Criteria to Reside'. Data for all wards and specialities is being monitored daily and reporting mechanisms are in place to continue to support adoption across the Trust.

1.8 The result of this work will be to encourage and support doctors in planning patient discharge from the point of admission. This will help patient flow across the hospital – as a consequence of which this initiative will also be supporting colleagues as they tackle the challenges facing them in Unscheduled care / ED.

1.9 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 at the 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 way in which the Trust communicates with the large number of patients waiting for care, many of whom have now waited more than a year for treatment, is a key focus and the Board's Quality and Performance Committee will be undertaking a "deep dive" into our approach at its June Committee. As ever, the Trust is trying to find the right balance of having enough to say about likely waiting times, for the communication to be useful and not provoke more anxiety or stimulate large amounts of contact that cannot then be effectively managed.

1.10 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 8.00am – 8.00pm and a nurse-led service overnight. The daytime service will be restored to its pre-pandemic state on 9 June 2021, including and the overnight Minor Injuries and Illness Unit will reopen on 30 June, in line with our commitments to restore the service ahead of 1 July.

Crucial to the success of these transfers is the transfer back of activity from GRH to CGH, given staff will move to support the safe resumption of services, the Trust will be working with system partners to ensure the public make full use of the services at Cheltenham including encouraging those who may previously have considered going to the walk –in service at GRH.

1.11 As signalled last month, the system submitted its draft Operational Plan on 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.

1.12 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. The system has now received feedback from NHSI and been commended on the quality of our return and as such have been "green" rated.

1.13 Last month I reported an unannounced inspection of urgent and emergency services by the Care Quality Commission (CQC); the draft report has now been received and the factual accuracy checking completed. Publication of the report is expected to be mid to late June subject to timely access to the national CQC calibration panel.

1.14 Given the above context, I read with interest that NHS England and Improvement (NHSE/I) have also just announced their intention to replace the existing four hour A&E target with a suite of ten metrics covering a broad range of measures aimed at capturing the whole patient journey and with a focus on those measures that capture safe, high quality and timely care. The proposed measures were widely consulted upon nationally with 80% of respondents welcoming a bundle of measures as opposed to the single four hour waiting time measures and 67% supported the proposed bundle of ten. Final plans still require government sign off and a timetable for implementation is awaited.

2 Key Highlights

2.1 A quieter month in respect of highlights but nevertheless some important achievements and not least the ongoing success in **cancer services** which was the focus on my fortnightly Vlog this week. Again, the Trust has delivered all eight of the national cancer waiting time standards, reflecting embedded improvement of a standard not previously achieved since 2014. Furthermore, the two key standards of two week wait and 62 Day GP referral, the Trust has the second highest performance nationally. In addition to improved performance the Vlog explored the impact of the pandemic on cancer services and we heard from Dr Charlie Candish, Oncologist and Miss Mags Coyle, Surgeon about some of the innovations that had flourished out of necessity but which would now be taken forward into future ways of working.

2.2 Linked to the "silver linings" of the pandemic, work to support **agile and flexible working** continues with large numbers of staff embracing the opportunity for some form of hybrid

working i.e. both on site and from home working. Colleagues are settling into a 3:2 or 2:3 pattern determined by the needs of their service and their personal preferences. Support to ensure that home working environments are safe and appropriate is in hand. Alongside homeworking, embedding digital or virtual care also remains a priority given the proven benefits to patients. Nationally, there is an ambition that 25% of care will be delivered non-face-to-face using digital platforms; currently our Trust is delivering c30% of outpatient care in this way, 80% of which is follow up care which is most amenable to high quality, low risk digital care. Given the likely presence of **digital care** in the future models of service we are now reviewing all of our development plans for digital technology and buildings e.g. the strategic site development, to ensure they are planned with these new models of care in mind.

2.3 A less well profiled success of the Trust's pandemic response was the extent to which the Trust was able to support **doctors in training** and whilst their learning was not as planned, the vast majority reported a very positive experience of their time in the Trust. These achievements reflect the dedication and enthusiasm for education shown by Dr Russell Peek, Director of Medical Education and the many educational supervisors who support learners, alongside the competence and passion of the management team led by Sam Taylor. I am therefore pleased to report a wide range of developments and achievements within postgraduate medical education in recent months. We have been awarded additional training posts in clinical oncology, medical oncology and radiology, reflecting our ability and capacity to deliver excellent training. Gloucestershire will also host a trailblazer programme for Enhancing Generalist Skills, a national Health Education England (HEE) initiative to better meet the needs of the future healthcare workforce. Our pilot multi-professional programme will be co-created with learners, patients and the public to address the recommendations of the *Future Doctor* report.

2.4 As described, COVID-19 had a significant impact on the training experience in many specialties. As part of restoration and recovery work, we need to support learners in catching up with curriculum objectives and requirements. To this end, the Trust has been allocated £100k to fund training recovery initiatives, with the aim of reducing the number of people needing additional time to complete their training.

2.5 A key **Post Graduate Medical Education** (PGME) objective for this year is developing our capability and capacity for clinical education research and innovation. This links with Trust and ICS ambitions to deliver greater research activity. We are hosting a networking event with higher education partners in July, to identify potential areas for collaboration and to scope opportunities, barriers and enablers to greater education research activity. With a successful bid for HEE innovation funding, we have been able to appoint a dedicated knowledge specialist to support this work and develop closer working relationships with the Research and Development team.

2.6 The education centres offer a thriving and expanding range of courses and training events, attracting additional funding from HEE. As restrictions on face to face training reduce, we are seeking to restore our full range of educational activities and explore new opportunities, including enhanced faculty development activity and delivering new courses in collaboration with Royal Colleges.

2.7 Since the last Board, the 2020 Staff Advice and Support Hub has celebrated its second anniversary and the value this team brings to the organisation was acknowledged and celebrated throughout the Trust. The recent launch of the Hub's financial support programme has already been welcomed by staff.

2.8 On 13 May, the Board engaged in "part 2" of our discussions in response to the **Big Conversation** led by partners DWC. The session was able to finalise our ambition both with respect to scale, how we will judge our success and the key planks of our culture improvement activities and the final proposals will be considered by the Board at the June meeting. One of the key responses to the DWC "conversation" was a review and strengthening of our approach to recruitment and our new Recruitment and Selection Policy, aimed at being at the forefront of inclusive practice, will be launched on 7 June starting with my own Vlog. I am very confident that this new approach will be a key plank of our plan to achieve and, indeed, exceed the *Model Employer* aspirations in respect of an ethnically diverse leadership community within Trusts.

Deborah Lee, Chief Executive Officer
27 May 2021

Gloucestershire Hospitals NHS Foundation Trust

TRUST BOARD – June 2021

Report Title
TRUST RISK REGISTER (TRR)
Sponsor and Author(s)
Author: Lee Troake, Corporate Risk, Health & Safety Sponsor: Emma Wood, Deputy CEO and Director of People and OD
Executive Summary
Purpose The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. At the Risk Management Group (RMG) Meeting on 5 May 2021 the following decisions were made. **Key issues to note** • No new risks were added to the Trust Risk Register • One risk was downgraded sufficiently to be removed from the TRR and placed on the Corporate Divisional 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. **Score:** Safety and Quality were C4 x L3=10 both reduced to C4 x L2 = 8 Risk reviewed. Infection Prevention Control visit shows we have good compliance, no nosocomial cases and community infection rate low. Reduced likelihood to a 2 in safety and quality. • 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			
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		
Divisional Board	**Trust Leadership Team**	**Other (Specify)**
		Risk Management Group 5 May 2021

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

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Date Risk to be reviewed by	Operational Lead for Risk	Approval status
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19 8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties 9. Review of % over breach report with validated administratively and clinically the values 10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	30/06/2021	Felicity Taylor-Drewe	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. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	Risk assessment and busines case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering. meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/03/2021	Candice Tyers	Trust Risk Register
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses Appointment of band 3 HCA's to maintain quality of care for patients in escalation areas. Review of safety checklist to incorporate comfort measures and oxygen checks. Introduction of pitstop trial to identify urgent patient needs including analgesia and comfort measures.	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	31/03/2021	Anna Blake	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	30/06/2021	Jonathan Lewis	Trust Risk Register
C2628COO	The risk of poor patient experience & outcomes resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards and the impact of Covid-19 in 2020/21.	The RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concern Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to implement. Reporting through Theatre Collaborative and PCDG. 7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	30/06/2021	Felicity Taylor-Drewe	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value £60m), resulting in patients and staff being	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group;	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/05/2021	Akin Makinde	Trust Risk Register
		1. Temporary Staffing Service on site 7 days per week.	To review and update relevant retention policies								

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.	2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes.	Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	30/04/2021	Carole Webster (Inactive User)	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.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	07/06/2021	Lee Troake	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times).	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	12/05/2021	Linford Rees	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 DoLS checklist Mental Capacity Act documentation Daily updates between GHFT Safeguarding Adults team and DoLS office. CQC updated with every DoLS outcome. MCA included as a mandatory element in Safeguarding Adults training MCA training has been provided live via MSTeams All divisions have developed MCA improvement plans. 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. Divisional improvment plans for MCA MCA and DoLS training included in Safeguarding Adults training Workforce planning	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	30/06/2021	Jeanette Welsh	Trust Risk Register
C3295COO	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required). Both systems were operational from end March. Activity: Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care. RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position. The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required. Harm reviews suspended aside from Cancer. The RAG process described above has moved into a P category status = all patients are now being validated under this prioritisation on the INPWL - a report has also been provided at speciality level to detail the volume completed	No Further actions	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	31/05/2021	Felicity Taylor-Drewe	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 Escalation of patients> 52 weeks to Head of GI physiology to review prioritisation Referral outside of Trust	to discuss alternative treatment options with upper GI surgeons review cost implications and resources for treatment option of bravo capsule 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% Capital application form completed, Candice Tyers presenting to MEF VCPs have been submitted / await outcome of approval	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	30/04/2021	Bernie Turner	Trust Risk Register
C3431S&T	The risk is that planned reconfiguration of Lung Function and Sleep 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. 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	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk	30/06/2021	Tom Hewish	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	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	04/06/2021	Richard Head	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. Ward 3B being assessed for ability to undertake works this Summer	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	30/09/2021	Alison McGirr	Trust Risk Register
S2917CC	The risk of patient and staff harm and loss of life as a result of an inability to horizontally evacuate patients from critical care	Presence of fire escape staircase Hover-jack to aid evacuation of level 3 patient Fire extinguisher training for staff	Fire extinguisher training Simulation training to evaluate hoverjack and slide sheets Discuss estates option for creating adequate fire escape facilities Purchase of twenty sliding sheets order oxygen cylinder holders Evacuation practice relocation of small O2 cylinders b end of unit	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	17/05/2021	Rebecca Offord	Trust Risk Register
C2970COOEFD	Risk of harm or injury to staff and public due to dilapidation and/or structural failure of external elevations of Centre Block and Hazelton Ward Ceiling – resulting in loose, blown or spalled render/masonry to external & internal areas.	1) Snapshot' visual survey undertaken from ground level to establish the scope of the loose, blown or spalled render and masonry to the external elevations of the building & any loose material removed (frequency TBC); 2) Heras fencing has been put up to isolate persons from the areas of immediate concern; 3) Areas of concern being monitored (frequency TBC). (All Controls to be reviewed and confirmed as active & appropriate).	Refurbish the roof outside and make safe To undertake a comprehensive structural survey of the external elevations of Centre Block to identify all areas requiring repair or replacement and to undertake those works Planning permission for investigatory works	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	29/10/2021	Akin Makinde	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 On site Estates team 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 Theatre refurbishment programme - Theatres being equipped as per HBM as part of a refurbishment plan	support Estates in delivery of the theatre refurbishment programme Work with manufacturers to obtain UPS specifically designed for use on endoscopic stacks Gather evidence of power failure incidents for theatres identify national standards for requiring UPS Creation of action plan to upgrade/replace UPS Plan for theatre in the event of mains & UPS failure	Safety	Catastrophic (5)	Rare - Less than annually (1)	5	4 - 6 Moderate risk	31/03/2021	Candice Tyers	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 Maintenance was extended until April 2021 to cover repairs Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab Project manager to resolve concerns regarding other departments phasing of moves to enable works to start	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/05/2021	Joseph Mills	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	Craig Bradley	Trust Risk Register
			Discussion with Matrons on 2 ward to trial process. Develop and								

C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	implement falls training package for registered nurses Discuss flow sheet for bed rails on EPR at documentation group. Alter falls policy to reflect use of hoverjack for retrieval from floo #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment review location and availability of hoverjacks Set up register of ward training for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	Craig Bradley	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 •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.) •Some short term patch repairs are undertaken (reactive remedial action); •Temporary use of water collection/diversion mechanism in event of water ingress •Risk assessment completed in 2019 and again in 2020 – issue escalated to Executive team •Options provided to TLT regarding building in June 2019	Long term repairs to roofs needed GRH 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 Discuss at Infrastructure Delivery Group whether there is sufficient slippage in the Capital Programme for urgent repairs to the Orchard Centre Roof	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	05/04/2021	Akin Makinde	Trust Risk Register
C2989COOEFD	The risk of patient, staff, public safety due to fragility of single glazed windows. Risk of person falling from window and sustaining serious injury or life threatening injuries. Serious injury from contact with broken glass / shattered windows. Glass shards may be used as a weapon against staff, other	1. All faults are logged on Backtraq via the Estates Helpdesk either on-line or via the 6800 number and reports are available as necessary; 2. Many windows have a protective film to prevent shards of glass fragmenting and causing harm; 3. Patient Risk Assessments are in place by the Trust for vulnerable patients to ensure that controls are in place locally to minimise and/or mitigating patient contact with windows/glass;	Replacement, or upgrade of windows. 100 windows need replacing throughout the Tower Block. Decision to be made as to whether each window needs to be replaced, or whether each window is replaced on a ward first at a cost of £30, 000 per ward Review, assess and enact agreed future actions/controls	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	29/10/2021	Akin Makinde	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 Put light risk on the risk register Add Apollo Lights to the risk assessment and MEF request Carry out surveys of the theatres requiring lights Replacement programme Work with estates to produce a list of outstanding lights Identify access to additional lighting in case of failure Action plan for lights replacement To produce risk assessment for light failure	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	30/04/2021	Candice Tyers	Trust Risk Register
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. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC and commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff after difficult incidents	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	30/06/2021	Vivien Mortimore	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Proide training to 5b in the use of cavilon advance +	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/03/2021	Craig Bradley	Trust Risk Register

S2045T&O	The risk to patient safety of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Supplemental Patient nutrition with nutrition assistant medical cover at weekends OG consultant review at weekends therapy services at weekends Theatre coordinator Golden patients on theatre list Discharge planning and onward referrals at point of admission	Deliver the agreed action fractured neck of femur action plan Develop quality improvement plan with GSIA Review of reasons behind increase in patients with delirium Development of parallel pathway for patients who fracture NOF in hospital Pull together complaints and compliments to understand patient/care views Pull together any complaints or compliments to understand patient/care views for #NOF patients develop joint training and share learning to reduce issues and optimise care discuss admitting patients to 3a with site team create SOP for prioritisation of #NOFs to 3rd floor with intention that other trauma should outlie first restart TATU to help reduce length of stay and improve discharges Identify potential capital works and funding for TATU revisit possibility of Mayhill taking planned trauma revisit community teams administering antibiotics agree targeted approach for high volume conditions engagement activities with staff on ideas for improving LOS Prioritise 3rd floor for ward rounds to aid flow creation of new inpatient clerking proforma progress pre op protocols through documentation committee launch pre op protocols early escalation by trauma coordinators of any trauma backlog to prioritise hip fracture patients review of escalation policy and relaunch if necessary creation of snapshot report to aid escalation re educate trainees that if femoral head if not out/guide wire not within 20 mins, requirement to request senior help Need to emphasise with trainees that access available to JUYI/SCR to inform full list of patient medication Feedback on ward care plan audit results and education of trauma coordinators and medical staff of importance feedback on care bundle audit and feedback to nursing teams and junior Drs of importance recruitment into vacant post for nutrition support practitioner good practice re optimisation for nutrition and hydration to be shared outside 3a Audit post op blood taking over weekends investigate options to increase junior orthogeri cover on call junior dr to be supported by 2nd registrar in MIU, freeing up on call Dr to see ward patients explore issue relating to complex patients not being assessed by COTE team before theatre process for escalation of DATIX to junir Dr and escaltion superviserd to aid learning undertake time and motion study of juniors to understand pressures work with HR to develop recruitment and retention plan for trauma nursing review feeback from nursing education programme engagement activities across T&O nursing Explore issues around Gallery ward taking NOF patients with complex needs review TOR for hip fracture mortality meetings Identify staff to undertake silver QI course to develop QI skills Review and update transfusion policy post surgery Review post op transfusion policy for NOF patients Learning disability passport to be included when appropriate fro NOF patients with learning disability EPR trigger to be implemented from transfusion policy Communicate with recovery staff the new transfusion guidance from the updated policy. Monitor NHFD KPI and mortality rate	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	25/06/2021	Will Mason	Trust Risk Register

			Increase out of hours ortho geriatric cover Continue engagement programme with nursing teams Therapy staff improve patient experiance Consider recruitment of 1 further NP for NOF ward								
M2268Emer	The risk of patient deterioration (Safety) due to lack of capacity leading to ED overcrowding with patients in the corridor	RN identified for ambulance assessment corridor 24/7 Identified band 3 24 hours a day for third radiology corridor with identified accountable RN on every shift Additional band 3 staffing in ambulance assessment corridor 24 hours a day - improvement in NEWS compliance and safety checklist Where possible room 24 to be kept available to rotate patients 9(or identified alternative where 24 occupied) (GRH) 8am - 12mn consultant cover 7/7 (GRH) reviewed by fire officers safety checklist; Escalation to silver/gold on call for extra help should the department require to overflow into the third (radiology) corridor. 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. 90% recovery plan May 2019. adherence. Pitstop process late shifts Mon - Fri to rapidly assess all patient arriving by ambulance - early recognition of increased acuity to prioritise into the department. Establishment of GPAU to stream GP referrals direct into alternative assessment area reducing demand in corridor.	Complete CQC action plan Compliance with 90% recovery plan Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	06/06/2021	Sally Hayes	Trust Risk Register
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. 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. 3)1.0wte DiSN commenced March 2021, funded by CCG for 12 month secondment. 4) 0.80 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	25/06/2021	Sandra Attwood	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/12/2021	Ben King	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. Business Continuity Plan - Second data Centre at different location if data centre were to become unusable. Fire alarms in place within data centre to alert if there is a fire Business case approved.	New / refurbished Data centre Plan	Environmental	Minor (2)	Almost certain - Daily (5)	10	8 -12 High risk	30/07/2021	Fraser Frizelle	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 •Perspex screens placed between beds •Clear procedures in place in relation to infection control •COVID-19 actions card / training and support •Planning in relation to increasing green bed capacity to improve patient flow rate •Transmission based precautions in place •NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control •H&S team COVID Secure inspections •Hand hygiene and PPE in place •LFD testing – twice a week •72 hour testing following outbreak •Regular screening of patients	CAFF inspections to be progressed	Safety	Major (4)	Unlikely - Annually (2)	8	8 -12 High risk	30/04/2021	Craig Bradley	Trust Risk Register
		• RAG rating of patients in clinical priorisation & Clinical Harm Reviews • Movement of the acute take from CGH to GRH (see issues outlined in gaps below) ED dept at CGH will operate as a minor injuries unit, all emergency patients are managed through GRH. This will enable CGH to manage planned patients who have tested negative to COVID. • All emergency surgery will move to GRH. Vascular emergency patients will move from CGH to GRH. 50% of benign Gynaecology elective day cases will transfer from GRH to CGH. Some Upper GI urgent activity may also move to CGH (Hot laparoscopic Cholecystectomy), if additional theatre capacity is required. • 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	Incremental step up of elective activities, including through the independent sector								

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	• 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 • 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 • 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 • Wider discussions with ICS Board and regional colleagues • Communication Strategy in place with affected staff • HR Business Partner point of contact to link with PMO • Impact assessment for completed in relation to surgical staff • Financial planning and COVID-19 cost recovery activities under development (e.g. consideration of 6/7 day working *Harm review Policy updated to reflect Covid-19 approach	Continued review of clinical waiting lists	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	31/05/2021	Felicity Taylor-Drewe	Trust Risk Register

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC TRUST BOARD – 10 June 2021
MS teams commencing at 12:30

Report Title
Compassionate culture follow up: setting an Ambition.
Sponsor and Author(s)
Author: Emma Wood, Director of People and OD, Deputy CEO Sponsor: Deborah Lee, CEO
Executive Summary

Purpose

To provide a summary and overview of the discussion held by Board and the Chiefs of Service during the April and May Board Strategy and Development (BSD) sessions regarding how we can continue to embed and articulate our compassionate culture ambition.

Key issues to note

DWC, the consulting group who led the Trust's 'Big Conversation' programme provided the Board and Chiefs of Service with an overview of their work, and recommendations for review including how the Board might wish to articulate its Inclusion Ambition. April's BSD discussed Ambition setting and reviewed a suggested methodology and means to improve the experience of staff in underperforming areas ('hot zones') with the intention to improve these and lead to cultural improvements. This 'Insights' methodology was supported and it was agreed to trail this in four to five areas as 'proof of concept.' In May's BSD the Board and Chiefs of Service considered the feedback collated from the April BSD regarding ambition setting and continued discussions on how best to articulate and measure this.

Ambition and target:

- A statement of Ambition was agreed for the strategic period 2019-2024 using the framing "Best Care for Each Other;"
- It was agreed the Board's ambition to deliver upon an Inclusive and Compassionate Culture could be measured through the lens of 'I would recommend my organisation as a place to work.' A measure in the staff survey;
- The Board agreed in order to be true to the Journey to Outstanding ambitions, the Trust would endeavour to achieve an upper decile performance in both question sets by 2024;
- The Board agreed that reducing the experience gap within this index was a useful means to measure performance and ensure parity of experience;
- The Board agreed to measure and improve upon five themes within the staff survey linked to the 'Insights' programme. These were; Staff Engagement, Equality and Diversity, Health and Wellbeing, Immediate Managers and Bullying and Harassment. Moving the score to best in class by 2024 was agreed;
- The Board ratified the Trust's ambition to increase the number of colleagues at Band 8+ and VSM level from an ethnic minority background to 18 by 2024 (as per Model Employer Aspirations).

The Right to meet at the table:

- The Board agreed the 'right to meet at the table' would require clear definition of purpose, mechanics, governance, commitment to release of time, training and

messaging to become a meaningful intervention;
- The Board discussed several ways in which colleagues were heard and agreed current governance channels and arrangements could be improved upon to increase and strengthen the visibility of colleague opinion and influence in decision making.

Conclusions

The Board agreed to enshrine our compassionate culture into a simple but bold statement 'Best Care for Each Other' with milestones, to be achieved by 2024, which would close the gap between the best and worse staff experiences. This ambition would be measured through the lens 'I would recommend my organisation as a place to work' and through achievement of the Model Employer Aspirations and Best in class scores for five staff survey themes.

Further work to understand how the Trust listens to the staff voice and consideration of how this can become more visible to the Board will be undertaken as part of the commitment to widen participation at decision making forums.

Implications and Future Action Required

- The Engagement and Communications team will consider the opportunities to simplify language regarding compassionate and inclusive cultures to introduce the "Best Care for Each Other" ambition linked to the 'recommend my organisation as a place to work.'
- The People and OD teams will continue to pilot 'Insights'
- The People and OD team will update the People and OD strategy with the new ambition and metrics.
- The Corporate Governance team will scope mechanisms to improve visibility of listening:
  - Work with Executives to map the current opportunities to improve the visibility of listening and engagement;
  - Review Board and Committee planners and terms of reference to ascertain opportunities to engage and involve colleagues in decision making;
  - Invite Chief of Service to Board Development Sessions to increase the Boards visibility of the staff voice as represented by them;
  - Improve the narrative within cover sheets/assurance report to better articulate the steps taken to engage and the impact this had on decision making;
  - Review options for more diverse governor appointments;
  - Ensure staff stories embed listening;
  - Consider how the Board can engage and listen to staff in new ways including use of members and governors.

Recommendations

Board are asked to **APPROVE** the next steps

Impact Upon Strategic Objectives

The steps outlined in this paper will impact on all strategic objectives through the development of cultural change.

Impact Upon Corporate Risks

There are no direct links to corporate risks.

There are links to the principle risks within our Board Assurance Framework linked to our strategic objectives including:

1. Risk that continued poor levels of staff engagement measured by national and local surveys may negatively impact upon retention, attraction and patient experience;

2. Risk that we fail to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve;
3. Risk of failure to deliver the Quality Framework and associated distributed quality leadership. This would delay the development of an empowered workforce close to the patient and prevent the required cultural change/embedding of quality improvement;
4. Risk that poor engagement (with/ from patients, staff, stakeholders and the public) leads to inadequate representation and low overall involvement meaning a wide range of views are not incorporated into design and decision making.

Regulatory and/or Legal Implications

There are number of regulatory and legal requirements on the Trust that relate to equality, discrimination and employment rights. These will continue to be applicable but the development of a compassionate culture and an inclusive and diverse environment will reduce and mitigate the likelihood of any breach of statutory duties or responsibilities.

Equality & Patient Impact

The paper outlines and describes steps that to address inequalities for staff and patients through fostering and embedding a compassionate culture that improves both patient experience and care alongside the working environment for Trust staff and volunteers.

Resource Implications

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

Action/Decision Required

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

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

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

Outcome of discussion when presented to previous Committees/TLT

N/A

Compassionate Culture: follow up and Ambition setting

1. Introduction

Over the course of two Board Development and Strategy (BDS) sessions the Board and the Chief of Services received feedback from DWC, the consulting organisation commissioned to manage and oversee the 'Big Conversation.' The interim report described feedback from staff regarding their experiences in the Trust alongside possible next steps to improve these. The emerging priorities were discussed and an overview provided on how other Boards have embedded Inclusion.

The Board committed to a new approach to embed a compassionate culture developing the concept of a cultural barometer or 'Insights' methodology, piloting this within four to five areas which DWC and the staff survey results highlighted as having poorer reported experiences.

The cultural barometer will seek to describe a teams' culture by reviewing responses across five themes (aligned to the staff survey) on a regular basis.

- Immediate Manager;
- Health and Wellbeing;
- Bullying and Harassment (civility);
- Engagement;
- Equality, Diversity and Inclusion.

In addition the Board:

- Committed to a rolling programme of cultural review across the Trust over the next three years;
- Accepted Inclusion and culture should be a golden thread through strategies, policies, procedures and practice;
- Recognised that the most powerful factor influencing culture is leadership and notably 'immediate managers' and make this central to our approach;
- Agreed to measure and understand colleague experience more frequently and in a contemporary fashion i.e. pulse surveys;
- Agreed to shift the narrative from simple metrics (turnover, stability, sickness) to culture;
- Agreed to the provision of a supportive framework for developing compassionate leaders and teams whilst clear on accountabilities, expectations and remedies where values and behaviours are not in keeping with a compassionate culture.

Over the two Board Development Sessions the Board and Chief of Services discussed and agreed how the Trust could better articulate its ambition to improve the experiences of all colleagues.

2. Ambition setting

The Board agreed that in setting an ambition it was important to:

- Be seen to be ambitious but no desire to "declare an emergency" or produce a charter!;
- Be simple but bold, with measurable milestones;
- Deliver improvements for all, whilst closing the gap between the best and worst experiences;
- Be clear on what are we responding to i.e. "you said; we did;"

- Answer the "what's in it for me question" e.g. compassionate, inclusive cultures deliver safer care, improved outcomes and better experience for patients and colleagues;
- Measure success as how people FEEL as well as evidenced in our data.

In agreeing a way forward the Board agreed to translate the Best Care for Everyone to Best Care for Each Other as a means to describe the ambition for colleagues. The Board agreed this ambition should be described as a journey towards being best in class to support our 'J2O' narrative.

The measure of success for this ambition was set as upper decile performance by 2024 in the question 'I would recommend my organisation as a place to work?' Additional measures to drive our compassionate culture included:

- Closing the gap affecting the three minority groups (ethnic minorities, LGBTQ++ and disabled colleagues) against this question;
- Moving the five themes measured as part of the People and OD strategy to meet best in class Acute metrics;
    - Immediate manager;
    - Health and well-being;
    - Bullying and Harassment (civility);
    - Engagement;
    - Equality, diversity and Inclusion.
- Meeting our Model Employer Aspirations to ensure further ethnic minority representation at Band 8 and VSM roles.

3. Embedding Inclusion and a compassionate culture

Embedding a compassionate culture through improved Board practice can serve to provide a signal to the organisation that culture and colleague experience and engagement is important.

The 'right to meet at the table' was discussed as a potential opportunity to ensure diverse voices were heard and involved in decision making. The Board considered some examples from the Council and University sector where diverse groups were more formally involved in decision making or discussions tabled when seeking staff feedback.

The Board agreed that the principle of involvement and shared decision making was aligned to many of our current governance processes, and it would be prudent to develop these rather than create a new initiative. The Board noted the involvement of colleagues in the design of strategy, policy and practice with the lens of the Pathways to Excellence and other groups such as Fit for the Future where involvement is sought.

The Board agreed to build upon current governance arrangements to improve the visibility of the staff voice. Opportunities could include:

- Inviting the Chief of Service to all Board Development sessions to represent divisional voices and to some Board Committees;
- Improving cover sheets to better explain how colleagues were engaged in papers and involved in decision making;
- Reviewing the shared decision making forums in place and understanding how the Board could better understand involvement (pathways to excellence, staff side forums, councils);

- Improving Board dialogue to ask questions on engagement and shared decision making and how staff views influenced papers – how have we heard voices? How did we use these inputs?;
- Providing NED assurance in chairs report on the engagement of staff in topics covered;
- Board and committee invites to formal groups for certain agenda items'
- Board events to listen to colleagues;
- Staff stories at Board.

Future developments could include:

- Focused attention on building membership services and diverse voices;
- Considering future governor roles; should we create governor roles with special interests – disability, ethnicity, sexual orientation?

Next steps

The Director of Engagement, Involvement and Communications will consider opportunities to utilise the Best Care for Each Other ambition and standardise the use of language to describe our ambitions inclusive of use of the Index measures of success.

The Corporate Governance team will progress options to improve the governance of shared decision making with the Chair, NEDs and Executive team.

The People and OD team will progress the pilot of the cultural barometer and update the People and OD strategy with the new ambitions and measures. Future reporting into the People and OD committee and Board will provide updates on the work programme.

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 10 JUNE 2021

Report Title
BOARD ASSURANCE FRAMEWORK
Sponsor and Author(s)
Author: Sim Foreman, Trust Secretary Sponsor: Emma Wood, Deputy CEO and Director of People and OD
Executive Summary
Purpose To present an update on the Board Assurance Framework (BAF). The risks have been reviewed by the Lead Executives and updated accordingly to present a summary covering Q3 and Q4 of 2020/21. Assurance committees received shortened versions of the BAF to cover those strategic risks for which they have oversight at the recent cycle of meetings and agreed the assurance ratings, with the Audit and Assurance Committee receiving the BAF in its entirety. The RED risks and assurance summary are presented for Board approval.
Recommendations
The Board is asked to **APPROVE** the BAF, noting the RED risks and assurance summary showing updates to the principal risk scores and assurance ratings.
Impact Upon Strategic Objectives
The BAF is an assurance framework relating to the delivery of all Strategic Objectives.
Impact Upon Corporate Risks
Related risks from the Trusts Risk Register have been identified and mapped to each principal risk.
Regulatory and/or Legal Implications
As a Foundation Trust it is important that the BAF works as a tool to support the Board's assurances in terms of self-certification on compliance with its Terms of Authorisation. The Care Quality Commission (CQC) well-led domain requires a robust management of risk and assurance framework of all good and outstanding Trusts.
Equality & Patient Impact
The management of risk and assurance that the Trust is being managed effectively to deliver the strategic objectives will positively impact upon patient safety and experience and the equitable provision of services.

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

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

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Estates and Facilities Committee**	**Trust Leadership Team**	**Other (specify)**
28 April	29 April	18 May	27 April	27 May		
Outcome of discussion when presented to previous Committees						
QPC, FDC, PODC and EFC all agreed the proposed risk scores and assurance ratings proposed by the Executive. The Audit and Assurance Committee NOTED the BAF in its entirety and requested further work to ensure the strategic risks in the next update reflected the work underway on compassionate culture and equality, diversity and inclusion.						

1. Introduction

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

It is the Committees' role to scrutinise the principal risks within the BAF and to seek assurance on the Board's behalf that appropriate controls and mitigating actions are in place and managed effectively. Board assurance committees receive the principal risks in the BAF that relate to strategic objectives for which they have been assigned oversight responsibilities with the Audit and Assurance Committee receiving the BAF in its entirety.

The Board last reviewed the whole BAF in December 2020. The updates planned through January to March were deferred to allow the Executives to focus on the pandemic response; quarterly reviews will resume from July 2021.

2. Key Points to note

There are currently **26** principal risks on the BAF. There are NO new risks and ONE risk is proposed for closure.

TWO risks (PR1.1 and PR1.4) have increased their risk scores and these were agreed at Quality and Performance Committee (QPC).

The Finance and Digital Committee note the assurance on SO-07 Financial Balance is LIMITED (RED) continued to be rated to apply due to the impact of the coronavirus pandemic on the NHS funding regime and uncertainty related to funding in the second half of the year and the longer period covered by the strategic plan (to 2024).

The Board will receive the BAF in June 2021 to see the tracking of scores and assurance ratings and the detail of the RED risks only.

3. BAF Summary

Below provides a risk profile and gives an 'at a view' of any changes made to the BAF that affect the risk profile.

Total number of risks by score:

Consequence	1	2	3	4	5
5			1	1	
4	1	3	2	3	
3	1	8	3	2	
2		1			
1					

Likelihood

Highlights of recent changes:

New Risks: NONE

Changes in Score: THREE

Closed Risks: ONE

4. Recommendation

The Committee is asked to **CONSIDER** the BAF and note the updates to the principal risk scores and assurance ratings.

Appendices

1) Summary of the BAF risk and assurance ratings for 2020/21
2) Risk and Assurance Ratings
3) BAF Risk Profile summary and Assurance Radar
4) FIVE RED RATED principal risks

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

Strategic Objectives		Principal risk ID	Executive Lead	Assuring Committee	Risk rating Q1	Q2	Q3	Q4	Target	Assurance rating Q1	Q2	Q3	Q4	Comments
1	**Outstanding Care** We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	1.1	Director of Quality and Chief Nurse	QPC	12	6	8	8	4	G	A	A	A	INCREASED
		1.2			9	9	9	9	3					
		1.3			8	8	8	8	1					
		1.4			12	12	16	16	4					INCREASED
2	**Compassionate Workforce** We have a compassionate, skillful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people	2.1	Director of People & OD	PODC	6	6	6	6	4	G	G	G	G	
		2.2			6	6	6	6	4					
		2.3			1									
		2.4			6	6	6	6	4					
3	**Quality improvement** Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other	3.1	Director of Safety and Medical Director	QPC	12	12	12	12	6	A	A	A	A	
		3.2			12	12	12	12	6					
4	**Care without boundaries** We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners	4.1	Chief Operating Officer	QPC	6	6	6	6	4	A	A	A	A	
		4.2	Director of People & OD		9	9	3	3	4					QPC agreed proposed CLOSE.
5	**Involved People** Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services	5.1	Dir of S&T	PODC	6					G	G	G	G	Merged into PR5.5
		5.2	Dir of S&T	PODC	12									
		5.3	Dir of S&T	Board	6									
		5.4	Dir of S&T	PODC	12									CLOSED– on programme risk register
		5.5	Director of People & OD / Director of Strategy and	PODC	12	12	12	12	4					Added Q1 2020/21

Strategic Objectives		Principal risk												
		ID	Executive Lead	Assuring Committee	Risk rating					Assurance rating				Comments
					Q1	Q2	Q3	Q4	Target	Q1	Q2	Q3	Q4	
			Transformation											
6	**Centres of Excellence** We have established Centres of Excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within the county	**No risks**	Director of Strategy and Transformation	QPC										
7	**Financial Balance** We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources	7.1	Director of Finance	FDC	15	15	**15**	**15**	6	**A**	**R**	**R**	**R**	
		7.2			6	6	**6**	**6**	1					
		7.3			20	20	**20**	**20**	12					
		7.4			16	16	**16**	**16**	4					
		7.5			6	6	**6**	**6**	3					
		7.6			9	9	**9**	**9**	4					
8	**Effective Estate** We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact	8.1	Director of Strategy and Transformation / Director of Finance / Chief Operating Officer	EFC	16	16	**16**	**16**	8	A	R	**A**	**A**	
		8.2			3									CLOSED Q1 20/21
		8.3			12	12	**12**	**12**	6					
9	**Digital Future*** We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care	9.1	Chief Information Officer	FDC	9	9	**9**	**9**	6	A	A	**A**	**A**	
		9.2			4									CLOSED: Target score reached.
		9.3			6	6	**4**	**4**	3					
		9.4			4	4	**4**	**4**	2					
10	**Driving Research** We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in	10.1	Director of Strategy and Transformation	PODC	4	4	**4**	**4**	4	A	A	**A**	**A**	
		10.2			8	8	**8**	**8**	4					
		10.3			12									Merged in PR10.5
		10.4			12									
		10.5			12	12	**12**	**12**	12					Added Q1 20/21

Strategic Objectives		Principal risk												
		ID	Executive Lead	Assuring Committee	Risk rating					Assurance rating				Comments
					Q1	Q2	Q3	Q4	Target	Q1	Q2	Q3	Q4	
	the UK													

QPC – Quality and Performance Committee
EFC – Estates and Facilities Committee
FDC – Finance and Digital Committee
PODC – People and Organisational Development Committee

Appendix 2 – Risk and Assurance Ratings

Assurance Ratings

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

Risk Ratings

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

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

Risk Profile (Q4 2020/21)

Gloucestershire Hospitals NHS Foundation Trust

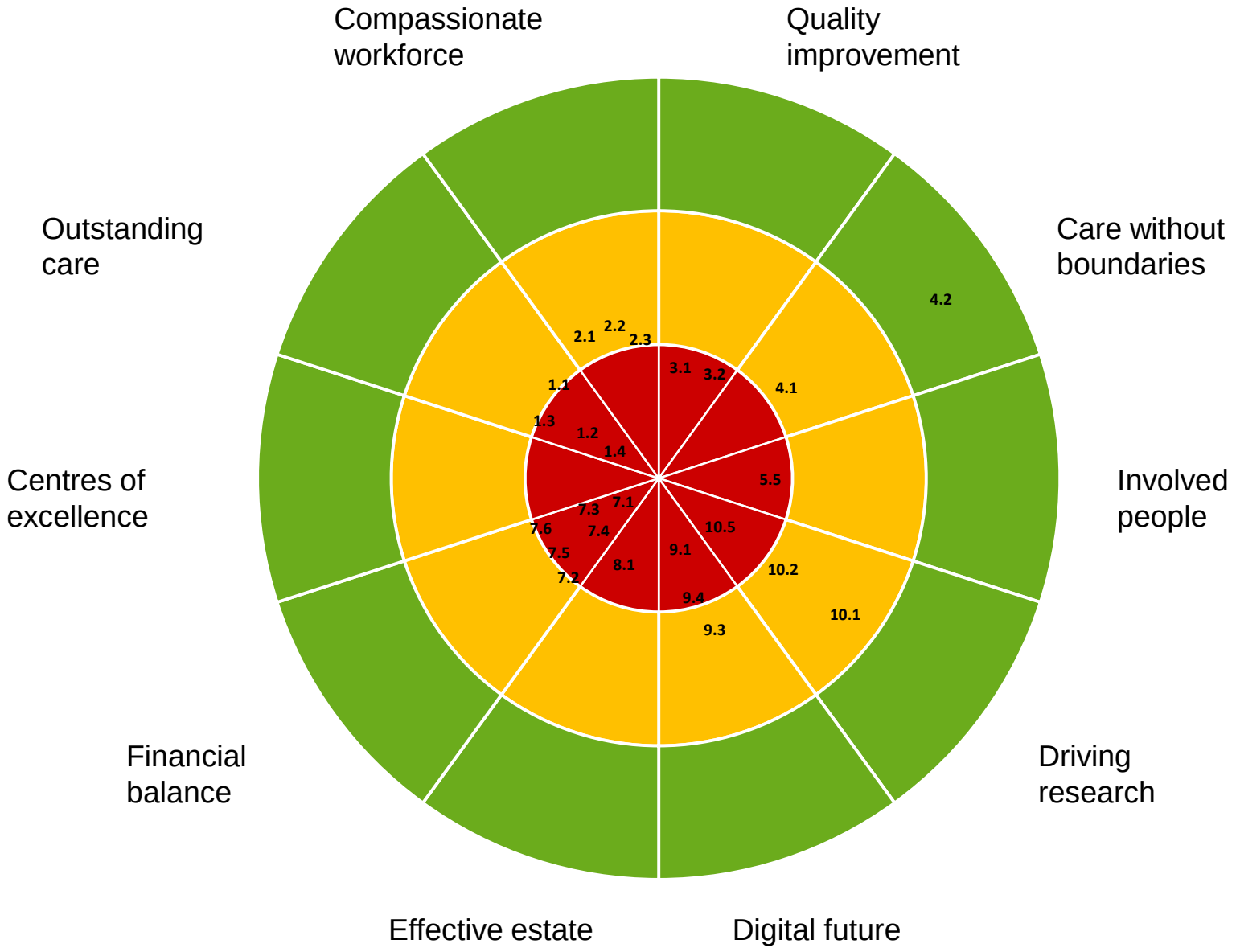
Profile of Principal Risks to Strategic Objectives					
Strategic Objectives	**Red**	**Orange**	**Yellow**	**Green**	**Total**
Outstanding Care	**1**	**3**	0	0	**4**
Compassionate Workforce	0	0	**3**	0	**3**
Quality Improvement	0	**2**	0	0	**2**
Care Without Boundaries	0	0	**1**	**1**	**2**
Involved People	0	**1**	0	0	**1**
Centres of Excellence	0	0	0	0	0
Financial Balance	**3**	**1**	**2**	0	**6**
Effective Estate	**1**	**1**	0	0	**2**
Digital Future	0	**1**	**2**	0	**3**
Driving Research	0	**2**	**1**	0	**3**
Total	**5**	**11**	**9**	**1**	**26**

There are FOUR RED risks (1.4,7.1; 7.3; 7.4; and 8.1).

TWO risk scores (1.1 and 1.4) have increased.

ONE risk score (4.2) has decreased and is proposed for closure on BAF on the basis it is no longer considered a strategic risk but is being managed within PODC framework.

All other existing risk scores remain unchanged.



Gloucestershire Hospitals NHS Foundation Trust

Assurance Radar

Assurance Formula

Red
Residual score is higher than the risk appetite score

Amber
Residual score is equal to risk appetite score

Green
Residual score is less than the risk appetite score

Gloucestershire Hospitals
NHS Foundation Trust

Strategic Objective 1: We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges					
Executive Lead		Oversight/Assurance Committee		Date Opened	Review Date
Director of Quality and Chief Nurse		Quality and Performance		July 2019	April 2021
PR1.4	**Risk that we breach CQC regulations or other quality related regulatory standards**				
Risk Rating	Consequence	Likelihood	Score	Rating	Risk Appetite
Inherent Risk	4	4	16		
Current Risk *(Residual Risk)*	4	4	16		Open
Target Score *(Risk Appetite)*	4	1	4		

What's going well?

- Cancer performance had been maintained and the organisation is a leader when compared regionally.
- CQC unannounced inspection for infection prevention and control standards included positive feedback.
- Our Critical care service was able to respond well to the pandemic and was supported by other services.
- Respiratory services were enhanced with the development of the 'yellow lanyard' respiratory high care team.

What are the current challenges?

- We are now out of escalation areas; elective bed base has not been stepped back up to pre-COVID numbers because of social distancing.
- We have 140-150 patients medically stable for discharge which is being reviewed within the ICS.
- CQC unannounced inspection in the emergency department, prompted by our ED performance (lack of flow and ambulance delays), highlighted that rapid improvement was required which the Trust has responded to and is monitoring very closely.
- Trust initiated Maternity Service external review had highlighted leadership issues and an improvement plan was now in place with delivery being monitored through the Maternity Service Delivery Group.
- Stroke service recovery plan in place in response to static low performance for stroke quality indicators.
- Clinical harm reviews are being carried out to mitigate potential harm through extended waiting which has been caused by the pandemic and the need to reduce services.
- Patient experience has been impacted by the pandemic for a number of reasons including waiting for care.
- Infection control nosocomial issues (number of patients approx. 200) have been written to through our duty of candour processes and we will be investigating and reviewing care.

How are we managing and addressing the challenges?

- Where quality risks have been identified improvement, plans have been established and these are being monitored through delivery groups

(Quality, Planned Care, Emergency Care and Maternity).
- Restoration and recovery of services continues at pace.

Action to be taken	Progress	Target Date	Closed Date
Implement consistent governance reporting and escalation from Specialist committees (e.g. Radiation\Transfusion) to Board Committees	Divisional Governance Review complete new structure being implemented.		
	Specialist Committee review delayed due to COVID will be established in August 2020.	New Q2 2020/21	
COVID-19 pandemic causing delays to access to treatment: **CLINICAL HARM REVIEWS** (MP/SH)	Clinical harm review process is in place and being monitored via executive reviews and Directors Operational Group. Elective Recovery plan for COVID-19 recovery in progress as per NHSI targets.	Q2 2021 Q2/Q3/Q4 2020/21	

Success Measures/KPIs (taken from Enabling Strategies / External assurance)	Performance/Rating By 2024 this should be in place	Updated
All relevant data presented longitudinally and in SPC.	50%	The QPR is under review and so this rating remains unchanged at no additional metrics put into SPC format.
100% of all relevant quality improvement programmes will have patient, carer or family involvement and we will be co-designing our improvements	5%	The Pandemic limited patient involvement in QI during the surges so has only happened in pockets so remains with very limited involvement.
Our colleagues are proud of the organisation and would recommend our organisation as a place to work (best Trust score 2018 Staff Friends and Family Test 81% our score 55.9%)	59.5%	Increase from 59.5% to 64.3%
Our Equality Delivery Assessment will be completed with 25% increase in “achieving” outcomes for the two patient goals across the protected characteristics.	Not due as a 4 year review measure	N/A
Improved Staff Survey score for equality diversity and inclusion (best score in 2018 9.6/10 our score 9.2/10).	2019 score 9.1	Decline from 9.1 to 9.0.
10% increase in our “Better” scores in the CQC National Survey Programme		National audits have been

(NSP) questions when benchmarked nationally.		impacted because of COVID-19 However benchmark not achieved pre COVID-19 with the exception of NELA.
Our Staff Survey questions relating to our safety culture will improve so that we are in the top 10% of Trusts (2018: Our score, 6.5. Best Trust score 7.2)	2019 6.5	Static score at 6.5
Our outcomes for key clinical conditions are in the upper quartile when benchmarked with other Trusts.		National audits have been impacted because of COVID-19 However benchmark not achieved pre COVID-19 with the exception of NELA.
Inspected and rated by the CQC as 'Good' in the responsive domain	2017 rated as requires improvement	Pandemic has impacted on performance
We are in the top 20% of Trusts across the breadth of the NHS Constitution Standards		Cancer performance is outstanding ED performance requires improvement. Planned care impacted because of COVID-19 Diagnostic performance is good with the exception of endoscopy and echo-action plans in place.

Key Controls	Assurances/Evidence	Gaps in Controls/Assurance & Action	Timescale
Quality Strategy, systems and processes	• QPR report • Exception reports from delivery groups to Sub Board Committees (Planned, Cancer, Emergency & Quality) • Specialist committee reports to Q&PC (Infection PC, Hospital Mortality RG, Safeguarding) • Quality account indicators and priorities	Quality strategy implementation plan needs review.	Q1
		New Delivery Group structure was delayed due to COVID and was implemented in June 2020 annual review of TOR due	Q1
		Consistent & effective governance arrangements for Divisions and specialty committees reporting to Board sub Committees	Q3

	• CQC inspections, ratings and improvement plans	COVID-19 pandemic causing delays to access to treatment	Q4
Health & Safety Systems and processes	• H&S reports to Board Sub-committees (PODC) • Risk Management Group Report to Trust Audit and Assurance committee • Freedom to Speak Up reports to Board Sub-committees (PODC)	Triangulation of H&S, risk management and Quality Data	Q3

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources					
Executive Lead		**Oversight/Assurance Committee**		**Date Opened**	**Review Date**
Director of Finance		Finance and Digital		July 2019	April 2021
7.1	**Risk that we lack the capacity and capability needed to identify and/or deliver transformational, sustainable savings schemes**				
Risk Rating	**Consequence**	**Likelihood**	**Score**	**Rating**	**Risk Appetite**
Inherent Risk	5	3	15		
Current Risk (Residual Risk)	5	3	15		
Target Score (Risk Appetite)	3	2	6		

What's going well?
What are the current challenges?
It is likely that the funding regime for H1 will not cover the level of pressures seen across the ICS. Funding for the second half of the year is yet to be confirmed but is likely to be a greater challenge as the first half of the year contained significant additional funding in the national settlement. This will require financial sustainability solutions to be identified and delivered against.
How are we managing and addressing the challenges?
The PMO are working with divisional colleagues to identify opportunities and to support the implementation and delivery of sustainability schemes. System working is also playing an active role in identifying pathway opportunities.

Action to be taken	Progress	Target Date	Closed
Finance strategy under development (KJ)	Update given to F&D on contents and timeline in August, with a draft strategy received to F&D in November. Feedback will be included within the final version planned for the end of Q1. The overarching theme of the strategy relates to ownership of the financial sustainability agenda.	June 2021	
Understand ROI on investments	A multi-disciplinary group has been setup to establish an approach to capturing ROI on schemes. Initially this is looking at completed digital schemes to determine how it can operate.	Sept 2021	

To promote and encourage the generation of transformational ideas across the Trust, and within Divisions in particular (Execs/SL)	A positive outcome of the pandemic has been the speed in which we have implemented change, some of the change is transformational and is being picked up by the Silver lining documentation. The challenge will be how we drive out the inefficiencies and push towards being a financially sustainable organisation.		
Strengthen organisational awareness to the need for financial sustainability (Execs/KJ)	Build on the Count Me In programme to ensure more staff become aware and engaged in the need to ensure the Trust is financially sustainable Senior finance team now in place and the focus is understanding the drivers of our deficit/spend Looking to develop a communication strategy around how we energise the organisation to drive and own their efficiencies. Having the right tools to give staff will enable them to own their position and make the right decisions to improve services and drive out waste and inefficiencies. Developing a change culture around quality improvement drives financial sustainability. Closer working with PMO, QI and GIRFT teams to maximise skills and drive change	Ongoing Initial meeting May 2021	

Success Measures/KPIs (taken from Enabling Strategies / External assurance)	**Performance/Rating**	**Updated**

Key Controls	**Assurances/Evidence**	**Gaps in Controls/Assurance & Action**	**Timescale**
1. Operational plan 2. Cost Improvement Programme 3. Engagement on CIP through Involve, CEO weekly blog, 100 Leaders, Extended Leadership Network 4. Improved engagement with budget holders on budget setting process 5. Capability development (Count Me In programme; PMO support to divisions)	1. Monthly CIP update to Finance and Digital Committee 2. Programme Management Office record and monitor the CIP progress 3. Financial Sustainability Delivery Group scrutiny of CIP delivery 4. Executive reviews with divisions include focus on financial recovery and CIP delivery 5. Audit reports		
Senior Finance team in place			

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources					
Executive Lead		**Oversight/Assurance Committee**		**Date Opened**	**Review Date**
Director of Finance		Finance and Digital		July 2019	April 2019
7.3	**Risk that the commissioner funding does not address structural funding deficit over the strategic period**				
Risk Rating	**Consequence**	**Likelihood**	**Score**	**Rating**	**Risk Appetite**
Inherent Risk	5	4	20		
Current Risk (Residual Risk)	5	4	20		
Target Score (Risk Appetite)	4	3	12		

What's going well?
The Trust has delivered a surplus position in 2020/21. ICS balanced plan focus?
What are the current challenges?
It is likely that the funding regime for H1 will not cover the level of pressures seen across the ICS. Funding for the second half of the year is yet to be confirmed but is likely to be a greater challenge as the first half of the year contained significant additional funding in the national settlement. This will require financial sustainability solutions to be identified and delivered against. Funding regime / COVID / lack of planning
How are we managing and addressing the challenges?
The PMO are working with divisional colleagues to identify opportunities and to support the implementation and delivery of sustainability schemes. System working is also playing an active role in identifying pathway opportunities.

Action to be taken	Progress	Target Date	Closed Date
Finance strategy under development (KJ)	Update given to F&D on contents and timeline in August, with a draft strategy received to F&D in November. Feedback will be included within the final version planned for the end of Q1. The overarching theme of the strategy relates to ownership of the financial sustainability agenda.	June 2021	

Work with the ICS to develop new approaches to contracting and a sustainable funding settlement (KJ)	Contract envelope agreed for 20/21, where growth is managed across the system. Risk share approach needs to be agreed. This has been superseded by the change in the financial framework due to COVID-19. New financial framework for the rest of 2020/21 continues to encourage system working. Large pot of system resource to be allocated across the system. Good system discussion and prioritisation. Beyond 2020/21 is unknown although it is likely that contractual agreements will continue to encourage system working.		
Future funding arrangements for 2021 and beyond not clear: ICS Finance group already established to understand the new guidance when it is published. To proactively engagement with regional colleagues to keep up to date on national changes (KJ)	Although the issue is being raised nationally, no guidance or indication on what next year looks like has been shared. Regular regional conference calls are in place to keep abreast of current and future plans.		

Success Measures/KPIs (taken from Enabling Strategies / External assurance)		**Performance/Rating**	**Updated**
Key Controls	**Assurances/Evidence**	**Gaps in Controls/Assurance & Action**	**Timescale**
Contract negotiations with commissioners informed by 'drivers of deficit' report	Financial performance report to Finance and Digital Committee and to Board ICS Board	Finance Strategy Limited influence over commissioner funding Ability to explain the structural deficit in a clear way Future funding arrangements for 2021 and beyond not clear ICS strengthening	

Strategic Objective 7: We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources					
Executive Lead		**Oversight/Assurance Committee**		**Date Opened**	**Review Date**
Director of Finance		Finance and Digital		July 2019	April 2021
7.4	Risk that we do not have sufficient capital funding for transformation including the Centres of Excellence Programme and the Strategic Site Development Programme and/or cash flow risk due to phasing of the programmes				
Risk Rating	**Consequence**	**Likelihood**	**Score**	**Rating**	**Risk Appetite**
Inherent Risk	4	4	16		
Current Risk (Residual Risk)	4	4	16		
Target Score (Risk Appetite)	2	2	4		

What's going well?
An outline business case was submitted and supported by NHSE for the SSD case. The full business case has now been submitted and will be evaluated by NHSE to confirm if the scheme is supported which will allow funding to be released. A capital envelope for main capital schemes has been received and supported by the ICS which provides CDEL coverage for the prioritised programme.
What are the current challenges?
The full business case for the SSD case has identified a funding challenge due to cost movements.
How are we managing and addressing the challenges?
Options surrounding the delivery of the SSD programme are being explored and approval has been given by the organisation to reduce expenditure in other scheme areas to offset the financial gap over the next two years if required.

Action to be taken	Progress	Target Date	Closed Date
Capital backlog maintenance: Identify and implement plans to address £60m backlog. (KJ)	New capital funding regime for 2020/21 that gives an allocation to systems as mentioned above. The Trust is looking at developing a refurbishment programme as the backlog maintenance will continue to be an issue for the Trust. The Trust was successful in bidding for funding targeted to reduce the critical infrastructure risk of over £2m. Although this doesn't clear the	Dec 2020	March 2021

	backlog it does allow the Trust to reduce the risk with schemes having been undertaken in the 2020/21 programme. Indicative 5 year capital plan developed – next steps to prioritise and then look at additional funding sources to support our capital need	Sep 2021	
Equipment asset register may not capture everything: Develop and strengthen full asset register for capital equipment (KJ)	No update, no progress to date: Currently working with IT regarding compatibility our current asset register with our current software.		
No long term capital allocation from the centre: Review plans to mitigate the impact of no central long term capital allocation (KJ).	The autumn statement provided capital funding for 2021/22 with no future years confirmed. The Trust has developed a high level 5 year programme which it included in its 2021/22 plan submission to give an indication of the funding required.	Ongoing	

Success Measures/KPIs (taken from Enabling Strategies / External assurance)		**Performance/Rating**	**Updated**
SSD FBC		Approved	
2021/22 Capital Plan submitted / Board approved April 2021			
Key Controls	**Assurances/Evidence**	**Gaps in Controls/Assurance & Action**	**Timescale**
1. Capital plan 2. NHSI funding bids 3. Estates Strategy 4. Strategic Site Development Programme Outline Business Case	1. Financial performance report to Finance and Digital Committee and to Board 2. Capital update to Finance and Digital Committee 3. External audit 4. Business cases (for Centres of Excellence Programme and for the Strategic Site Development Programme) presented to Finance and Digital Committee and to Board for approval 5. Oversight of Strategic Site Development Programme at Estates and Facilities Committee 6. Board approved Capital plan (Apr 2021)	Finance Strategy Capital backlog maintenance Equipment asset register may not capture everything No long term capital allocation from the centre. Strategic capital funding options	

Gloucestershire Hospitals
NHS Foundation Trust

Strategic Objective 8: We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact					
Executive Lead			**Oversight/Assurance Committee**	**Date Opened**	**Review Date**
Director of Finance / Director of Strategy & Transformation			Estates and Facilities	July 2019	April 2021
PR 08.1	Risk that the Trust cannot access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings, preventing delivery of the clinical and estates strategy and/or resulting in continued cumulative degradation.				
Risk Rating	Consequence	Likelihood	Score	Rating	Risk Appetite
Inherent Risk	4	4	16		
Current Risk (Residual Risk)	4	4	16		
Target Score (Risk Appetite)	4	2	8		

What's going well?

- FBC to support Phase 1 of Estates Strategy approved by Trust Board and submitted to NHSE/I & Dept. Health & Social Care for approval (27 May 2021).
- Rolling 5-year Capital Programme developed to capture future requirements
- 2021/22 Capital Programme approved by Trust Board included £5.8M for lifecycle & refurbishment, £4.5M for equipment and £3.9M for strategic developments
- £8.9M of additional capital secured in 2020/21

What are the current challenges?

- Reliance on availability on capital from NHSE to progress next phase of Estates Strategy
- Lack of progress in exploring and agreeing additional routes to capital
- Growing Backlog maintenance.

How are we managing and addressing the challenges?

- Work underway to define Phase 2 of Estates Strategy focussing on years 3 to 5, 5 to 10 and 10+
- Procurement process started to develop business case for Radiology Managed Equipment Service (MES)
- 6 Facet report-out due in May 2021 that will define scale of Critical Infrastructure Risk (CIR) and Backlog Maintenance

Action to be taken	Progress	Target Date	Closed Date
Finance strategy under development (KJ)	Update given to F&D on contents and timeline Due for Board sign off in Q1 2021/22.	Q1 2021/22	

Success Measures/KPIs (taken from Enabling Strategies / External assurance)		Performance/Rating	Updated
Strategic Site Development (SSD) Full Business Case		APPROVED	
Key Controls	**Assurances/Evidence**	**Gaps in Controls/Assurance & Action**	**Timescale**
1. Capital programme priorities informed by Trust and Divisional risk registers 2. Develop pre-emptive business cases in anticipation of national calls for capital bids 3. Operationalise GHFT Estates Strategy to produce a Development Control Plan 4. Develop Managed Equipment Service (MES) Business Case 5. £39.5M Strategic Site Development Programme (SSDP) 6. Investigate and develop alternative sources of capital funding	1. Capital programme update to Finance and Digital Committee and Trust Board 2. Progress on operationalising Estates Strategy reported to Estates Committee 3. MES business case to Finance & Digital Committee and Trust Board 4. Monitor and respond to national calls for capital bids 5. Use Estates Strategy and Development Control Plan to prioritise investment 6. All GHFT enabling strategies being approved by appropriate Board committees and then presented to Trust Board for assurance		

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 10 JUNE 2021
MS Teams

Report Title
TRUST STATEMENT ON MODERN SLAVERY
Sponsor and Author(s)
Author: Sim Foreman, Trust Secretary Sponsoring Director: Emma Wood, Deputy CEO and Executive Director of People
Executive Summary

Purpose

To provide an update on the Trust statement on Modern Slavery and seek APPROVAL from the Trust Board for the publication of the statement on the Trust website.

Key issues to note

There is a mandatory requirement for the Trust to have a public statement by the Board on our recognition of and work towards compliance with the Modern Slavery Act (2015) (the Act). The statement must be updated each financial year to reflect the organisations' ongoing commitment to its aims and requirements. Delays due to the pandemic meant that the Board approved the statement for the period to the end of March 2020 in February 2021 and this was published on the Trust's website.

The February 2021 update also provided ongoing assurance from relevant leads within Safeguarding, Procurement, Counter Fraud and HR teams that combatting and eradicating modern slavery is ongoing business as usual work.

Since the last update the Trust Secretary has again contacted relevant leads in the departments list above to seek confirmation on any matters that have arisen during the period from February to end of March 2021.

It was confirmed that there had been no specific actions or initiatives during 2019/20; the statement has been updated to provider greater assurance that this is very much a continuous element for the Procurement team. The updated statement is provided for approval by the Board and publication on the Trust's website.

Next Steps

Following approval, the updated statement will be posted on the Trust website.

Recommendations
The Board is asked to NOTE the ongoing work taking place across the Trust to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business and to APPROVE the updated statement for Board approval.
Impact Upon Strategic Objectives
Identification and eradication of modern slavery links to Outstanding Care (for patients), Compassionate Workforce (through safeguarding and training) and Effective estate (linked to the human and socio-economic elements of the supply chain).

Impact Upon Corporate Risks
Failure to meet and fulfil duties related to modern slavery could impact on ethical and reputational risk.
Regulatory and/or Legal Implications
The Trust has statutory duties and responsibilities under the Modern Slavery Act 2015 and failure to update the statement would be a breach of these.
Equality & Patient Impact
Applicable to the extent of providing public, patient and staff assurance about the Trust's practices and to ensuring patients suspected of being subjected to modern slavery are provided with the appropriate care, support and protection.

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

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

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
18 May 2021							
Outcome of discussion when presented to previous Committees/TLT							
The Audit and Assurance Committee recommended the statement for Board approval.							

TRUST STATEMENT ON MODERN SLAVERY

We fully support the Government's objectives to eradicate modern slavery and human trafficking.

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Trust (GHNHSFT) fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses.

Slavery and human trafficking statement for financial year 2020/21

During the last financial year the Trust took, and continues to take, the following steps to ensure that slavery and human trafficking is not taking place:

- We confirm the identities of all new employees and their right to work in the United Kingdom
- All staff are appointed subject to references, health checks, immigration checks and identity checks. This ensures that we can be confident, before staff commence duties, that they have a legal right to work within our Trust
- We have a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the selection process
- By adopting the national pay, terms and conditions of service, we have the assurance that all staff will be treated fairly and will comply with the latest legislation. This includes the assurance that staff received, at least, the national minimum wage from 1 April 2015
- We have various employment policies and procedures in place designed to provide guidance and advice to staff and managers but also to comply with employment legislation
- Our equality and diversity, grievance, respect and dignity at work for staff policies additionally give a platform for our employees to raise concerns about poor working practices
- Our policies and practices promote and support diversity and inclusion both as an employer and service provider; we recognise and acknowledge that diversity and inclusion are key corporate social responsibilities and a Diversity Network for all staff has been in place since 2017
- Our mandatory safeguarding training includes modern slavery as a topic; all clinical staff receive training as part of our Trust bespoke level 2 safeguarding adult e-learning training and also level 3 safeguarding adult training
- Our Trust "Safeguarding Adult at Risk Policy", and the countywide multi-agency safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery and we have produced communications materials to raise awareness amongst staff and anyone working on or otherwise attending our sites

- Our Freedom to Speak: Raising Concerns (Whistleblowing) Policy gives a platform for employees to raise concerns for further investigation, and our Freedom To Speak Up Guardian and Safeguarding teams actively ensure they are accessible to staff
- The Procurement Team work on the principle of zero tolerance of modern slavery in our supply chain. Our standard terms and conditions require suppliers to comply with relevant legislation and tender evaluations include Social Economic factors. A large proportion of the goods and services procured are sourced through Government supply frameworks and contracts also require suppliers to comply with relevant legislation
- We continue to work with our suppliers directly and via partners, such as NHS Supply Chain, to support initiatives related to modern slavery.

Review of effectiveness

The Trust will continue to take further steps to identify, assess and monitor potential risk areas in terms of modern slavery and human trafficking, particularly within supply chains. We aim to:

- Raise awareness and support our staff to understand and respond to modern slavery and human trafficking, and the impact that each and every individual working at our Trust can have in keeping present and potential future victims of modern slavery and human trafficking safe
- Ensure that all staff continue to have access to training on modern slavery and human trafficking which will provide the latest information and the skills to deal with it
- Embed Social Value best practice into commercial processes which will achieve improved Social Value awareness and compliance across all our commercial activities
- Impact assess all new or reviewed policies for diversity and inclusion compliance

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2021.

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 10 JUNE 2021
Via MS Teams commencing at 12:00

Report Title
Application of the Trust Seal Report
Sponsor and Author(s)
Author: Becky Smith, Corporate Governance Apprentice Sponsor: Sim Foreman, Trust Secretary
Executive Summary
Background The application of the Trust's seal to documents is reported to the Audit and Assurance Committee on a quarterly basis with a full report received annually at Board. The application of the Trust's seal to documents was last reported to the Board in April 2019. The 2020 report was deferred due to shortened agenda due to COVID-19. The recurrence of the Annual Trust Seal Report has been changed from September to follow the end of the financial year. Seals Applied Since the last report presented to the Board in April 2019, the Trust seal has been applied to the following documents: • April 2020 – Retail Unit at GRH • April 2020 – Lease of Cobalt House • February 2021 – Lease of 10 Pullman Court
Recommendations
The Board is asked to NOTE the applications of the Trust Seal as reported above.
Impact Upon Strategic Objectives
N/A
Impact Upon Corporate Risks
N/A
Regulatory and/or Legal Implications
Ensures compliance with statutory requirements.
Equality & Patient Impact
N/A

Resource Implications			
Finance		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 TLT							
Audit & Assurance Committee	**Finance and digital Committee**	**GMS Committee**	**People and OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
18 May 2021							
Outcome of discussion when presented to previous Committees/TLT							
The Audit and Assurance Committee NOTED the report.							

TRUST BOARD – JUNE 2021

APPLICATION OF THE TRUST SEAL REPORT

1. Background

The application of the Trust's seal to documents was previously reported to the Board monthly via an addition at the end of the Chief Executive's report. These are now reported to Audit and Assurance on a quarterly basis with a full report received annually at Board.

The last annual report was received at Main Board in April 2019.

2. Seals applied

Since the last Committee report (July 2019) and the Board report (April 2019), the Trust seal has been applied to the following documents:

- 09 April 2020: Retail Unit at GRH
- 15 April 2020: Lease of Cobalt House
- 23 February 2021: Lease of 10 Pullman Court

3. Recommendation

The Board is asked to NOTE the sealings.

Author: Sim Foreman, Trust Secretary

11 May 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO MAIN BOARD – JUNE 2021
From Audit and Assurance Committee Chair – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee on 18 May 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
Risk Assurance Report	Regular assurance report confirming: • Changes to register • No new risks • Location of each risk in terms of assurance Cttee oversight • Existing/planned mitigations and controls • Continued improvement in in risk KPIs • Some increased delays arising from movement of tasks to divisions.	• Does the register correctly capture risks concerning new cleaning standards especially in terms of Emergency Dept? • Does the fall in 7 day response KPI give rise for concern about divisional resource adequacy for the new responsibilities? • Why were risks around 8 hour ED waits discussed at Risk Management Group in April but not in May? • Re ED >8 hr waits and stroke care risks, is there any concern that these are taking too long to pass	Yes and further work taking place. Variability in divisional approach was discussed and on reflection the transfer of tasks to divisions could have been better planned. Relevant divisional input to correctly analyse the risk still in progress. Time is taken to correctly analyse complex risks in order to correctly identify	

		through our risk management governance arrangements. Are we sure that there are not delays around correct articulation of the risk. • Comment re lack of executive attendance and risk of loss of continuity between assurance committees (QandP) and the Risk Management Group	mitigations, but this does not lead to delays in action being taken.	Further consideration to take place at QandP Cttee Next Audit Cttee report to include commentary on levels of divisional compliance and consistency.
External Audit update	Update from Deloittes on good progress. Main areas emerging relate to VAT and management judgements and estimates. Areas for adjustment of financial statement were discussed. Positive feedback re relationship, responsiveness etc	Are there any specific concerns to be brought to the Cttee's attention? Discussion as to reason for reclassification of transactions related to junior doctors' training.	No, good progress was reported and a healthy level of challenge. Request from GMS FD for some specific matters to be discussed and progressed.	
Internal Audit update	Regular progress report to Committee. Confirmed good progress against 2020/21 audit plan for both Trust and GMS. Two audits to complete.	Discussion included: • Whether the plan had been reviewed by Exec to check for its relationship to Covid recovery intentions. • Recusc compliance	Yes and timing of hospital discharge audit altered following that review. Update provided on	

	Moderate assurance has been given for the Trust for the year in the internal auditor's annual report, which should be regarded positively after such a challenging year.	checks	completeness of checks	
Counter Fraud update	Regular report updating Cttee on a range of activities, training, national reporting etc Cttee was briefed on the annual Counter Fraud Functional Standards Return which will be reported to next cycle. Specific report discussed on **Security of patients' property** Need for improvements identified in terms of completeness of a policy and executive ownership		CEO confirmed responsibility will lie with Director of Nursing and Quality and that a review of policy and implementation will be brought back to the July Cttee.	
Annual Report and Accounts	Update confirmed good progress on both financials and text. Chair thanked colleagues for supporting a detailed review			

	meeting at which it was possible for NEDs to engage in the detail of the accounts with colleagues from Finance team.			

Claire Feehily
Chair of Audit and Assurance Committee
June 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – June 2021

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

This report describes the business conducted at the Estates and Facilities Committee held 27 May 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
GMS Chair's Report	The Trust has received a considerable amount of equipment from NHS national teams – there is a problem with storage.	How are these assets accounted for and who owns them (Trust or GMS)?	It was confirmed that these items should be treated as "non-cash donations".	
		Do we have any means to track them to ensure they are secure and accounted for?	There was an ICS-wide project looking at how to monitor and control portable assets.	Status report to come back to Committee on the progress of this work.
Contracts Management Group Exception Report	GMS performance is meeting or exceeding all contractual KPIs for Mar'21 with exception of two waste KPIs, which were due to lack of resource to write-up the reports. New portering service has gone live. CCTV enhancements have been implemented. For the PFI contract, a small number of urgent calls were not closed in contractual time, which were due to lack	Has the shadow reporting of performance against the new (2021/22) KPIs given any cause for concern for the new financial year?	There are no early warnings that there may be issues, so this year's performance will now be against the agreed new KPIs.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	of access to the areas and spare parts.			
Capital Programme	This report provided an overview of the capital projects activity undertaken by GMS through 20/21 financial year (a total of £18.5mln) and a look forward to the current capital programme confirmed by the Trust for 21/22.	Do GMS have the capacity and capability to deliver the extensive 21/22 programme, especially with some of the new technologies being installed?	GMS provided verbal assurance that they do have the capacity, but there needs to be good coordination with the Trust on scheduling. Sophisticated equipment will be installed by specialist contractors.	
		Do the projects agreed in the programme actually address the Estates and Facilities risks that were reviewed in the last meeting?	Capital programme against risks is reviewd by the IDG on an ongoing basis. There is also the intention for the Trust to review long-term (up to 5 years) plans against the Risk Register. The 6-facet survey results, due in June, will also provide intelligence on higher-risk areas of the estate.	
Green Plan	This was an interim report to explain that the Green Plan is currently in draft and is likely to come to Committee in July. The work is being overseen by the Trust's Green Council. There are 108 Green Champions and 10 activity streams based on the UN's			

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Sustainable Development Goals.			
GMS Business Plan 2021/22	The GMS Plan was first presented for approval to this Committee in March. Some changes were requested, and further approvals required. It has since been signed-off by the TLT and Finance & Digital Committee before coming back here.	Is the Plan a true reflection of what is required by the Trust – does it meet Trust's needs?	Assurance was provided by both GMS leaders and Trust Executives. The Plan address a number of legacy issues while also taking up opportunities for improvement.	.
Annual Review of Estates Return Information Collection (ERIC)	The report provided a commentary of the comparison between the GHFT ERIC data submitted by GHFT in September 2020, and the Model Hospital benchmarks for the GHFT Peer Group of Large Acute Hospitals. Of note are the movements in FM service costs closer to the benchmark for services delivered at GHFT, the improvement in energy costs for GHFT against the benchmark, the rising costs for waste disposal and that GHFT non-clinical space continues to drop in line with government targets.	While these are mandatory returns, it was questioned as to how useful the cost benchmarks are – for instance, reduced spend on maintenance is not necessarily a good thing.	It was agreed that these individual measures need to be approached with caution and balanced against other metrics and data points. They need to looked at in the light of other output measures.	
Input to Phase 2	A presentation was given on	The strategy needs to	It was acknowledged that	This will be the subject of a

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Estates Strategy	the next phase of the estates strategy (after the strategic site development), taking into account long-term requirements, backlog maintenance, critical infrastructure and buildings beyond their economic life.	take account of the trend towards greater digitalisation and virtual working, and the context of the ICS.	further work is required and this Committee will be consulted, as will the Board.	forthcoming Board Development session, possible in July or August.

Mike Napier
Chair of Estates and Facilities Committee
1 June 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 10 JUNE 2021
Microsoft Teams – Commencing at 12:30

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

Purpose

This report summarises the key highlights and exceptions in Trust performance for the May 2021 reporting period.

The Quality and Performance Committee (QPC) 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.

Number of falls per 1,000 bed days
The number of falls per 1000 bed days is now at 6.1, which is a decrease from a peak of 8.6 in January 2021. The most recent three month performance is showing an 18.5% improvement than the three months preceding it, highlight the impact the pandemic surge had on the number of falls. Divisions have been asked to provide updates to Quality Delivery Group (QDG) on their divisional falls improvement plans, to focus on where other factors are impacting on the number of falls such as repeat and follow up falls assessments not being completed, the number of patient moves and the staffing ratios.

Number of falls resulting in harm (moderate/severe)
All falls resulting in moderate or severe harm are presented at the rapid review panel each week and actions planned at ward level. Themes emerging include lack of risk assessments completed and the use of bed rails where not indicates, and these themes will feed in to the corporate and divisional falls improvement plans.

% of adult inpatients who have received a Venous thromboembolism (VTE) risk assessment
The newly reformed VTE Committee has had an initial set up meeting and will now establish a Terms of Reference and a safety improvement plan. The introduction of electronic prescribing and automatic capture of the data will support the improvement on VTE compliance from the consistent baseline data of 90% to the target of 95%, with the ability to audit and monitor in real time.

Number of unstageable pressure ulcers
All unstageable pressure ulcers are reviewed at the rapid review panel each week. Actions are agreed at ward level, and the most recent focus has been on supporting colleagues with the correct grading of pressure sores. Patient compliance and length of stay are key factors.

% C-section rate (planned and emergency)
The Maternity Improvement Group has been set up which reviews all quality metrics and improvement plans, which reports directly into QPC. At the most recent meeting it was agreed that the parameters for C section rate against which we report would be reviewed to

be in line with national metrics, and a review is currently underway with the Business Intelligence team to support benchmarking of data against other maternity units.

% Massive PPH > 1.5 litres
The service is in the process of analysing the audit data for PPH, and the findings and associated improvement plans will be reported one the audit is completed.

% of PALS concerns closed in five days
The % of PALS concerns closed in five days is currently at 81.6%, which remains below the target of 95%, due to the increase in the volume and complexity of the concerns received as we re-introduce a number of services. The FTC in place to support the team has been extended to ensure there is capacity and cover while we support the phased return of colleagues on sickness and maternity leave.

Friends and Family Test (FFT) data
Outpatients FFT positive score remains stable at above 94%, which it has been for the last six months.

The positive FFT score for Inpatients is currently amber, and has stayed consistent in Q4 2020/21 and into Q1 21/22. Divisional teams are setting up patient experience groups to identify key areas for improvement and lead projects using their FFT and PALS data. The national inpatient survey scores are expected in the summer and will support the work within divisions and also corporate plans to support inpatient experience improvement.

The positive FFT score for Emergency Department (ED) has decreased this month to 76.3%. The ED team have a patient experience action plan in place which is being reviewed incorporating FFT feedback and also the embargoed results of the National Urgent and Emergency Care Survey. There is a picker workshop planned to review the data in more depth on 1 June, and the team will be presenting the updated plan at June QDG.

Performance

There remains significant focus and effort from operational teams to support performance recovery and restoration and to maximise activity within existing resources.
In May 2021, the Trust performance against the 4hr A&E standard was 71.36%.

In respect of RTT, we are reporting 70% for May 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 (utilising prioritisation codes) within the capacity constraints.
Our performance against the cancer standard saw delivery in delivery for the two week standard at 94.7% (un-validated) for March. Cancer 62 day Referral to Treatment (GP referral) performance for April was 80% 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 COVID-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
NOTED and to be presented to Board for assurance.

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period April 2021

Presented at May 2021 QPC and June 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 April, 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 April was 64.55%, against the STP trajectory of 85.79%. The system did not meet the delivery of 90% for the system in April, at 78.28%.

The Trust did not meet the diagnostics standard for April at 15.11%. 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 94.5% in April but did not meet the standard for 62 day cancer waits at 80.2%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.61% (un-validated) in April, 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 2,721 in April. 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		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	61	57	88	78	166	140	152	166	333	286	262	362	316
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	5	1	36	21	42	95	440	336	219	382	237
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	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%	77.06%	77.82%	78.62%	80.00%	78.28%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.32%	85.37%	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%	85.79%
	Actual	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	68.82%	69.50%	69.77%	64.55%
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	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	68.84%	69.89%	68.23%	69.75%	69.61%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	156	366	694	1037	1233	1279	1285	1411	1602	2234	2679	3061	2721
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%
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	90.60%	99.10%	98.00%	96.50%	90.80%	95.20%	93.10%	91.60%	93.70%	90.10%	96.90%	97.00%	94.50%
2 week wait breast symptomatic referrals	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	87.90%	97.80%	95.70%	96.40%	95.90%	93.40%	97.10%	85.20%	91.80%	70.60%	98.70%	99.00%	93.60%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.00%	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	96.60%	96.00%	95.30%	98.10%	96.70%	96.40%	99.30%	99.30%	97.60%	97.70%	99.10%	98.60%	96.60%
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%	94.00%	97.00%	100.00%	100.00%	100.00%	100.00%	98.00%	98.10%	96.60%	99.30%	98.50%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	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	98.30%	96.70%	86.50%	83.00%	98.30%	97.30%	98.70%	94.70%	98.50%	97.40%	100.00%	95.20%	97.60%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	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	98.20%	92.60%	81.30%	78.90%	87.20%	96.20%	96.80%	96.80%	100.00%	93.90%	95.20%	93.60%	89.00%
Cancer 62 day referral to treatment (screenings)	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	90.90%	54.50%	60.00%	66.70%	77.80%	88.90%	100.00%	96.80%	100.00%	93.30%	91.70%	89.50%	84.10%
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	100.00%	88.90%	73.70%	91.70%	90.00%	91.70%	85.00%	70.80%	61.90%	59.40%	88.90%	73.30%	96.20%
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	78.00%	69.00%	78.00%	85.60%	87.60%	81.50%	84.60%	79.70%	84.80%	86.30%	81.10%	83.10%	80.20%

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	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	% growth Monthly (Apr)	% growth YTD
GP Referrals	3,076	3,946	3,185	8,119	7,784	8,181	8,746	7,679	6,937	6,713	6,895	8,457	8,215	167.1%	167.1%
OP Attendances	26,018	30,419	40,646	44,330	39,151	49,790	51,948	51,957	46,742	45,157	45,359	57,227	49,455	90.1%	90.1%
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	15,480	121.1%	121.1%
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	33,975	78.7%	78.7%
Day cases	1,473	1,786	2,721	3,467	3,109	4,414	4,586	4,396	3,972	3,266	3,140	4,269	4,058	175.5%	175.5%
All electives	1,780	2,183	3,252	4,242	3,965	5,366	5,640	5,275	4,599	3,603	3,569	4,869	4,906	175.6%	175.6%
ED Attendances	6,861	8,913	9,819	10,957	11,636	10,904	10,279	9,475	9,309	8,289	8,021	10,687	11,063	61.2%	61.2%
Non Electives	3,110	3,728	4,205	4,421	4,320	4,495	4,584	4,233	4,202	3,973	3,725	4,534	4,440	42.8%	42.8%

Trust Scorecard - Safe (1)

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

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission	1,395	250	64	9	5	4	18	48	224	193	444	112	29	3	585	3	No target	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	265	68	7	1	1	0	1	3	57	71	42	11	3	0	56	0	No target	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	192	38	1	2	1	0	0	0	55	48	41	5	1	0	47	0	No target	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	188	33	4	1	1	1	0	0	57	56	30	3	2	0	35	0	No target	
Number of trust apportioned MRSA bacteraemia	0	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	0	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	75	4	7	2	7	0	4	8	4	4	4	11	8	3	23	3	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	1	4	1	2	6	1	1	2	1	2	5	3	3	10	3	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	3	3	1	5	6	3	7	2	3	2	6	5	0	13	0	<=5	
Clostridium difficile – infection rate per 100,000 bed days	22.7	25.6	38.6	9.9	30.3		15.7	29.2	15.8	15.2	19.2	21.8	30.9	13.5	31.9	13.5	<30.2	
Number of MSSA bacteraemia cases	18	1	0	3	1	1	0	1	1	4	1	2	3	1	6	1	<=8	
MSSA – infection rate per 100,000 bed days	6.4	6.4		14.9	4.3	4		3.6	3.9	15.2	3.8	5.9	11.6	4.5	8	4.5	<=12.7	
Number of ecoli cases	30	1	3	2	4	3	0	6	3	1	2	3	2	4	7	4	No target	
Number of pseudomona cases	6	0	2	0	0	0	0	0	0	2	0	1	1	1	2	1	No target	
Number of klebsiella cases	12	1	2	0	1	1	1	0	1	0	3	0	2	2	5	2	No target	
Number of bed days lost due to infection control outbreaks	9		0	0	4	0	0	5					0	0		0	<10	>30

Trust Scorecard - Safe (2)

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	Zero	
Number of falls per 1,000 bed days	7.4	6	7.9	7.2	7	7.3	7.5	6.9	7.7	8.5	8.6	7.5	6.6	6.1	7.6	6.1	<=6	
Number of falls resulting in harm (moderate/severe)	53	2	4	4	3	4	3	6	6	5	4	6	6	4	16	4	<=3	
Number of patient safety incidents – severe harm (major/death)	58	4	1	5	2	7	4	5	6	7	4	3	10	7	17	7	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	No target	
Medication error resulting in moderate harm	35	2	3	2	6	1	2	1	1	1	6	6	4	2	16	2	No target	
Medication error resulting in low harm	134	9	15	7	8	14	14	9	15	8	14	10	11	11	35	11	No target	
Number of category 2 pressure ulcers acquired as in-patient	246	13	15	16	9	24	13	23	28	30	27	19	29	16	75	16	<=30	
Number of category 3 pressure ulcers acquired as in-patient	20	0	1	0	1	3	4	5	3	1	0	1	1	1	2	1	<=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	55	3	4	7	4	5	9	7	6	4	2	3	1	4	6	4	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	64	4	6	1	2	6	4	12	5	11	6	3	4	1	13	1	<=5	
RIDDOR																		
Number of RIDDOR	55	2	1	5	3	0	2	1	3	3	3	2	4	4	10	4	SPC	
Safeguarding																		
Number of DoLs applied for				41	59	38				45	32	46	29	54	107	54	No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures		1			18			9	6	7	0	7	3	2	10	2	No target	
Total attendances for infants aged < 6 months, other serious injury		17			30			3	1	0	0	0	1	1	1	1	No target	
Total admissions aged 0-18 with DSH		6			31			6	11	3	4	16	12	12	32	12	No target	
Total ED attendances aged 0-18 with DSH		26			55				51	31	36	32	32	46	100	46	No target	
Total number of maternity social concerns forms completed				48								50	62	68	112	68	No target	

Trust Scorecard - Safe (3)

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	71.00%			68.00%			74.00%			67.00%				70.00%		70.00%	>=90%	<50%
Serious Incidents																		
Number of never events reported	8	0	0	2	0	0	1	0	3	0	0	2	0	0	2	0	Zero	
Number of serious incidents reported	31	0	0	2	2	5	4	3	4	2	2	5	4	4	9	4	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	91.2%		90.1%	94.0%	93.8%	90.7%	87.0%	89.8%	94.6%	91.0%	90.4%	89.2%	92.2%	89.9%	90.7%	89.9%	>95%	

Trust Scorecard - Effective (1)

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	68.0%	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%		>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway	0.60%	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%		No target	
% C-section rate (planned and emergency)	29.44%	27.73%	28.82%	25.94%	26.51%	27.80%	31.13%	32.91%	28.09%	34.76%	28.12%	26.79%	31.67%	30.37%	29.16%	30.37%	<=27%	>=30%
% emergency C-section rate	15.56%	12.73%	15.27%	12.08%	12.73%	16.20%	15.14%	19.50%	15.73%	20.09%	15.65%	12.24%	17.71%	16.27%	15.41%	16.27%	No target	
% of women booked by 12 weeks gestation	92.8%	89.6%	93.1%	93.3%	93.0%	92.4%	95.0%	92.3%	95.4%	92.7%	94.2%	93.1%	93.6%	92.9%	94.0%	92.9%	>90%	
% of women that have an induced labour	31.42%	27.50%	28.60%	29.70%	35.49%	31.20%	32.41%	28.72%	32.58%	32.51%	33.91%	30.72%	30.63%	28.42%	31.89%	28.42%	<=30%	>33%
% stillbirths as percentage of all pregnancies > 24 weeks	0.39%	1.14%	0.00%	0.20%	0.42%	0.00%	0.21%	0.83%	0.68%	0.22%	0.25%	0.23%	0.62%	0.00%	0.38%	0.00%	<0.52%	
% of women smoking at delivery	10.90%	9.55%	10.97%	11.29%	9.39%	13.80%	11.30%	12.58%	11.24%	11.06%	8.80%	9.24%	10.21%	9.54%	9.49%	9.54%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	58.0%	61.1%	56.4%	57.8%	57.1%	57.8%	51.7%	59.4%	56.2%	58.5%	60.2%	56.7%	54.0%	58.3%	54.0%		
% breastfeeding (initiation)	79.9%	79.7%	81.4%	76.1%	80.5%	79.7%	77.5%	76.6%	80.8%	80.4%	81.1%	83.1%	82.4%	81.0%	82.2%	81.0%	>=81%	
% Massive PPH >1.5 litres	4.4%	3.9%	4.7%	5.9%	4.8%	3.7%	5.8%	3.8%	4.3%	4.5%	3.9%	2.5%	5.2%	5.9%	4.0%	5.9%	<=4%	
Number of births less than 27 weeks	19	2	0	2	0	0	2	1	3	2	2	1	3	2	6	2	No target	
Number of births less than 34 weeks	104	6	12	5	6	10	9	8	8	16	6	7	10	7	23	7	No target	
Number of births less than 37 weeks	379	30	41	33	30	43	29	38	21	34	23	27	29	28	79	28	No target	
Number of maternal deaths	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	No target	
Total births	5,570	438	473	511	481	497	472	482	443	445	408	437	483	463	1,328	463	No target	
Percentage of babies <3rd centile born > 37+6 weeks	1.7%											1.8%	1.0%	2.3%	1.6%	2.3%	No target	

Trust Scorecard - Effective (2)

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.0	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)	107.9	111.3	110.7	107.1	104.6	105.1	104.7	103.9	105.2	108.2	107.9						Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	111.7	117.4	117.5	114.4	110.8	108.8	107.4	105.5	108.9	109.8	111.7						Dr Foster	
Number of inpatient deaths	2,036	252	126	112	120	143	147	142	182	245	278	160	129	145	567	145	No target	
Number of deaths of patients with a learning disability	19	4	2	0	1	3	4	1	1	1	2	1	0	2	3	2	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	8.0%	9.5%	8.5%	7.2%	7.9%	8.5%	7.4%	7.8%	8.0%	7.7%	9.0%	8.2%	7.9%		8.3%		<8.25%	>8.75%
Research																		
Research accruals	4,152	1,079	633	54	126	350	629	461	578	382	177	110	220	198	507	198	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	53.2%	37.0%	53.0%	45.0%	63.5%	60.9%	52.9%	46.6%	54.7%	51.7%	56.1%	62.5%	54.4%	53.5%	58.6%	53.5%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	83.5%	88.5%	78.0%	84.0%	95.1%	89.7%	96.9%	81.3%	87.5%	90.1%	84.6%	88.4%	85.0%				>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	45.00%	49.00%	21.00%	65.00%	74.50%	50.70%	51.60%	34.50%	36.50%	16.10%	24.40%	38.80%	49.20%	37.00%	37.50%	37.00%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	68.00%	68.00%	76.00%	65.00%	78.60%	59.30%	62.70%	63.50%	64.70%	70.60%	71.80%	74.60%	60.70%	63.20%	69.00%	63.20%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	69.0%	75.0%	62.4%	72.7%	56.7%	71.9%	63.6%	60.7%	85.1%	77.0%	75.8%	61.5%	64.1%	84.4%	67.1%	84.4%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	66.00%	53.10%	60.60%	70.91%	56.70%	70.20%	62.10%	58.80%	83.00%	73.00%	75.80%	61.50%	64.10%	84.40%	67.10%	84.40%	>=65%	<55%

Trust Scorecard - Caring (1)

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	90.0%	90.2%	91.9%	87.0%	86.0%	88.7%	86.4%	85.7%	84.8%	89.7%	89.4%	89.6%	88.3%	89.6%	88.3%	>=90%	<86%
ED % positive	81.4%	90.2%	85.8%	86.8%	81.8%	77.2%	73.0%	75.4%	83.7%	77.6%	87.2%	83.9%	77.5%	76.3%	83.0%	76.3%	>=84%	<81%
Maternity % positive	92.9%	97.2%	100.0%	90.2%	100.0%	85.2%	93.9%	88.9%	88.4%	96.7%	98.6%	92.9%	92.6%	96.2%	95.2%	96.2%	>=97%	<94%
Outpatients % positive	94.0%	94.0%	93.6%	93.9%	93.7%	93.5%	92.8%	94.0%	94.1%	94.2%	94.7%	94.7%	94.5%	94.4%	94.6%	94.4%	>=94.5%	<93%
Total % positive	91.8%	92.9%	91.8%	92.4%	91.3%	90.0%	90.1%	91.7%	92.2%	91.9%	93.2%	92.9%	92.1%	91.5%	92.7%	91.5%	>=93%	<91%
Number of PALS concerns logged	2,394						273	312	227	163	137	204	262	256	597	256	No Target	
% of PALS concerns closed in 5 days	79%						73%	75%	81%	82%	86%	86%	83%	82%	84%	82%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	6	13	21	23	1	0	0	0	0	2	0	1	0	3	0	<=10	>=20

Trust Scorecard - Responsive (1)

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait	75.1%	53.9%	79.6%	77.9%	79.9%	79.4%	76.1%	77.1%	78.3%	77.8%	76.3%	75.2%	78.0%	80.2%	75.7%	80.2%	No target	
Cancer – 28 day FDS breast symptom two week wait	97.1%	91.4%	95.7%	98.6%	99.1%	80.6%	98.3%	77.1%	95.4%	77.8%	97.9%	96.8%	100.0%	98.6%	98.0%	98.6%	No target	
Cancer – 28 day FDS screening referral	72.3%	76.0%	50.0%	76.9%	100.0%	78.6%	65.4%	77.1%	61.8%	77.8%	52.8%	82.6%	86.5%	82.0%	75.9%	82.0%	No target	
Cancer – urgent referrals seen in under 2 weeks from GP	94.7%	90.6%	99.1%	98.0%	96.5%	90.8%	95.2%	93.1%	91.6%	93.7%	90.1%	96.9%	97.0%	94.5%	94.9%	94.5%	>=93%	<90%
2 week wait breast symptomatic referrals	92.5%	87.9%	97.8%	95.7%	96.4%	95.9%	93.4%	97.1%	85.2%	91.8%	70.6%	98.7%	99.0%	93.6%	90.7%	93.6%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	97.9%	96.6%	96.0%	95.3%	98.1%	96.7%	96.4%	99.3%	99.3%	97.6%	97.7%	99.1%	98.6%	96.6%	98.3%	96.6%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.4%	100.0%	100.0%	94.0%	97.0%	100.0%	100.0%	100.0%	100.0%	98.0%	98.1%	96.6%	99.3%	98.5%	98.9%	98.5%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.2%	98.2%	92.6%	81.3%	78.9%	87.2%	96.2%	96.8%	96.8%	100.0%	93.9%	95.2%	93.6%	89.0%	95.5%	89.0%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	98.0%	98.3%	96.7%	86.5%	83.0%	98.3%	97.3%	98.7%	94.7%	98.5%	97.4%	100.0%	95.2%	97.6%	98.8%	97.6%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	83.3%	78.0%	69.0%	78.0%	85.6%	87.6%	81.5%	84.6%	79.7%	84.8%	86.3%	81.1%	83.1%	80.2%	83.8%	80.2%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	90.8%	90.9%	54.5%	60.0%	66.7%	77.8%	88.9%	100.0%	96.8%	100.0%	93.3%	91.7%	89.5%	84.1%	90.3%	84.1%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	83.0%	100.0%	88.9%	73.7%	91.7%	90.0%	91.7%	85.0%	70.8%	61.9%	59.4%	88.9%	73.3%	96.2%	79.3%	96.2%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	4	8	8	21	2	3	3	1	0	3	0	0	2	3	2	Zero	
Number of patients waiting over 104 days without a TCI date	269	33	79	66	38	15	8	8	9	13	14	14	12	14	34	14	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	41.95%	43.43%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	19.48%	15.11%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	1,969	1,035	1,230	1,367	1,465	1,569	1,648	1,665	1,772	1,949	1,969	1,946	1,919	1,773	1,945	1,773	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	58.1%	55.4%	57.8%	60.1%	60.0%	57.5%	61.2%	60.7%	58.3%	52.3%	53.5%	59.4%	58.8%		57.2%		>=88%	<75%

Trust Scorecard - Responsive (2)

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	75.11%	87.46%	85.41%	85.06%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	68.82%	69.50%	69.77%	64.55%	69.39%	64.55%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	83.18%	89.93%	88.72%	89.94%	90.05%	83.26%	82.34%	80.21%	79.64%	77.06%	77.82%	78.62%	80.00%	78.28%	79.03%	78.28%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	98.98%	95.42%	96.43%	98.93%	99.85%	99.91%	99.95%	99.84%	99.94%	99.88%	99.92%	100.00%	99.52%	99.73%	99.77%	99.73%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	73.95%	84.28%	80.59%	84.01%	84.46%	73.53%	71.74%	68.96%	69.40%	65.43%	68.82%	69.50%	69.77%	64.55%	69.39%	64.55%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	168	0	0	0	0	1	0	0	14	36	95	21	1	0	117	0	Zero	
ED: % of time to initial assessment – under 15 minutes	66.0%	80.4%	77.0%	72.7%	72.5%	63.7%	61.3%	66.9%	66.5%	61.3%	64.5%	62.4%	48.8%	54.6%	57.6%	54.6%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	42.6%	68.0%	57.5%	52.0%	44.5%	31.4%	30.9%	38.1%	41.8%	40.8%	48.9%	44.2%	27.8%	26.6%	39.1%	26.6%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	5.00%	2.09%	1.74%	2.57%	2.04%	4.17%	3.67%	3.95%	4.59%	8.70%	8.14%	8.06%	9.82%	8.61%	8.71%	8.61%	<=2.96%	
% of ambulance handovers that are over 60 minutes	3.67%	0.00%	0.00%	0.15%	0.03%	0.90%	0.55%	1.09%	2.63%	11.50%	9.57%	6.74%	10.36%	6.45%	8.97%	6.45%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	-120.00%	100.00%	100.00%	94.00%	86.67%	94.74%	95.83%	90.50%	78.30%	14.30%	76.50%	92.30%	92.00%	69.40%	92.00%	>=95%	
Urgent cancelled operations	66	0	0	0	11	2	10	7	4	14	4	3	3	0	10	0	No target	
Number of patients stable for discharge	54	14	33	45	66	68	72	99	84	71	118	136	110	112	121	112	<=70	
Number of stranded patients with a length of stay of greater than 7 days	329	204	213	248	288	332	325	379	392	417	403	380	366	353	383	353	<=380	
Average length of stay (spell)	5.04	5.22	4.49	4.54	4.69	4.66	4.78	4.86	4.79	5.57	6.25	5.62	5.26	4.72	5.67	4.72	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.46	5.37	4.75	4.81	5.13	5.15	5.34	5.44	5.43	6.04	6.42	5.95	5.59	5.23	5.96	5.23	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.61	3.74	2.2	2.64	2.47	2.32	2.47	2.59	2.12	2.87	4.38	2.99	2.91	2.31	3.14	2.31	<=3.4	>4.5
% day cases of all electives	83.98%	82.75%	81.81%	83.67%	81.73%	78.41%	82.26%	81.28%	83.34%	86.37%	90.65%	87.98%	87.68%	82.72%	88.66%	82.72%	>80%	<70%
Intra-session theatre utilisation rate	88.30%	91.80%	87.60%	84.05%	87.30%	88.60%	86.70%	85.70%	87.70%	77.40%	79.30%	84.40%	88.30%	90.40%	84.00%	90.40%	>85%	<70%

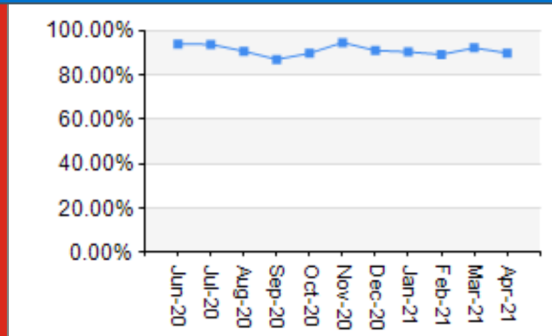
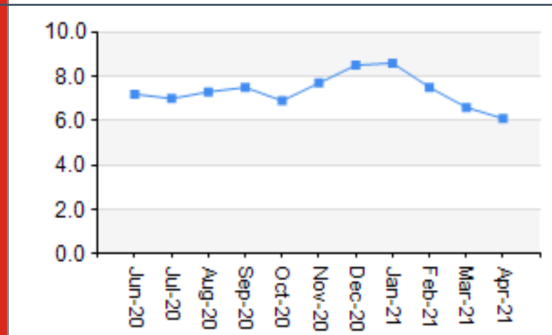
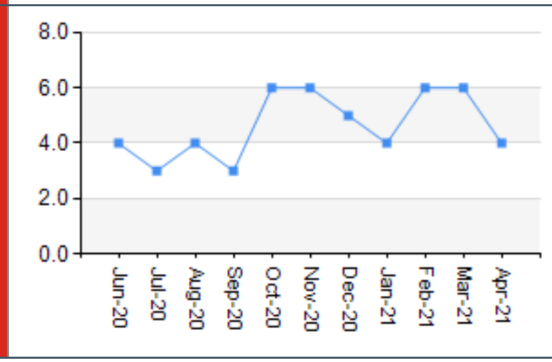
Trust Scorecard - Responsive (3)

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.09	2.49	2.32	2.28	2.03	1.99	1.94	1.88	1.96	2.15	2.14	2.22	2.08	2.07	2.14	2.07	<=1.9	
Did not attend (DNA) rates	5.80%	4.20%	4.30%	4.70%	5.50%	6.20%	6.50%	6.30%	6.30%	6.50%	6.50%	5.80%	5.70%	5.90%	6.00%	5.90%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.55%	73.61%	66.53%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	68.84%	69.89%	68.23%	69.75%	69.61%	69.28%	69.61%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,347	2,719	3,794	4,967	6,226	7,155	7,748	8,404	8,352	7,256	6,628	6,534	6,474	6,651	6,545	6,651	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,887	707	1,197	1,768	2,172	2,724	3,084	3,253	3,035	3,854	4,787	4,374	3,747	3,642	4,303	3,642	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,420	156	366	694	1,037	1,233	1,279	1,285	1,411	1,602	2,234	2,679	3,061	2,721	2,658	2,721	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)	127	0	2	5	17	57	77	86	111	163	243	309	459	612	337	612	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	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%		>=99%	
Percentage of records submitted nationally with valid NHS number	99.9%	99.8%	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%	

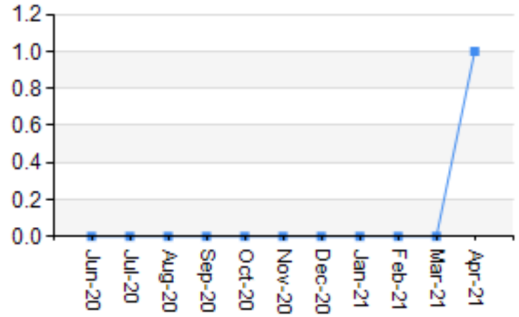
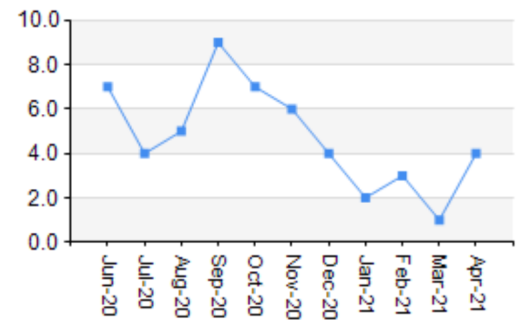
Trust Scorecard - Well Led (1)

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	20/21 Q4	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	85.0%	85.0%	78.0%	80.0%	82.0%	84.0%	83.0%	83.0%	82.0%	80.0%	80.0%	83.0%	85.0%	83.0%		>=90%	<70%
Trust total % mandatory training compliance	90%	90%	90%	90%	91%	91%	94%	93%	93%	93%	93%	92%	90%	91%	90%		>=90%	<70%
Finance																		
Total PayBill Spend		32.5	33.8	34.3	33.2	33.9	34.7											
YTD Performance against Financial Recovery Plan		0	-0.1	0	0	0	0											
Cost Improvement Year to Date Variance		0	0	0														
NHSI Financial Risk Rating		3	3	3														
Capital service		3	3	3														
Liquidity		4	4	4														
Agency – Performance Against NHSI Set Agency Ceiling		3	3	3														
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	94.80%			90.52%	100.77%	102.10%	93.82%	96.30%	94.90%	90.64%	90.88%	95.00%	93.10%		92.88%		>=75%	<70%
% registered nurse day	94.40%			89.23%	100.82%	101.90%	93.04%	95.49%	94.40%	91.04%	93.76%	93.10%	90.71%		91.11%		>=90%	<80%
% unregistered care staff day	105.00%			110.83%	120.86%	117.50%	106.50%	101.36%	102.40%	93.42%	99.20%	95.50%	101.28%		97.31%		>=90%	<80%
% registered nurse night	96.60%			92.99%	100.69%	102.60%	95.27%	97.77%	95.90%	89.93%	94.75%	98.20%	97.31%		95.97%		>=90%	<80%
% unregistered care staff night	113.30%			112.80%	131.01%	131.70%	114.61%	113.36%	112.00%	97.48%	99.23%	113.20%	108.91%		106.75%		>=90%	<80%
Care hours per patient day RN	5.7			6.2	5.8	5.6	5.2	5.2	5.7	5.4	6.1	6.4	5.9		6.1		>=5	
Care hours per patient day HCA	3.8			4.5	4.2	3.9	3.5	3.4	3.7	3.5	3.9	4	3.8		3.9		>=3	
Care hours per patient day total	9.5			10.8	10.1	9.5	8.6	8.6	9.4	8.9	10.1	10.3	9.7		10		>=8	
Vacancy and WTE																		
% total vacancy rate				5.97%	5.14%	7.10%	5.26%	5.74%	6.03%	5.99%	5.57%	4.36%	4.75%	4.30%			<=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%	1.38%			<=5%	>5.5%
% vacancy rate for registered nurses				8.12%	8.44%	8.90%	10.01%	7.76%	9.06%	8.70%	8.80%	5.08%	7.92%	7.24%			<=5%	>5.5%
Staff in post FTE		6421.87	6549.97	6573.86	6485.99	6463.25	6548.39	6557.43	6551.18	6546.28	6560.89	6666.58	6653.99	6678.31			No target	
Vacancy FTE				416.06	358	494.04	365.97	399.63	420.14	417.44	409.32	286.96	330.61	298.88			No target	
Starters FTE		32.81	30.05	57.65	49.45	62.46	151.56	73.19	46.87	52.85	50.64	48.84	67.2	86.69			No target	
Leavers FTE		43.37	46.93	38.57	96.43	106.66	66.41	76.11	68.76	40.52	50.03	34.82	45.79	36			No target	
Workforce Expenditure and Efficiency																		
% turnover		10.8%	10.9%	10.4%	10.2%	10.3%	10.3%	9.6%	10.1%	9.5%	9.5%	9.5%	9.2%	9.2%			<=12.6%	>15%
% turnover rate for nursing		10.59%	10.72%	10.14%	9.98%	10.34%	10.10%	9.41%	10.23%	9.61%	9.83%	9.83%	9.86%	8.88%			<=12.6%	>15%
% sickness rate		3.8%	3.8%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.7%			<=4.05%	>4.5%

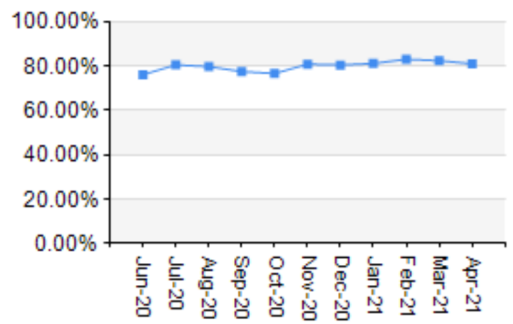
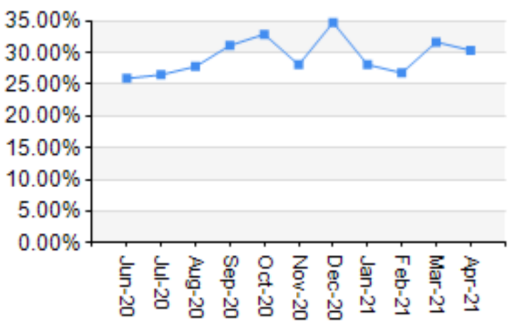
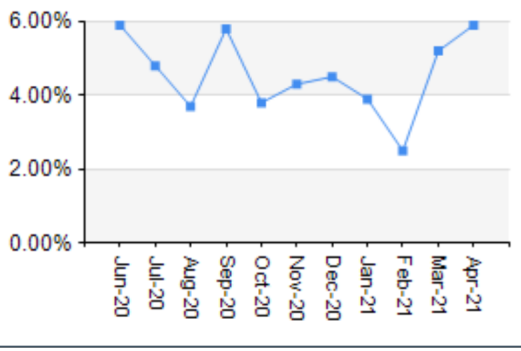
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment Standard: >95%		The newly reformed VTE Committee has had one set up meeting and will now establish TOR and a safety improvement plan. Progress on VTE compliance will only significantly improve from the consistent baseline data of 90% to the target of 95% with electronic prescribing and automatic capture of the data	**Quality Improvement & Safety Director**
Number of falls per 1,000 bed days Standard: <=6		The number of falls per 1000 bed days is now at 6.1 from a peak of 8.6 in January 2021. There has been a decrease since then. The previous 3 month performance is 18.5% better than the 3 month period preceding it. This indicates a pandemic surge effect on the number of falls. Other factors are repeat and follow up falls assessments not being completed, staffing ratios not at 60:40 RN to HCA and the number of moves.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls resulting in harm (moderate/severe) Standard: <=3		All falls resulting in moderate or severe harm are presented at the rapid review panel each week and actions planned at ward level. Themes are lack of risk assessment completed and use of bed rails when not indicated.	**Associate Chief Nurse, Director of Infection Prevention & Control**

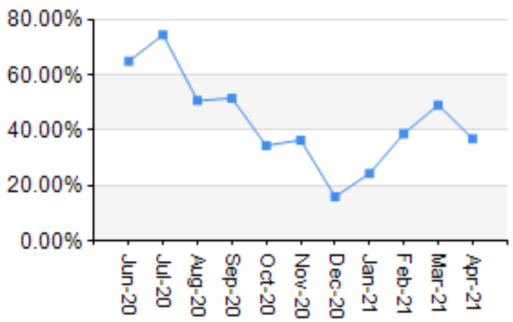
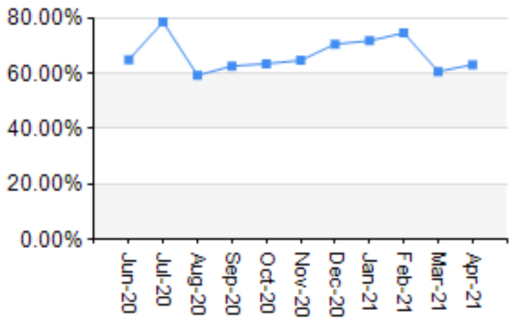
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patient safety alerts outstanding **Standard: Zero**		The Safety alert that is outstanding involves the tracking of patients on high dose steroids. A potential electronic alert on TrakCare is being developed but implementation will take longer than anticipated. Internal safety alerts will be issued. The aim is to design a more permanent solution into the electronic prescribing system over the next 12months. The Medicines Management Committee are overseeing the implementation.	**Quality Improvement & Safety Director**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		All unstageable pressure ulcers are reviewed at the rapid review panel each week. Actions are agreed at ward level. A focus has been on correct grading of pressure sores. Patient compliance and length of stay are factors.	**Associate Chief Nurse, Director of Infection Prevention & Control**

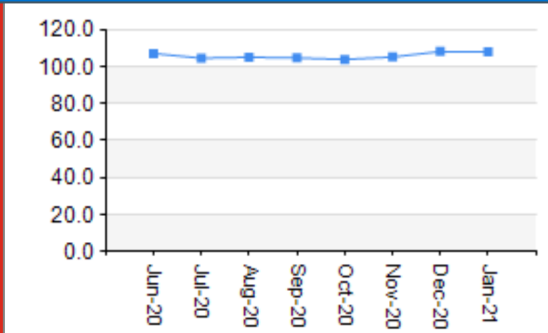
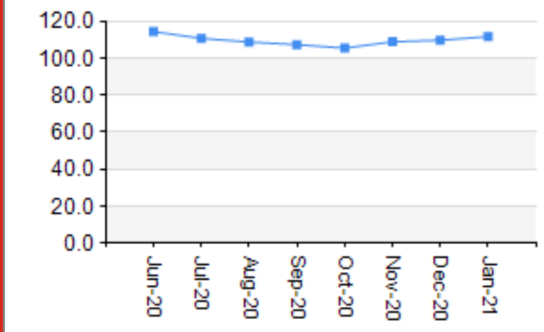
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) Standard: >=81%		Breastfeeding Target = 81%. Achieved 80.99% for April, which if rounded up is 81%, so have actually met target.	**Divisional Director of Quality and Nursing and Chief Midwife**
% C-section rate (planned and emergency) Standard: <=27%		At the Maternity Improvement Group we agreed to re-assess the parameters against which we report to ensure that they are in line with national metrics. A meeting has been set up for the Business Intelligence team to evaluate what metrics are being used for the National Maternity Report and how we compare with other maternity units.	**Divisional Director of Quality and Nursing and Chief Midwife**
% Massive PPH >1.5 litres Standard: <=4%		The service is still in the process of analysing the audit data for PPH. Findings will be reported once audit complete.	**Divisional Director of Quality and Nursing and Chief Midwife**

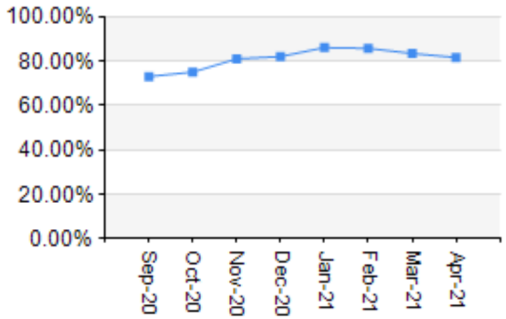
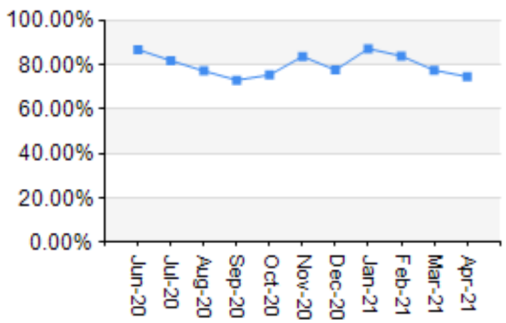
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=75%**		Deterioration of 12.2% on March (49.2%). 4 patients were delayed due to lack of HASU beds (shared space with Cardiology) 14 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 4 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 0 patients had an unknown breach reason listed 0 patients were either COVID positive or COVID exposed and therefore could not be placed on HASU 0 patient was already an inpatient 0 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**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=75%**		Improvement of 2.50% on March performance (60.70%). 4 patients were delayed in receiving a bed on the Stroke Unit and therefore had a delayed swallow screening. 14 patients were delayed due to an unclear diagnosis which led to them initially being admitted to AMU for further tests. 5 patients were too unwell to receive a swallow screen within the four hour target. 0 patient had an unknown breach reason listed 0 patient was already an inpatient on another ward at the time of the stroke 0 patient was COVID positive and unable to be safely screened within target 4 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**

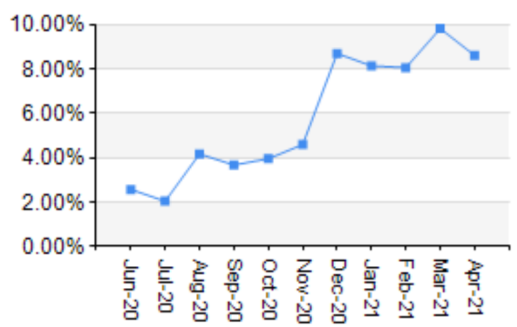
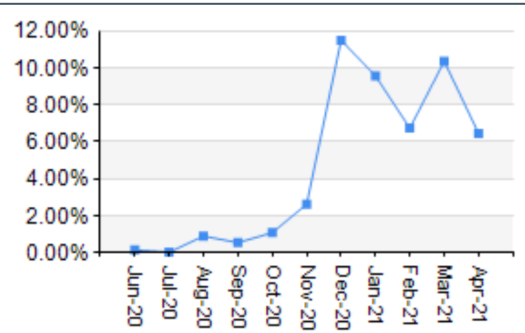
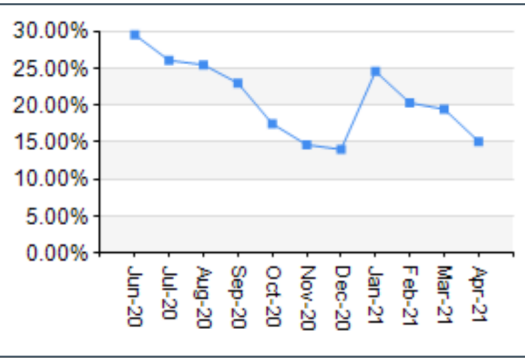
Exception Reports - Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**		This has increased in January again and as described before this reflects COVID activity. Dr Fosters data shows that if you exclude COVID activity there is no increase in mortality rate in the trust. The HSMR is not able to standardize for COVID, it compares it to a normal viral pneumonia which is known to have a much lower expected mortality	**Medical Division Audit and M&M Lead**
Hospital standardised mortality ratio (HSMR) – weekend **Standard: Dr Foster**		This has increased in January again and as described before this reflects COVID activity. Dr Fosters data shows that if you exclude COVID activity there is no increase in mortality rate in the trust. The HSMR is not able to standardize for COVID, it compares it to a normal viral pneumonia which is known to have a much lower expected mortality	**Medical Director**

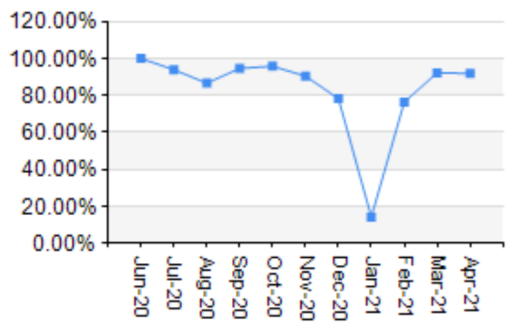
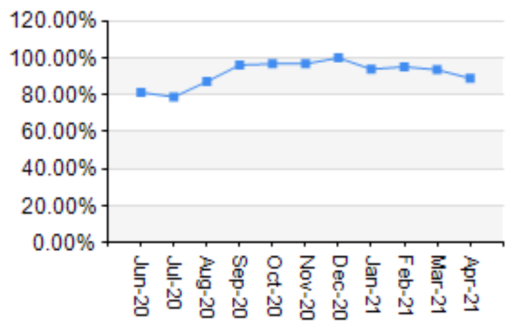
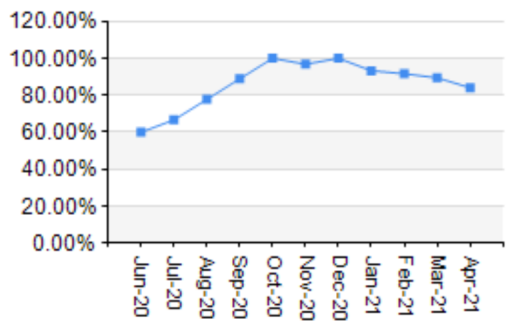
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		% of PALS concerns closed within 5 days remains below the target of 95% at 81.6%, as the team have seen increased volume and complexity of calls as we are reintroducing services (as well as colleagues on maternity and sick leave). The Deputy Chief Nurse and Deputy Director of Quality is supporting extending the FTC of PALS advisors to support the team in being able to ensure capacity is maintained while colleagues on maternity/sickness absence have a phased return to the team. We anticipate this % closure within 5 days improving over the coming months with colleagues returning and capacity increasing within the team.	**Head of Quality**
ED % positive **Standard: >=84%**		The positive FFT score for ED has decreased this month; the team have a patient experience action plan which is being reviewed, incorporating FFT feedback and also the embargoed results of the national urgent and emergency care survey. There is a Picker workshop planned to review the data in more depth on 1 June, and the team will be presenting the updated plan to QDG in June	**Head of Quality**

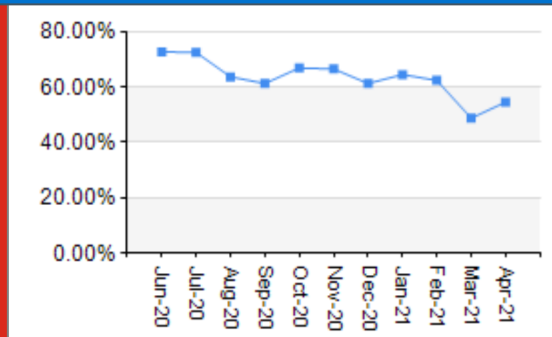
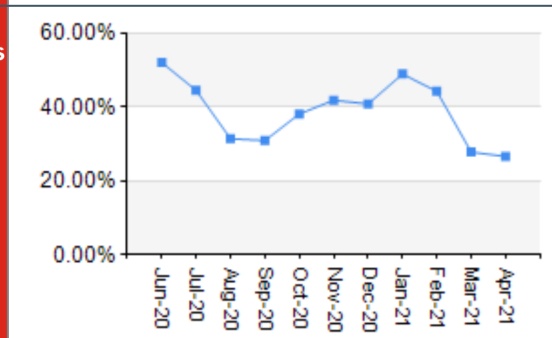
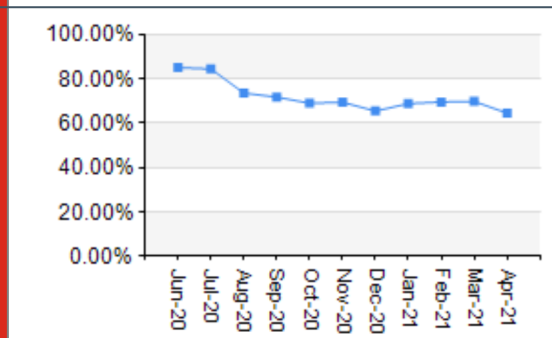
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		A reduction of 46 ambulance handover delays over 30 minutes in April, from 362 to 316. This still remains high but has significantly reduced further in May.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		A reduction of 145 ambulance handover delays over 60 minutes in April, from 382 to 237. This still remains high but has significantly reduced further in May.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% waiting for diagnostics 6 week wait and over (15 key tests) **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**

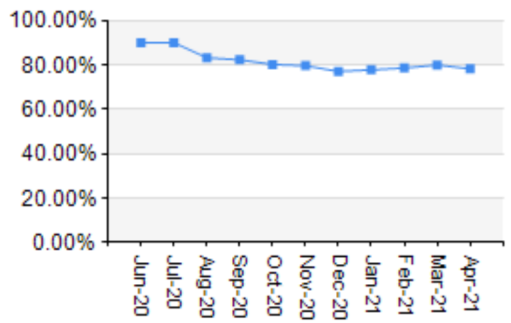
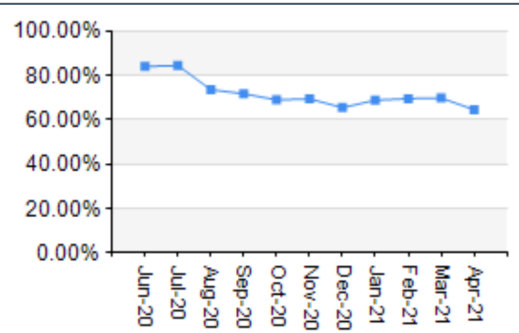
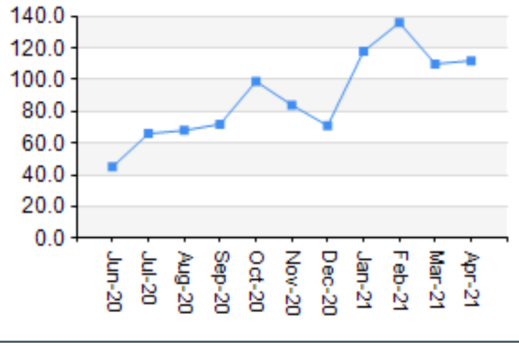
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In March 4 patients were cancelled on the day that could not be rescheduled within 28 days. This included 2 Cardiology patients, 1 Gastroenterology and 1 Vascular.	**Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		31 day subs surgery performance (unvalidated) = 91.6% target = 94% National performance = 86.4% 83 treatments 7 breaches 5 breaches relating to RALP procedures. GLANSO lists running in May and June to reduce waiting times Annual performance still above target - 95.6%	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (screenings) **Standard: >=90%**		62 day screening performance (unvalidated)= 84.1% target = 90% National performance = 75.1% 5 breaches on Bowel screening/LGI pathway. 3 related to covid (1 c19 postive and 2 covid delays) 2 breaches related to patient requiring multiple tests. Annual performance now currently meeting the standard with 90.8%	**Director of Planned Care and Deputy Chief Operating Officer**

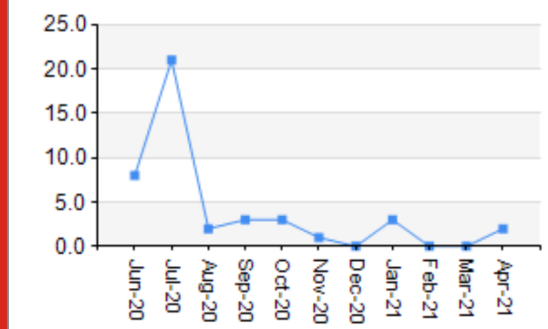
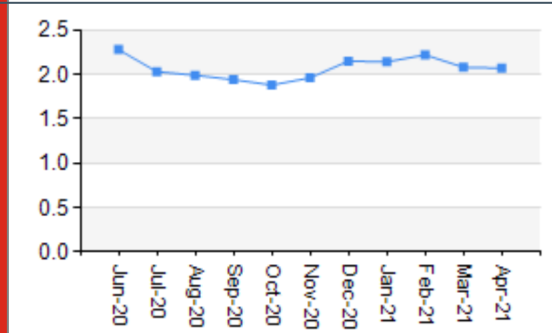
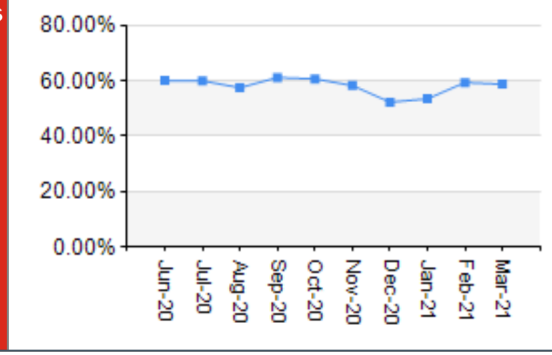
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Average time to initial assessment (15 minutes) has improved in April for both patients attending by ambulance and walk in patients. Ambulance arrivals were assessed on average within 19.5 minutes of arrival, an improvement of 5.5 minutes. Walk-in patients were assessed on average at 25.3 minutes which is an improvement of 4 minutes.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Average time to treatment has increased in April compared to March by an average of 9 minutes across the Trust. The biggest increase has been seen at CGH which has increased by an average of 14 minutes to 61 minutes in total.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		ED 4-hour performance has decreased in April to 64.55%. The average total wait in ED has increased by an average of 11.8 minutes compared to March. Attendances have also increased significantly in month.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

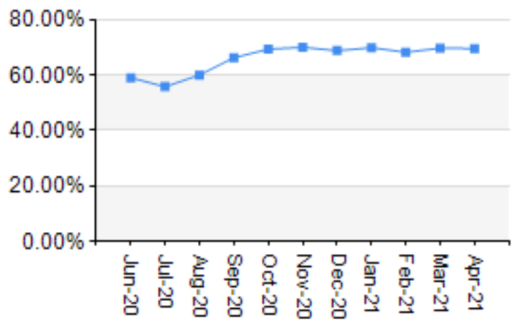
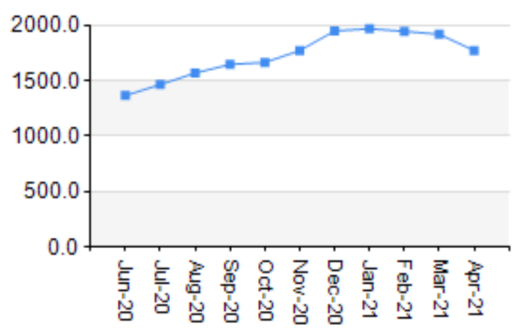
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		ED 4-hour performance has decreased in April to 78.28%. The average total wait in ED has increased by an average of 11.8 minutes compared to March. Attendances have also increased significantly in month.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		ED 4-hour performance has decreased in April to 64.55%. The average total wait in ED has increased by an average of 11.8 minutes compared to March. Attendances have also increased significantly in month.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		Ongoing system work on patients flow supported by ECIST. Cyclic improvements which see significant improvements but are then not sustainable due to community capacity. This has led the MOFD numbers to swing from between 60 - 120. This work has identified need for a single coordinated approach to community based care for both discharge and admission avoidance, also identifying a clear gap in the capacity of the home first model to manage the numbers of discharges now being referred.	**Head of Therapy & OCT**

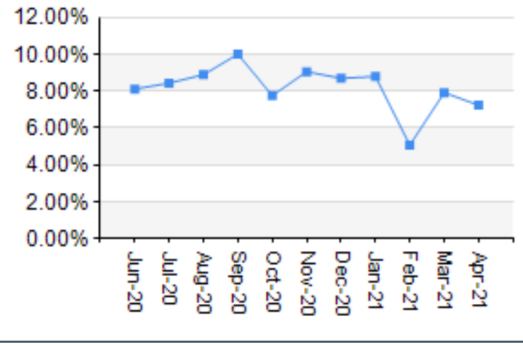
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Specialty TCI recorded Urological 2 Grand Total 2	**Director of Planned Care and Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **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.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		There has been no significant improvement with this metric. As of this month Doctors handover has gone live on sunrise EPR, this will hopefully provide a focus on expected discharge dates and may help improve it. However it will be unlikely to reach the target until the discharges are done on Sunrise which is some way off	**Medical Director**

Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **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 increased together with theatre availability (with normal timetables having resumed on 12th April). Performance remains relatively consistent with previous months and in line with many other Trusts nationally, with a part validated position for April being 69.61% and anticipated to be 69.9% 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 **Standard: <=600**		DM01 target was failed for Endoscopy due to a lack of capacity to balance all demand coming into the Endoscopy service; including 2WW, treatments, 6WW, planned surveillance From 1st April, the service has safely resumed its pre-COVID number of points per list, where previously it has been restricted by infection control and flow concerns. Endoscopy has a clear plan on how to recover the remaining patients within the breach cohort and is making significant progress against this target each month.	**Medical Director**

Exception Reports - Well Led (1)

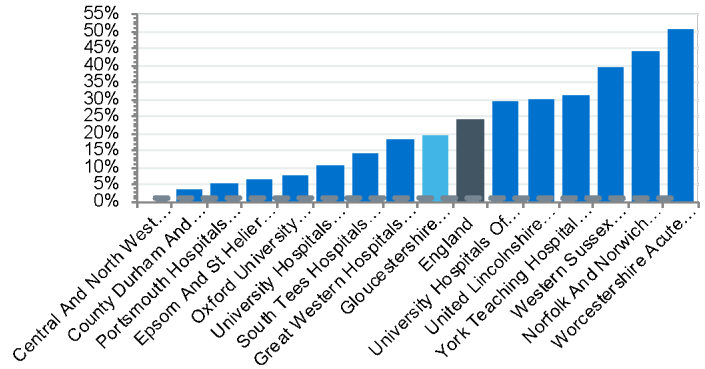
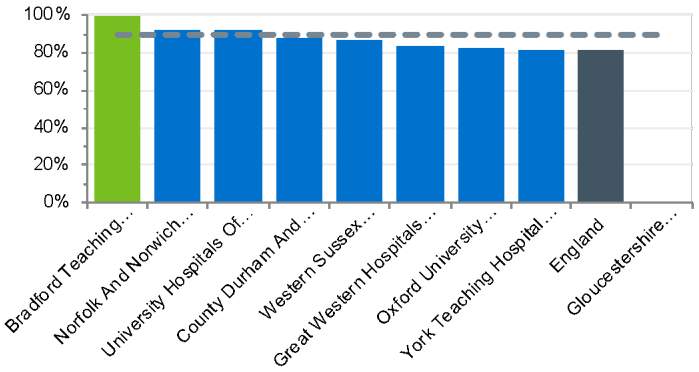
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		Recruitment to registered nurse vacancies remains a priority, with active overseas pipelines. Work has been completed to ensure that we can offer our incoming overseas Nurses safe accommodation in which to quarantine, with support from the Trust onboarding team	**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

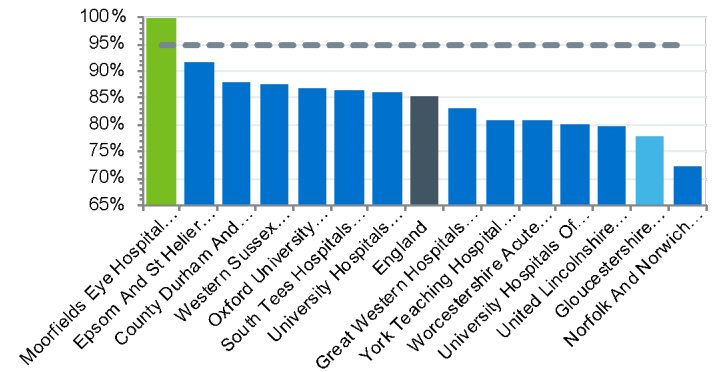
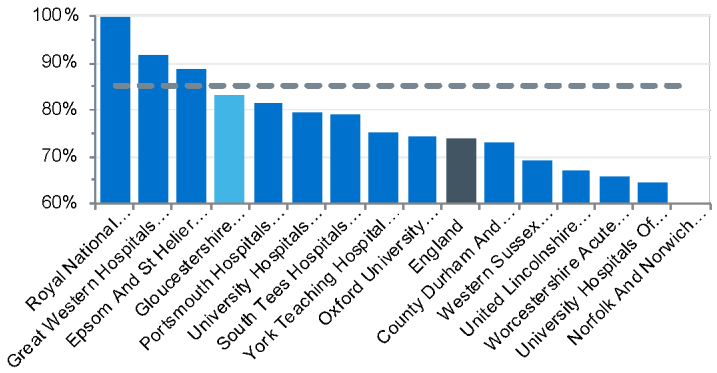
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	March-21		85 / 159	3rd
Dementia	February-20		82 / 82	4th

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

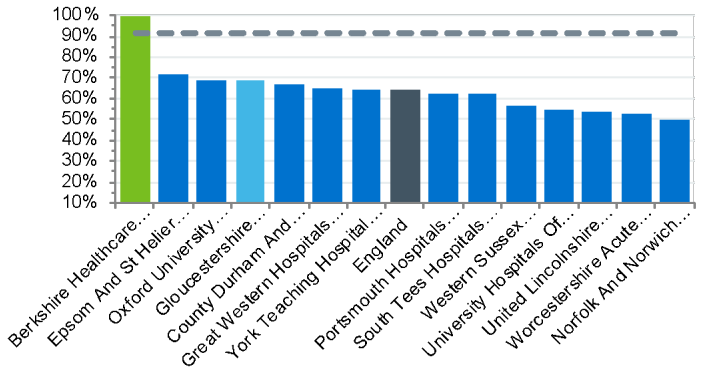
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	April-21		101 / 113	4th
Cancer 62 Days GP Referrals	March-21		32 / 134	1st

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	March-21		73 / 155	2nd

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period April 2021

Presented at May 2021 Q&P and June 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 April, 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 April was 64.55%, against the STP trajectory of 85.79%. The system did not meet the delivery of 90% for the system in April, at 78.28%.

The Trust did not meet the diagnostics standard for April at 15.11%. 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 94.5% in April but did not meet the standard for 62 day cancer waits at 80.2%, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 69.61% (un-validated) in April, 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 2,721 in April. 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

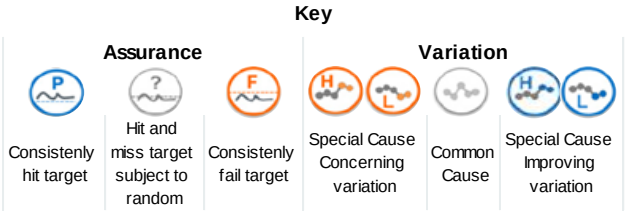
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer – 28 day FDS two week wait	No target	Apr-21	80.2%
Cancer	Cancer – 28 day FDS breast symptom two week wait	No target	Apr-21	98.6%
Cancer	Cancer – 28 day FDS screening referral	No target	Apr-21	82.0%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Apr-21	94.5%
Cancer	2 week wait breast symptomatic referrals	>=93%	Apr-21	93.6%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Apr-21	96.6%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Apr-21	98.5%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Apr-21	89.0%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Apr-21	97.6%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Apr-21	80.2%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Apr-21	84.1%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Apr-21	96.2%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Apr-21	2
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Apr-21	14
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Apr-21	15.11%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Apr-21	1,773
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Mar-21	58.8%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Apr-21	64.55%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Apr-21	78.28%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Apr-21	99.73%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Apr-21	64.55%

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	Apr-21	0
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Apr-21	54.6%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Apr-21	26.6%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Apr-21	8.61%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Apr-21	6.45%
Maternity	% of women booked by 12 weeks gestation	>90%	Apr-21	92.9%
Operational Efficiency	Number of patients stable for discharge	<=70	Apr-21	112
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Apr-21	353
Operational Efficiency	Average length of stay (spell)	<=5.06	Apr-21	4.72
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Apr-21	5.23
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Apr-21	2.3
Operational Efficiency	% day cases of all electives	>80%	Apr-21	82.7%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Apr-21	90.4%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Apr-21	92.0%
Operational Efficiency	Urgent cancelled operations	No target	Apr-21	0
Outpatient	Outpatient new to follow up ratio's	<=1.9	Apr-21	2.07
Outpatient	Did not attend (DNA) rates	<=7.6%	Apr-21	5.9%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Mar-21	7.9%
Research	Research accruals	No target	Apr-21	198

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%	Apr-21	69.61%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target	Apr-21	6,651	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target	Apr-21	3,642	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero	Apr-21	2,721	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target	Apr-21	612	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%	Apr-21	53.5%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%	Mar-21	85.0%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%	Apr-21	37.0%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%	Apr-21	63.2%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%	Mar-21	100.00%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%	Mar-21	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%	Apr-21	84.40%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%	Apr-21	84.4%	

Access:
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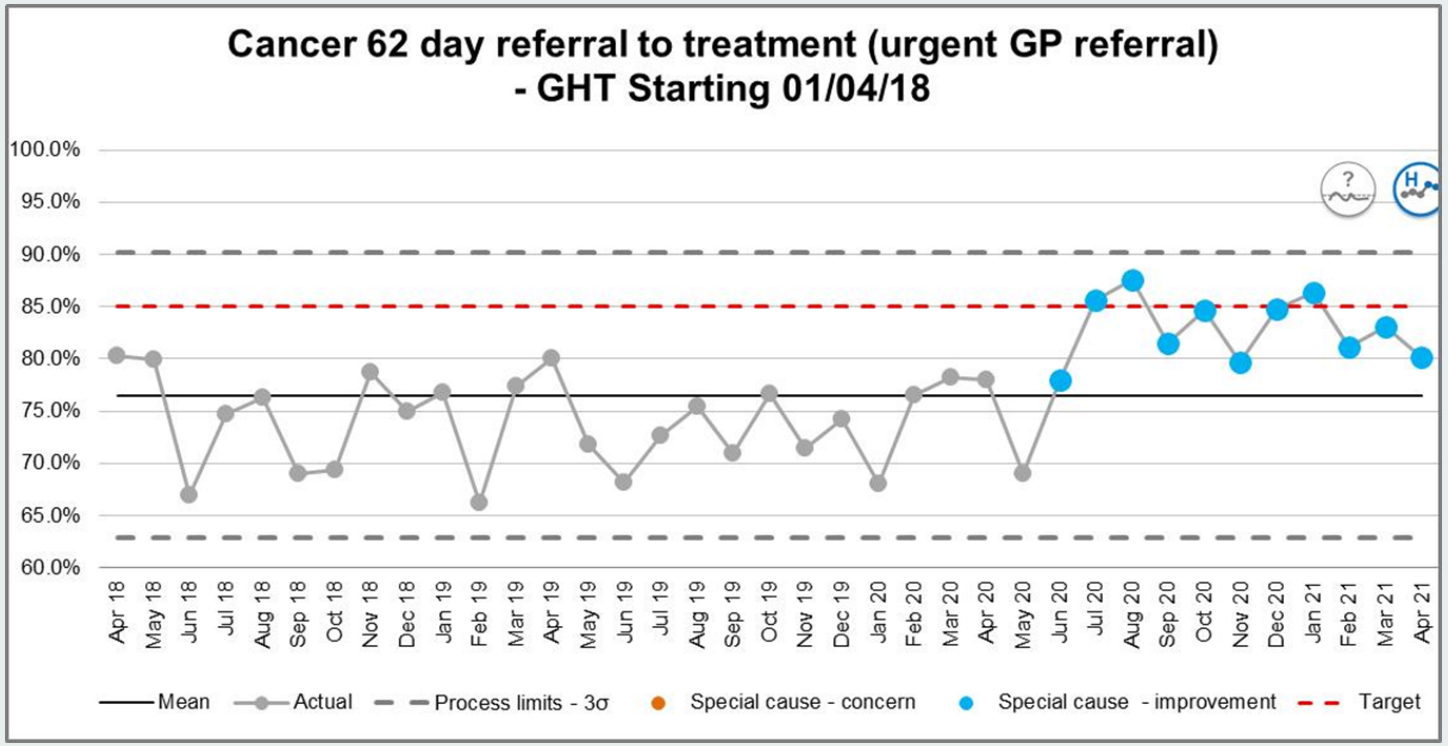
Gloucestershire Hospitals NHS Foundation Trust



Commentary

62 day GP performance (unvalidated) = 80.0% Target = 85% National performance = 73.9%
177.5 treatments & 35.5 breaches: LGI 10 Urology 8.5 Gynae 5

Main focus is on Urology and Lower GI pathways. High level meetings requested with clinical and operational colleagues to review pathways and areas for possible improvement

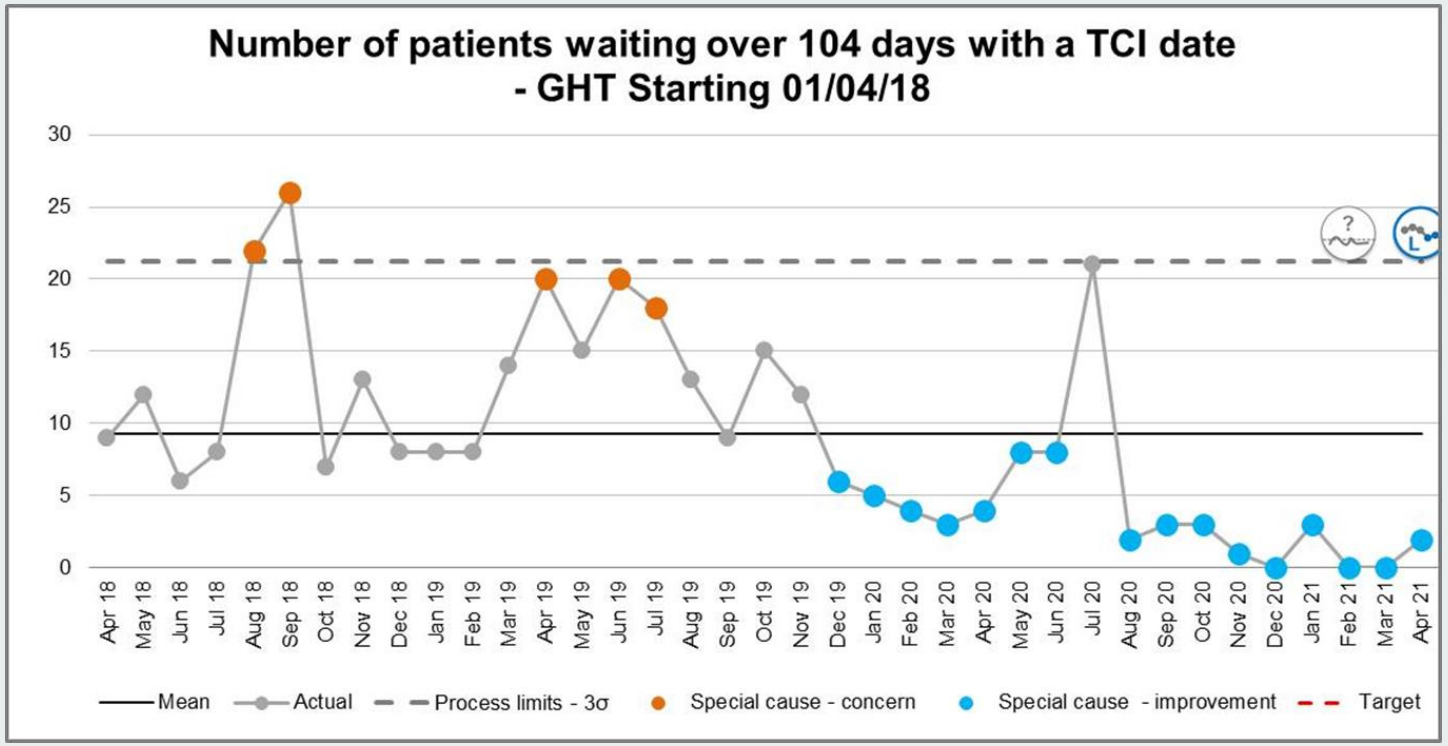
Annual performance 83.4%
- Director of Planned Care and Deputy Chief Operating Officer

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 2
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.
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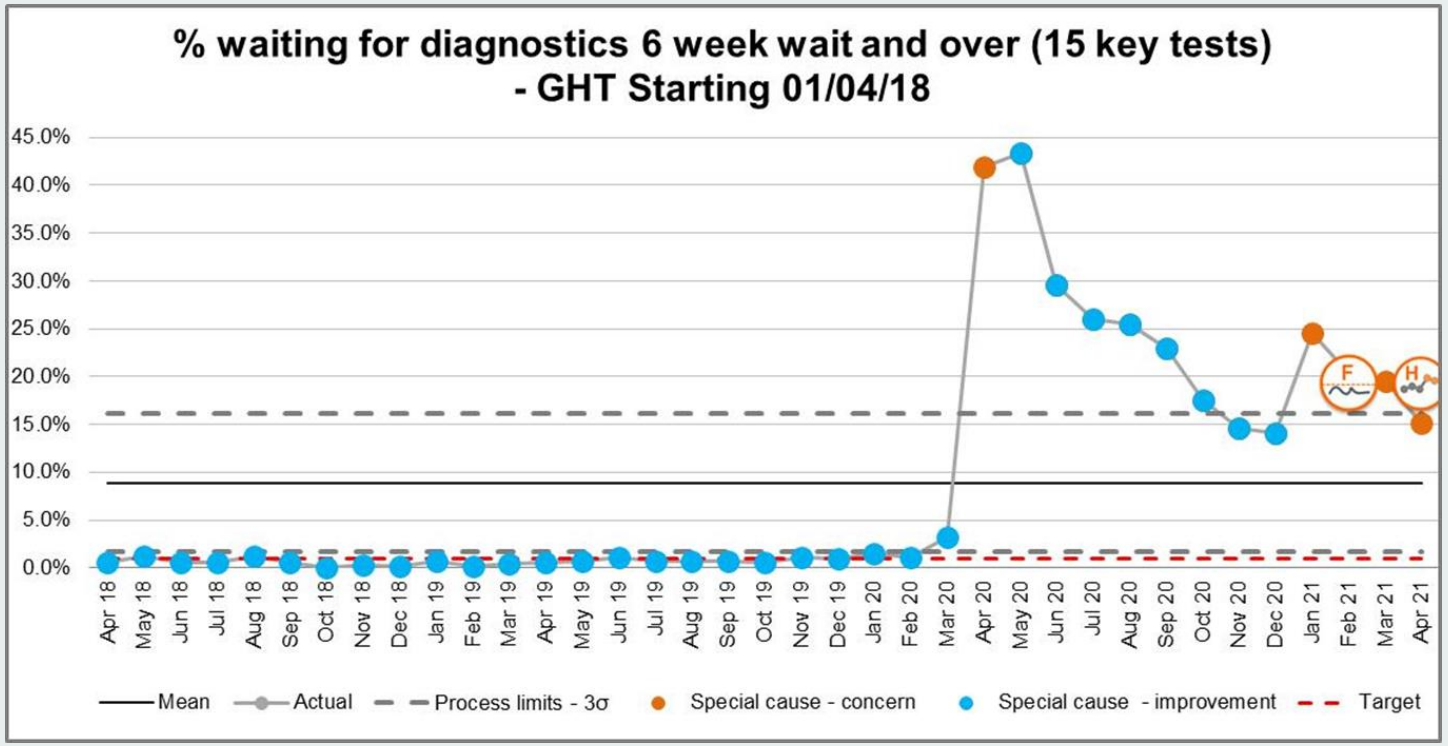

Commentary

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
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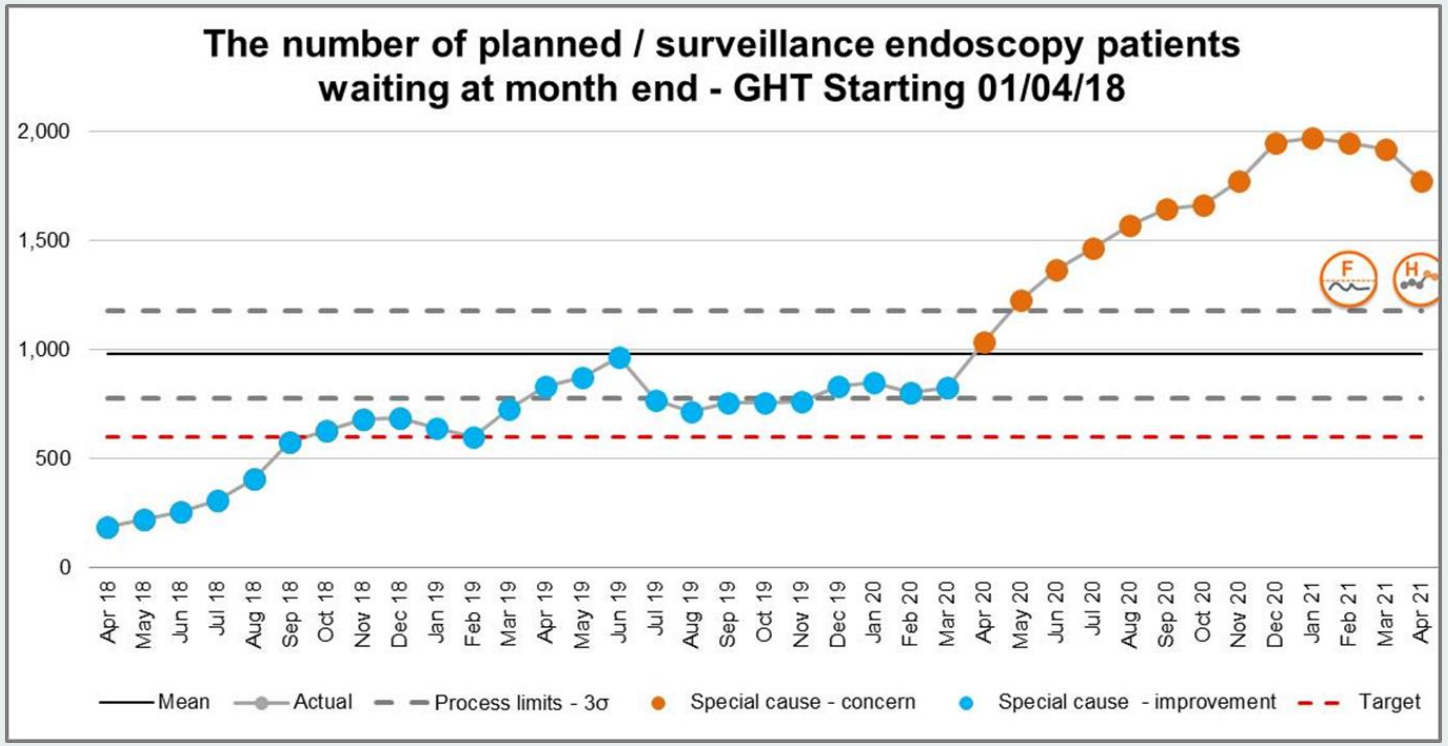
Gloucestershire Hospitals NHS Foundation Trust



Commentary

DM01 target was failed for Endoscopy due to a lack of capacity to balance all demand coming into the Endoscopy service; including 2WW, treatments, 6WW, planned surveillance From 1st April, the service has safely resumed its pre-COVID number of points per list, where previously it has been restricted by infection control and flow concerns. Endoscopy has a clear plan on how to recover the remaining patients within the breach cohort and is making significant progress against this target each month.

- 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 12 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
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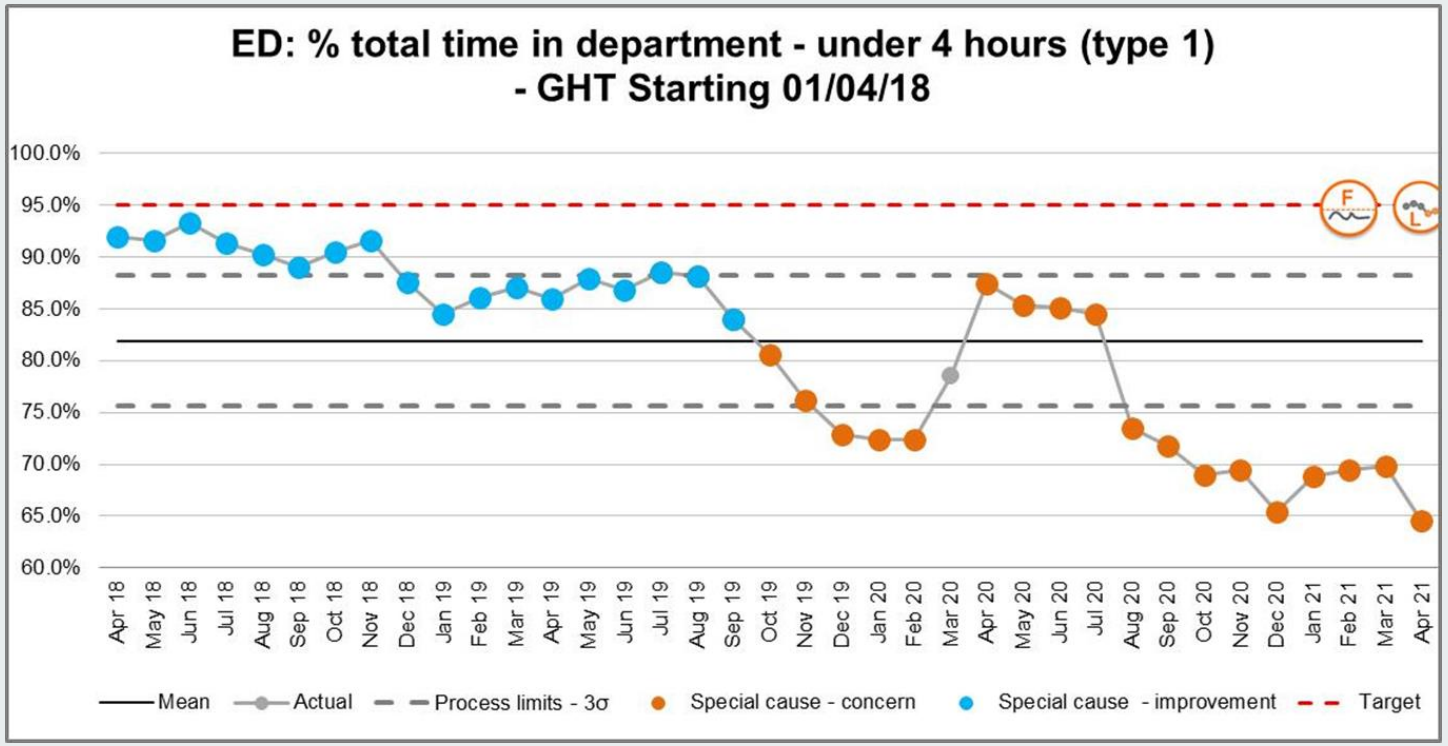
Gloucestershire Hospitals NHS Foundation Trust



Commentary

ED 4-hour performance has decreased in April to 64.55%. The average total wait in ED has increased by an average of 11.8 minutes compared to March. Attendances have also increased significantly in month.

- 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 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
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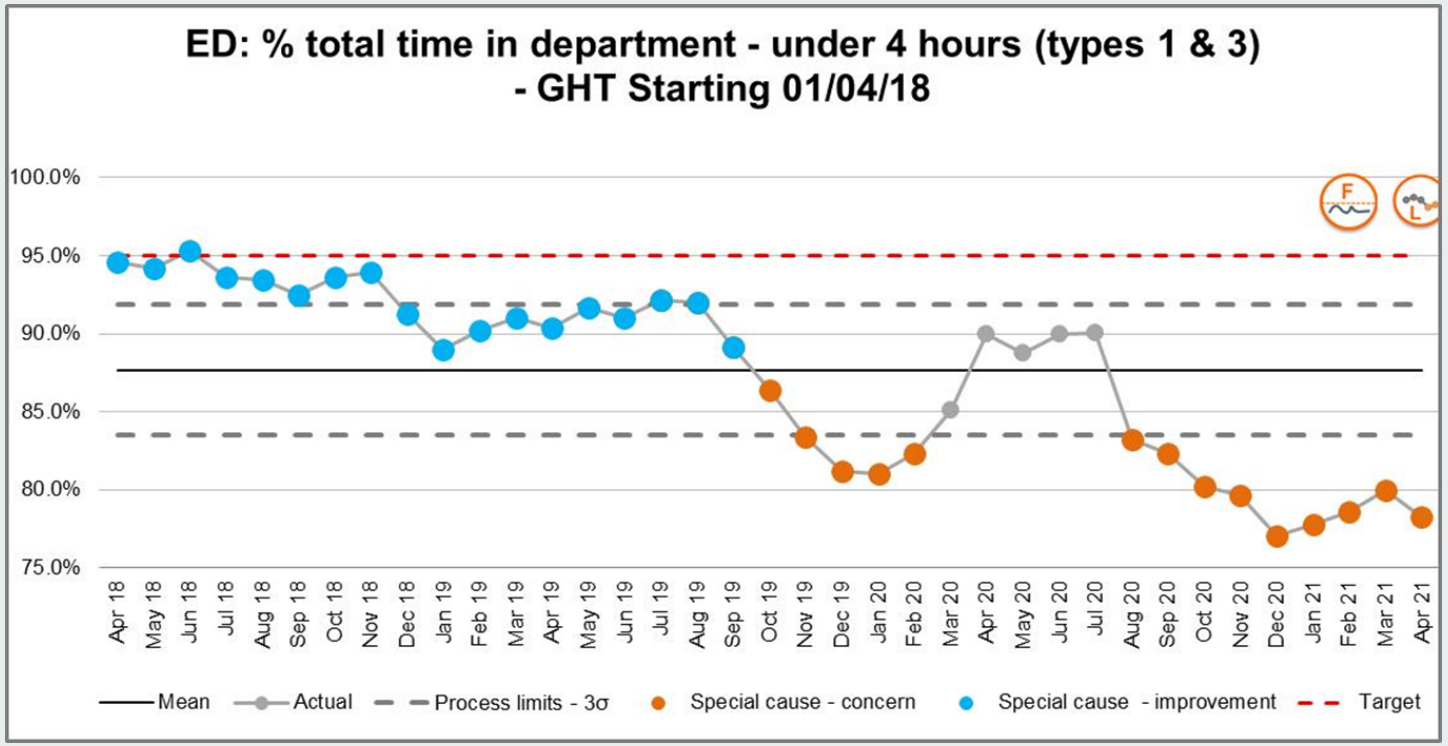

Commentary

ED 4-hour performance has decreased in April to 78.28%. The average total wait in ED has increased by an average of 11.8 minutes compared to March. Attendances have also increased significantly in month.

- 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 13 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.
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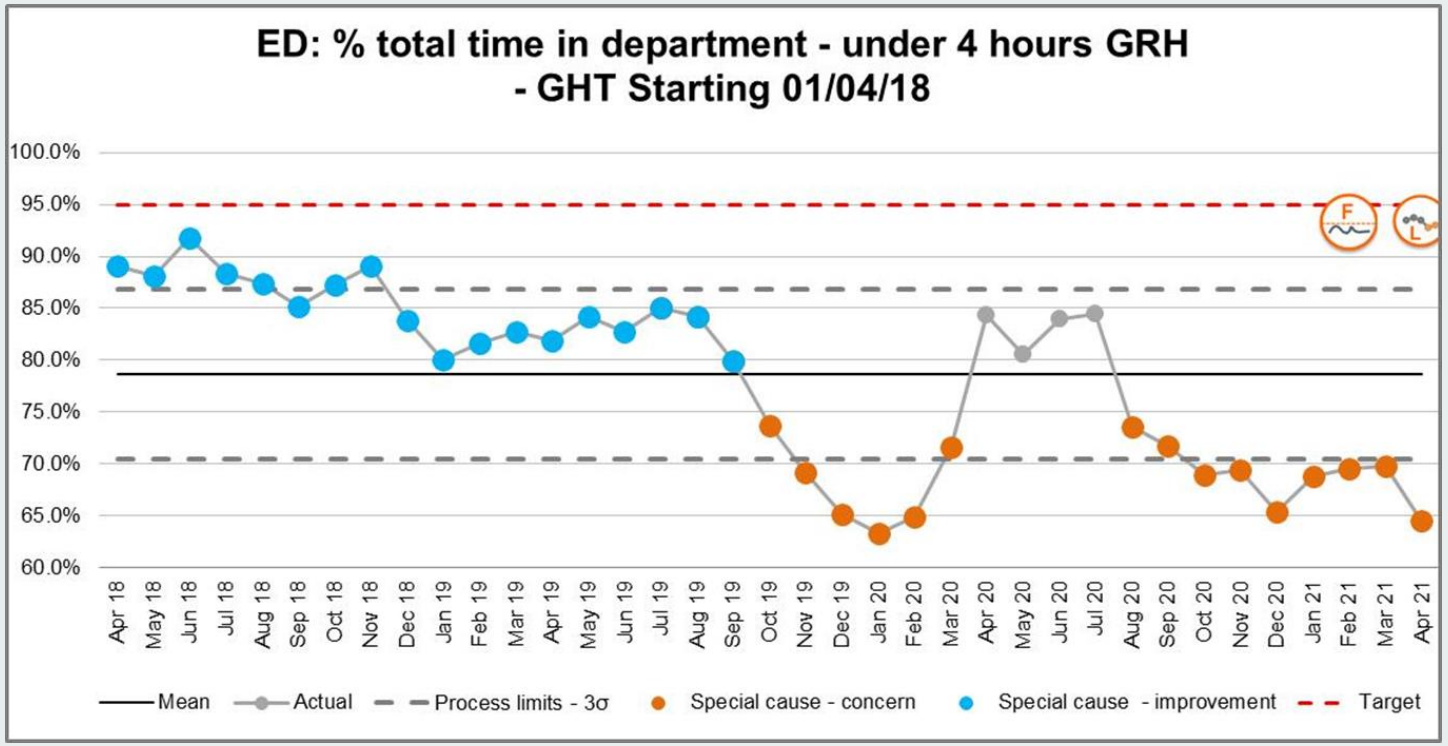

Commentary

ED 4-hour performance has decreased in April to 64.55%. The average total wait in ED has increased by an average of 11.8 minutes compared to March. Attendances have also increased significantly in month.

- 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 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
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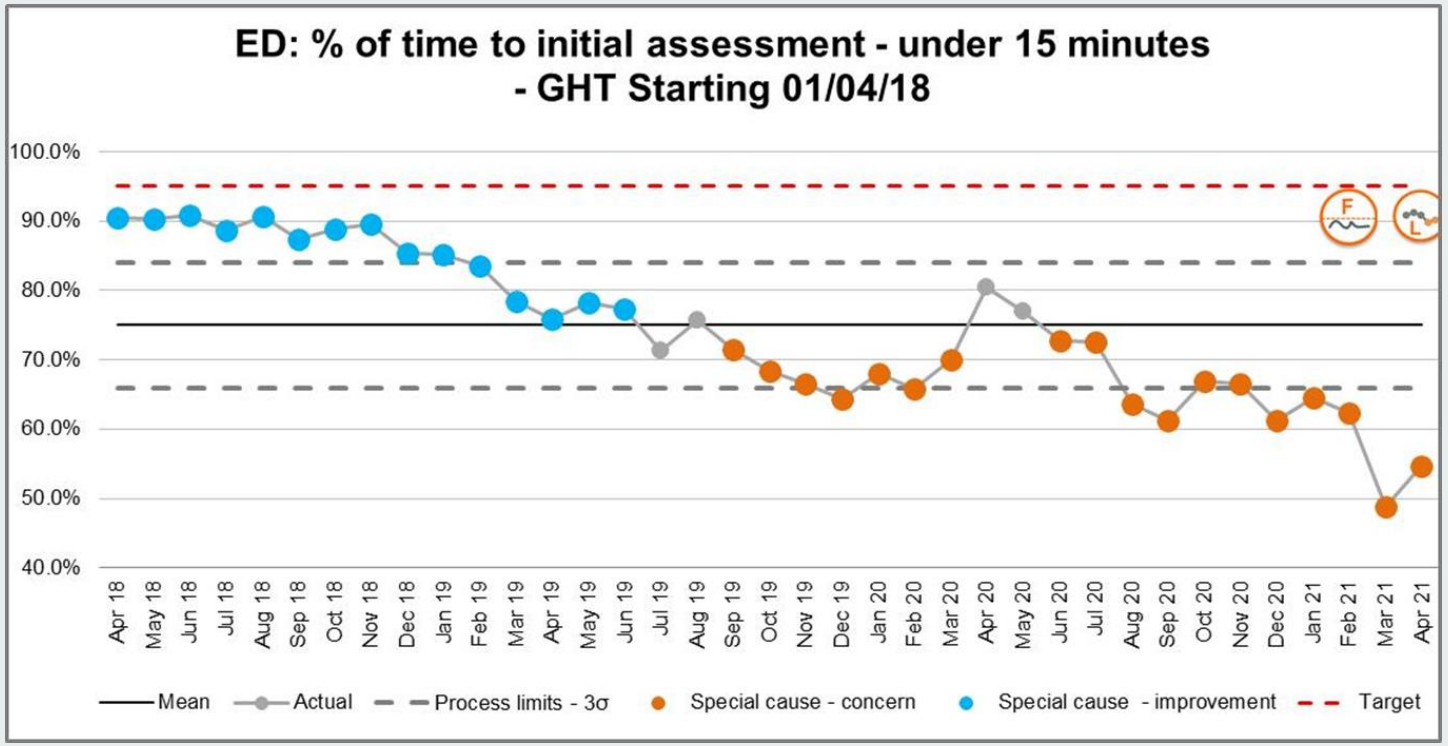

Commentary

Average time to initial assessment (15 minutes) has improved in April for both patients attending by ambulance and walk in patients. Ambulance arrivals were assessed on average within 19.5 minutes of arrival, an improvement of 5.5 minutes. Walk-in patients were assessed on average at 25.3 minutes which is an improvement of 4 minutes.

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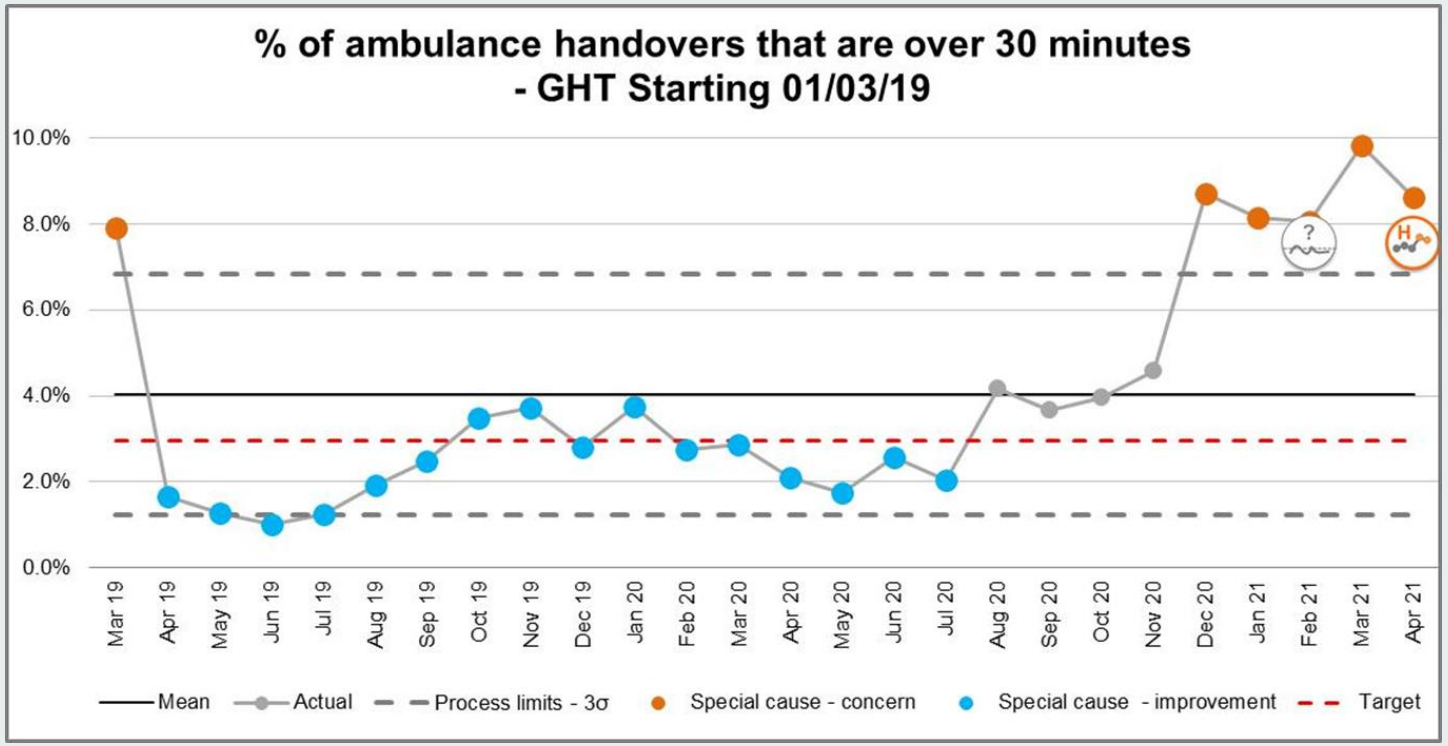

Commentary

A reduction of 46 ambulance handover delays over 30 minutes in April, from 362 to 316. This still remains high but has significantly reduced further in May.

- 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 6 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

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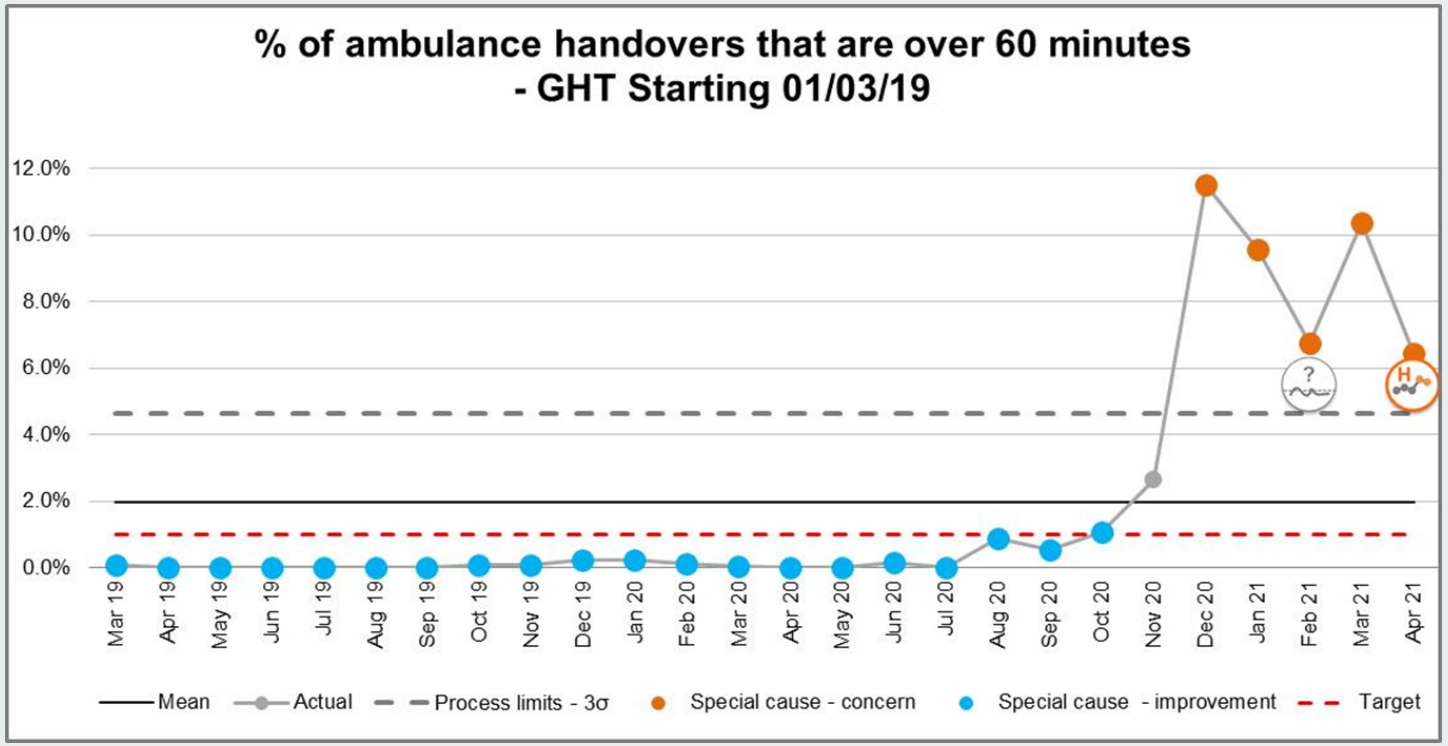

Commentary

A reduction of 145 ambulance handover delays over 60 minutes in April, from 382 to 237. This still remains high but has significantly reduced further in May.

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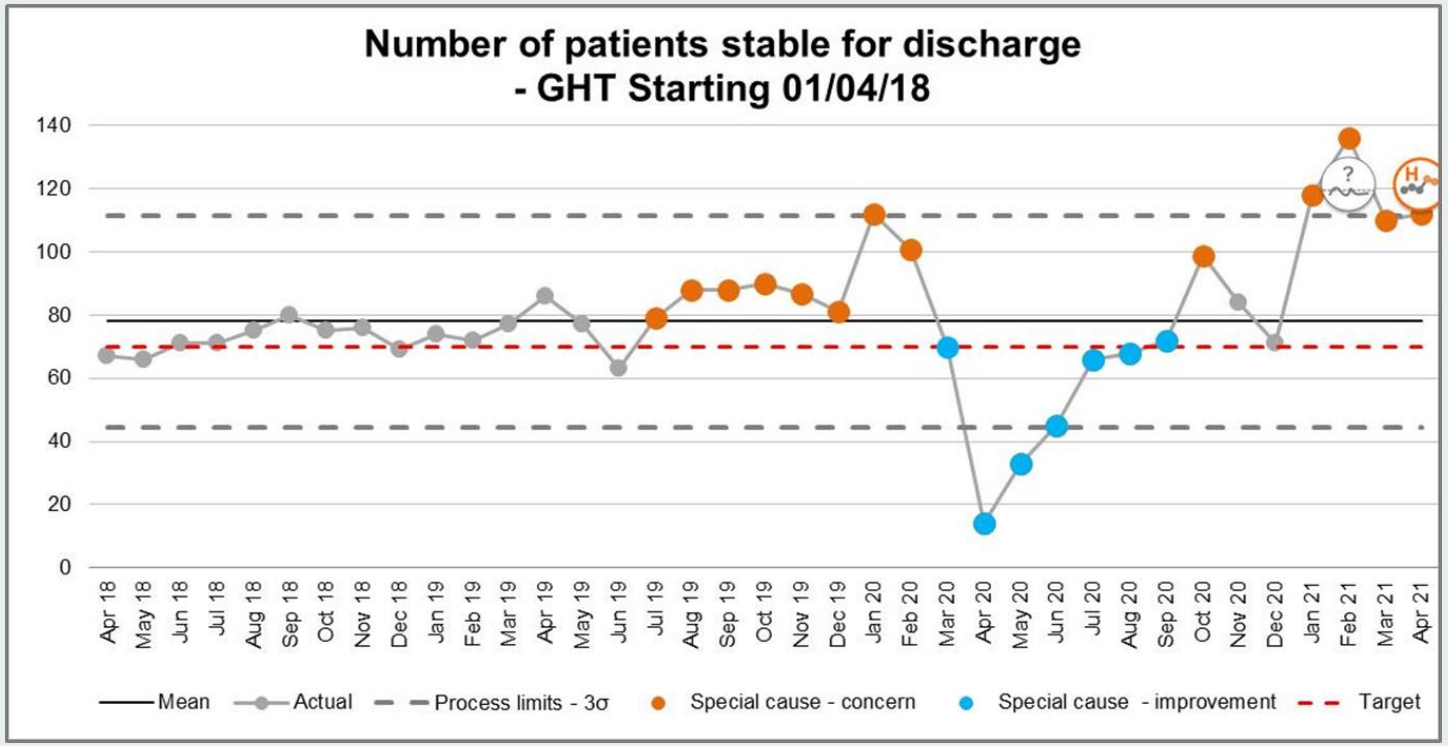

Commentary

Ongoing system work on patients flow supported by ECIST. Cyclic improvements which see significant improvements but are then not sustainable due to community capacity. This has led the MOFD numbers to swing from between 60 - 120. This work has identified need for a single coordinated approach to community based care for both discharge and admission avoidance, also identifying a clear gap in the capacity of the home first model to manage the numbers of discharges now being referred.

- 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 4 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

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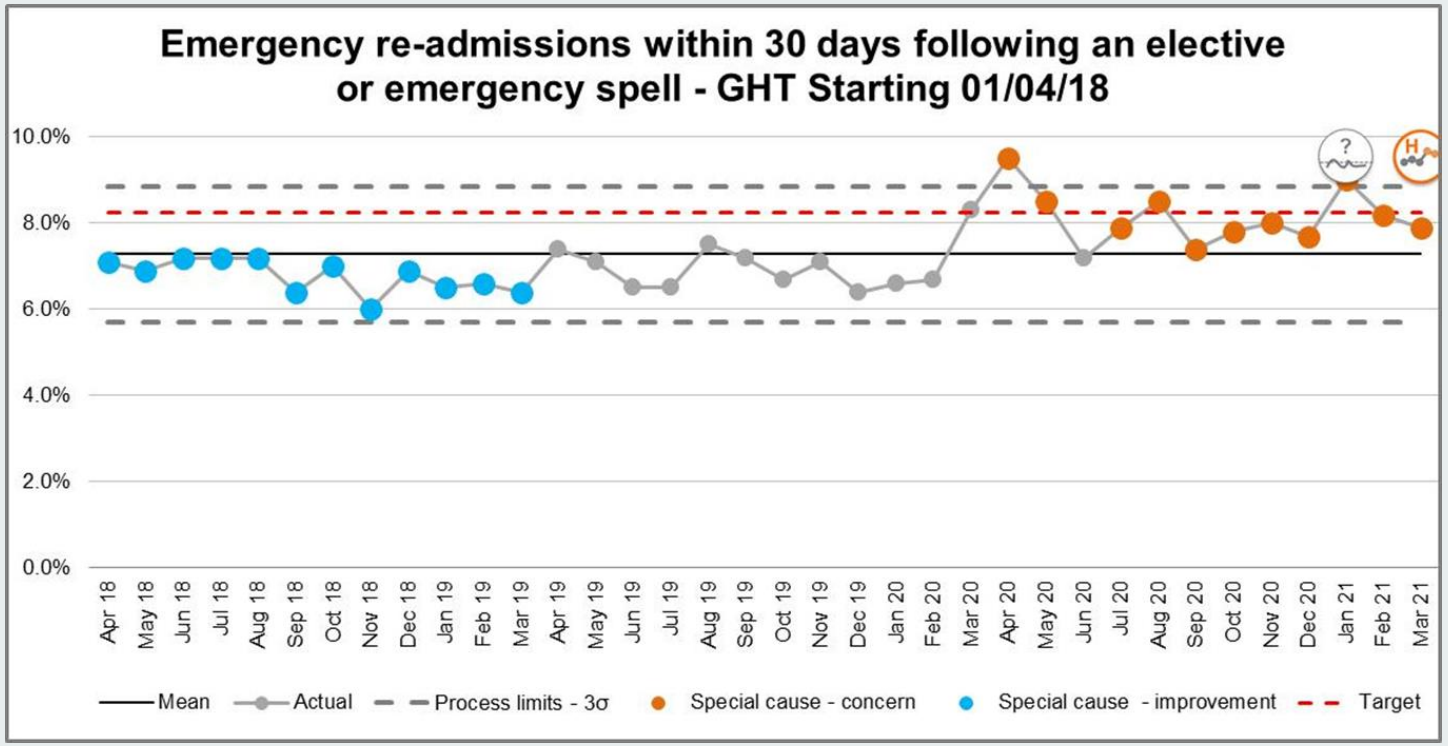

Commentary

This metric peaked in January which is related to the effects of COVID, the exact same pattern was observed in the first wave. The metric is now gradually improving in February and March as the COVID activity reduces. It is not the COVID activity itself but its effect on other hospital activity eg a reduction in elective admission which by their Nature are less likely to have emergency readmissions

- 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.
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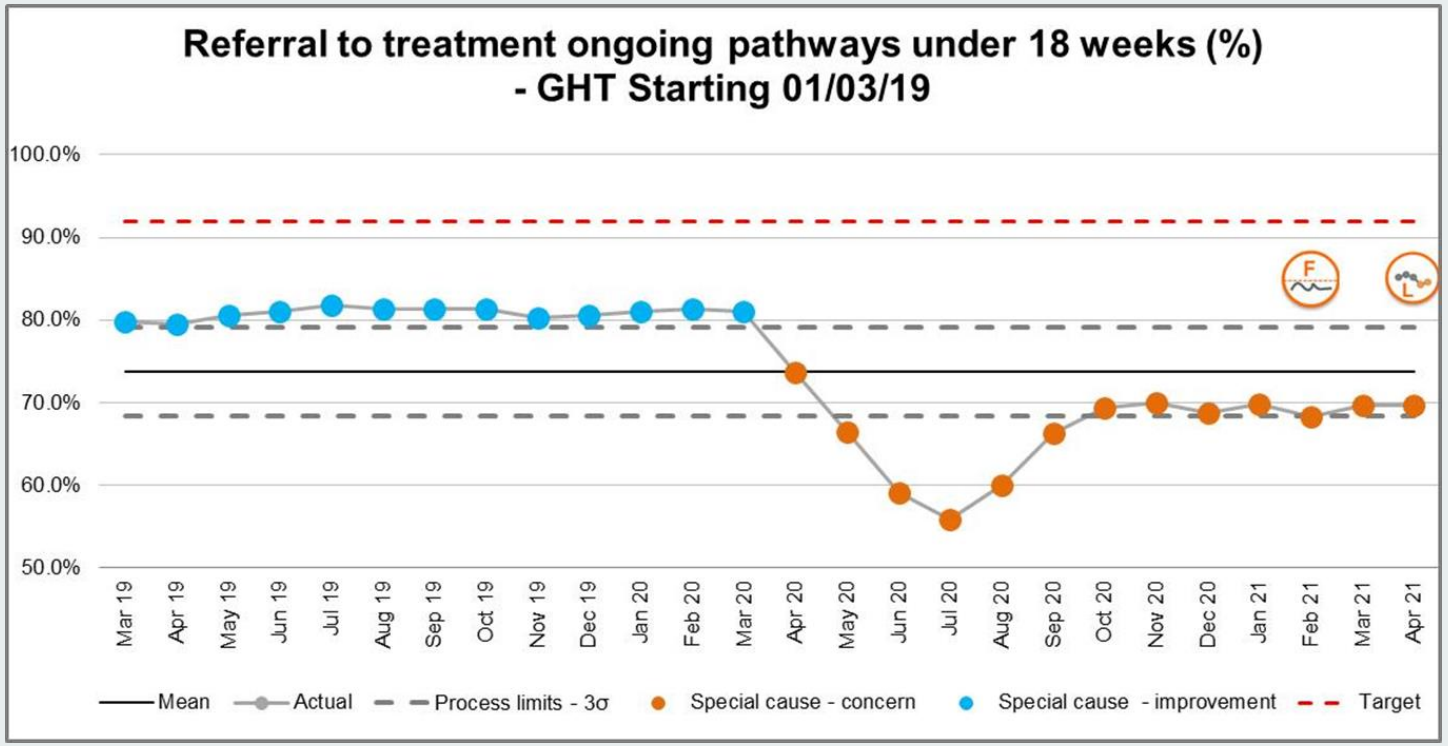

Commentary

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 increased together with theatre availability (with normal timetables having resumed on 12th April). Performance remains relatively consistent with previous months and in line with many other Trusts nationally, with a part validated position for April being 69.61% and anticipated to be 69.9% 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 13 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.
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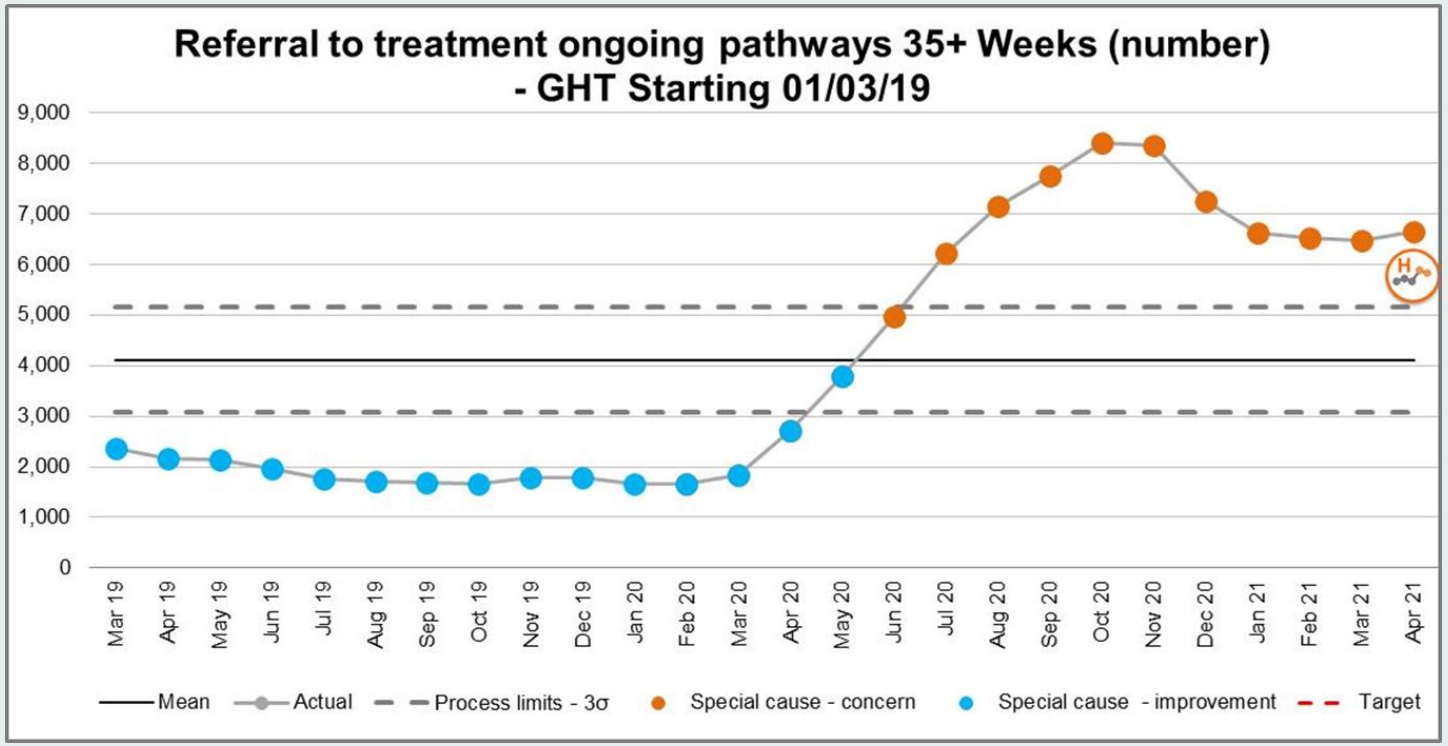

Commentary

Outpatient clinic activity has increased together with theatre availability (with normal timetables having resumed on 12th April). However the cohort of patients over 35+ weeks has increased by approximately 200, which is the first time an increase has been seen in 5 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 10 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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
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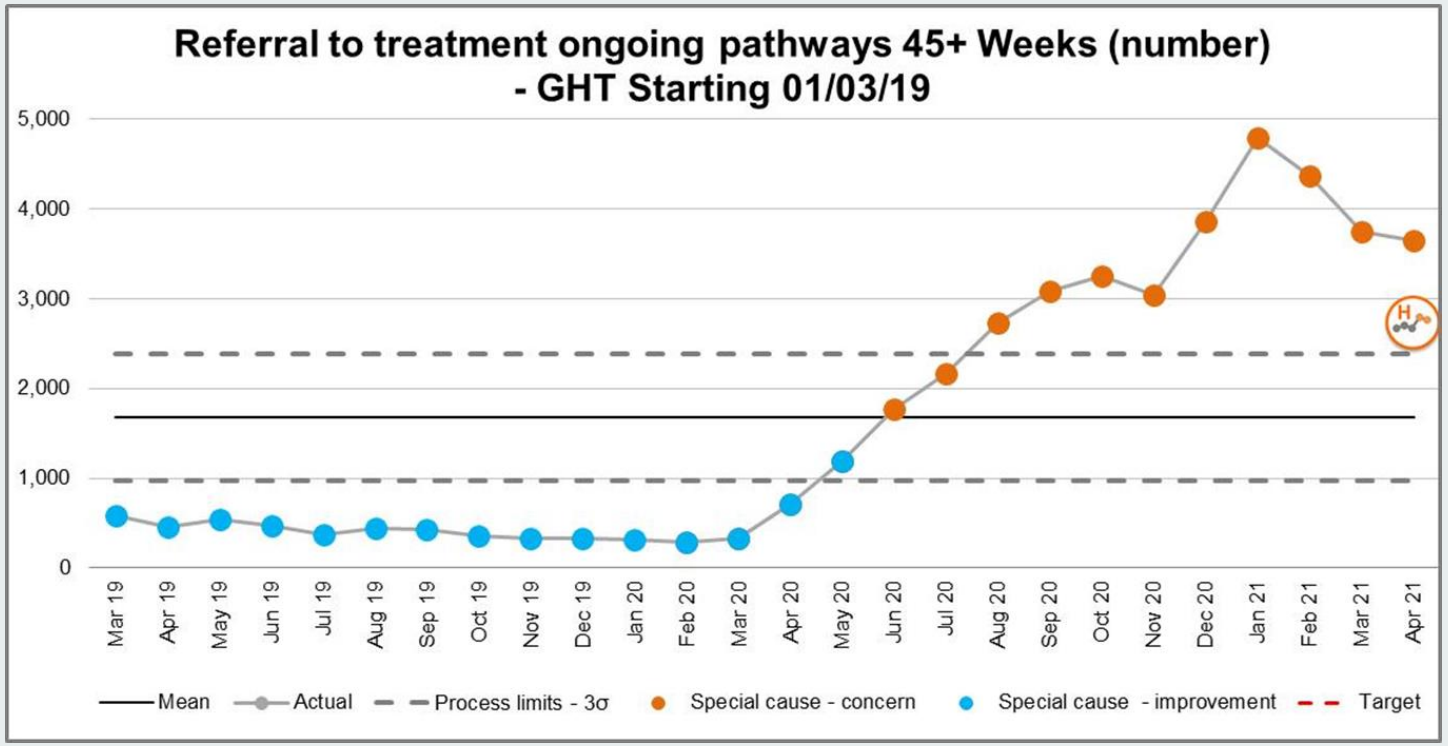

Commentary

Outpatient clinic activity has increased together with theatre availability (with normal timetables having resumed on 12th April). As per recent months, a decrease in the number of patients in this cohort has been seen in month, albeit small (~100).

- 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.
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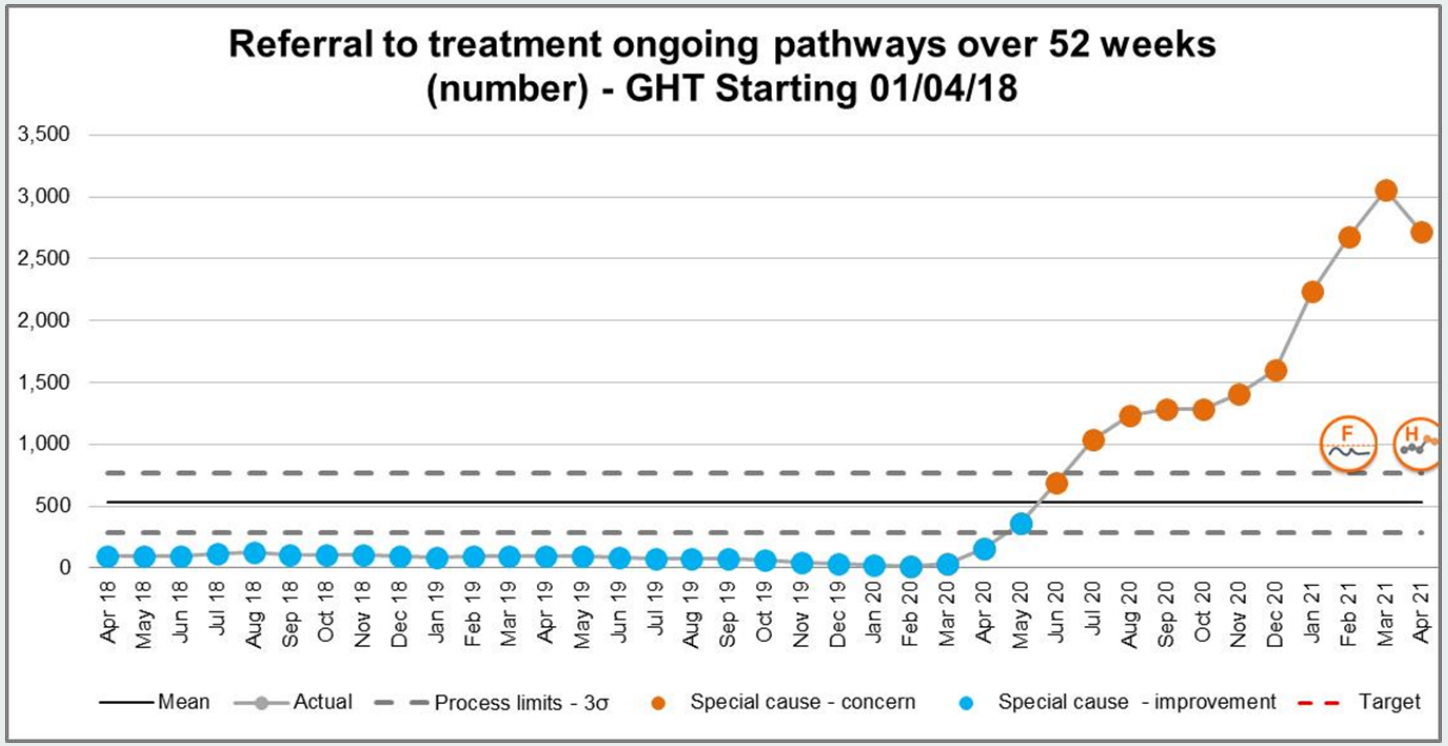

Commentary

See Planned Care Exception report for full details. Restoration and recovery has resumed with both an increase in outpatients and theatre availability. This increase in activity coupled with a decrease in referrals in April 2020 has allowed a sizeable reduction to be made in April, with an approximate reduction of 350 patients. Given TCIs are allocated on clinical priority, this does mean that some of those waiting greater than 70 and 78 weeks have increased.

- 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 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
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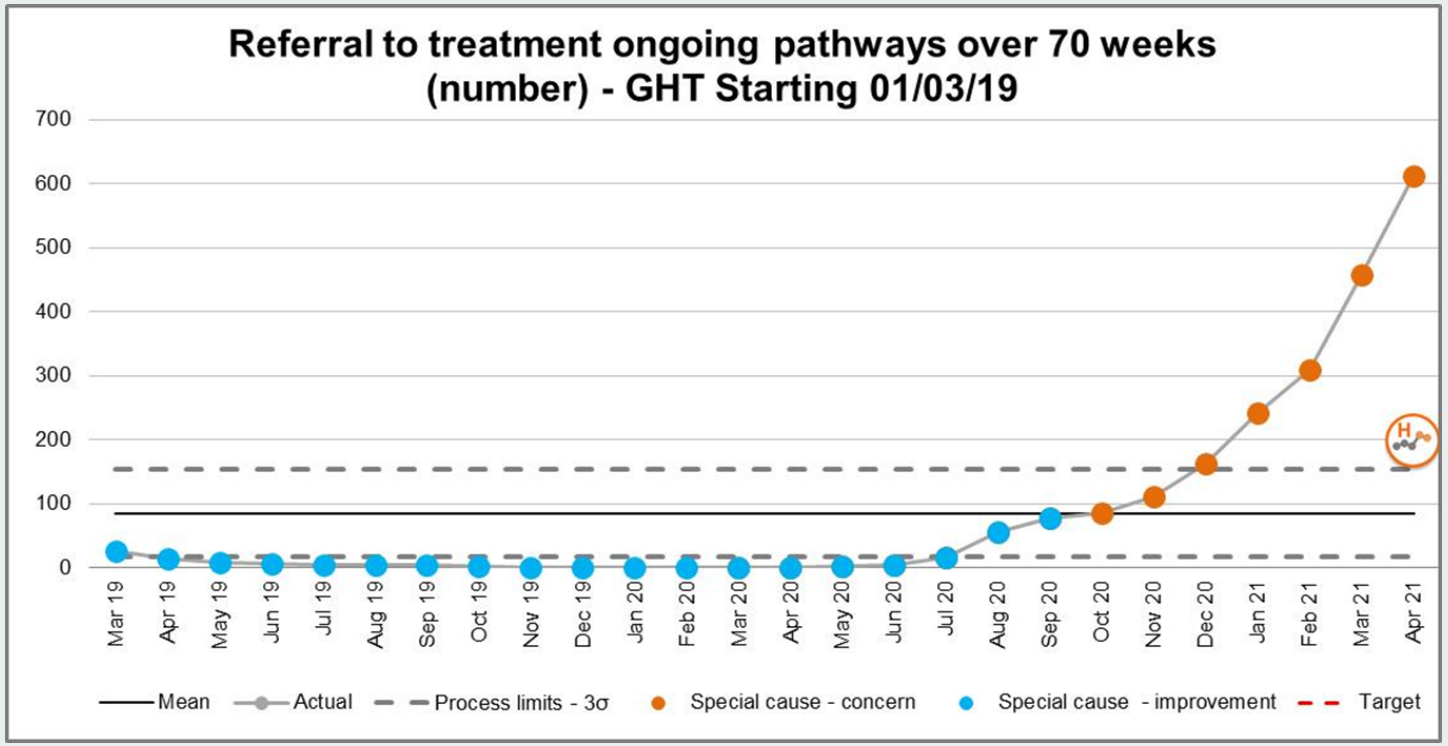

Commentary

Restoration and recovery has resumed with both an increase in outpatients and theatre availability. However P1 and P2 patients continue to be the focus, which can result in P3 and P4 having extended waits. In month there has been an approximate increase of 150 patients waiting more than 70 weeks. Those patients over 70 weeks are predominantly 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 5 data points which are above the line. There are 15 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

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Mar-21	70%	
Friends & Family Test	Inpatients % positive	>=90%	Apr-21	88.3%	
Friends & Family Test	ED % positive	>=84%	Apr-21	76.3%	
Friends & Family Test	Maternity % positive	>=97%	Apr-21	96.2%	
Friends & Family Test	Outpatients % positive	>=94.5%	Apr-21	94.4%	
Friends & Family Test	Total % positive	>=93%	Apr-21	91.5%	
PALS	Number of PALS concerns logged	No Target	Apr-21	256	
PALS	% of PALS concerns closed in 5 days	>=95%	Apr-21	82%	
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Apr-21	0	
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Apr-21	0	
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Apr-21	3	
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Apr-21	0	
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Apr-21	3	
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Apr-21	13.5	
Infection Control	Number of MSSA bacteraemia cases	<=8	Apr-21	1	
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Apr-21	4.5	
Infection Control	Number of ecoli cases	No target	Apr-21	4	
Infection Control	Number of pseudomona cases	No target	Apr-21	1	
Infection Control	Number of klebsiella cases	No target	Apr-21	2	
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Apr-21	0	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	No target	Apr-21	3	

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	Apr-21	0	
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	No target	Apr-21	0	
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	No target	Apr-21	0	
Maternity	% C-section rate (planned and emergency)	<=27%	Apr-21	0	
Maternity	% emergency C-section rate	No target	Apr-21	16.3%	
Maternity	% of women smoking at delivery	<=14.5%	Apr-21	0	
Maternity	% of women that have an induced labour	<=30%	Apr-21	28.4%	
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Apr-21	0.00%	
Maternity	% of women on a Continuity of Carer pathway	No target	Mar-21	0.00%	
Maternity	% breastfeeding (initiation)	>=81%	Apr-21	81.0%	
Maternity	% Massive PPH >1.5 litres	<=4%	Apr-21	5.9%	
Maternity	Number of births less than 27 weeks	NULL	Apr-21	2	
Maternity	Number of births less than 34 weeks	NULL	Apr-21	7	
Maternity	Number of births less than 37 weeks	NULL	Apr-21	28	
Maternity	Number of maternal deaths	NULL	Apr-21	0	
Maternity	Total births	NULL	Apr-21	463	
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Apr-21	2.27%	
Maternity	% breastfeeding (discharge to CMW)	NULL	Apr-21	54.0%	
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Dec-20	1	
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Jan-21	107.9	
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Jan-21	111.7	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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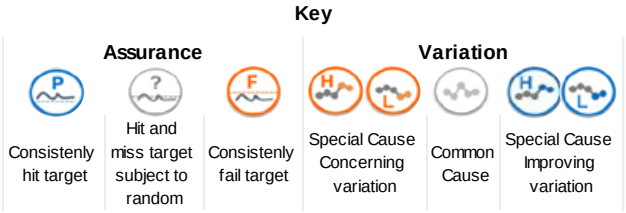
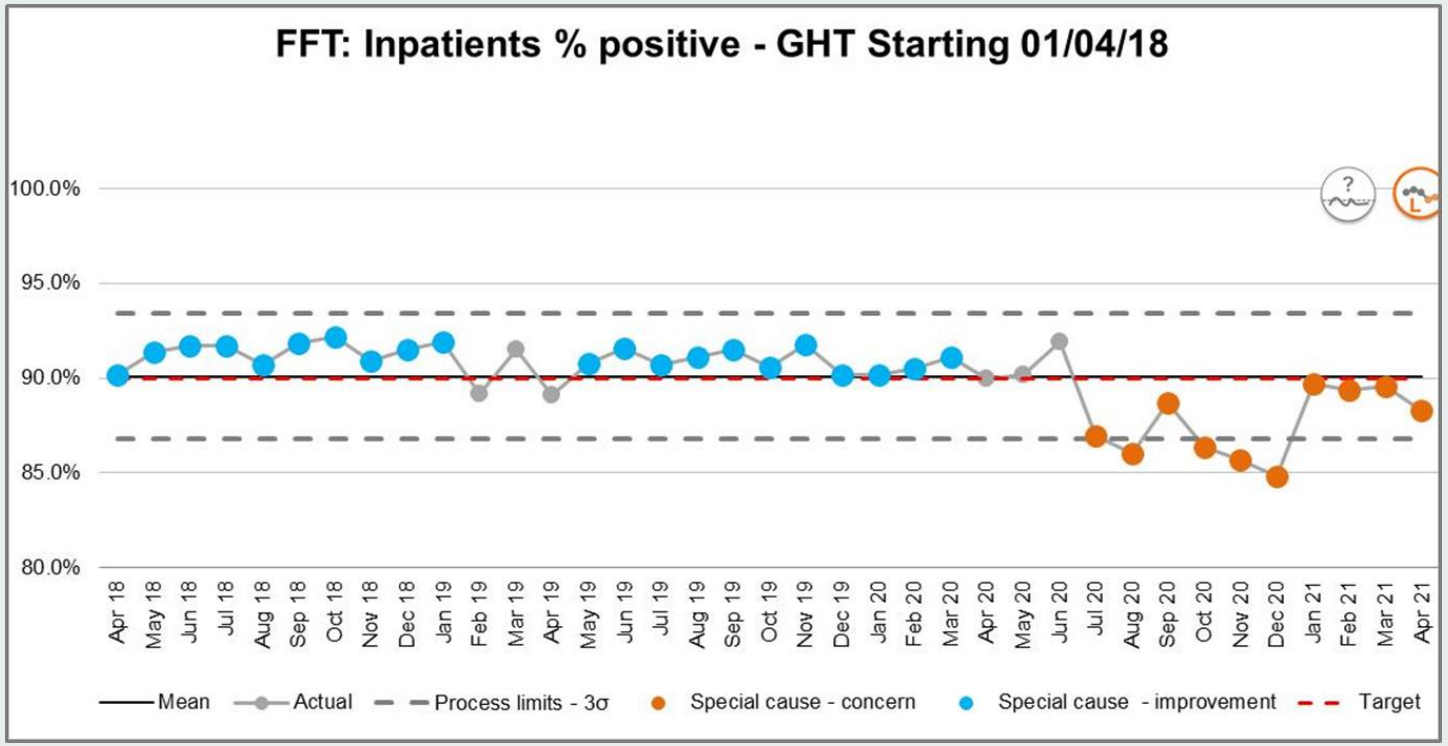


MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	Apr-21	145	
Mortality	Number of deaths of patients with a learning disability	No target	Apr-21	2	
MSA	Number of breaches of mixed sex accommodation	<=10	Apr-21	0	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Apr-21	1	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Apr-21	6.1	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Apr-21	4	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Apr-21	7	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Apr-21	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Apr-21	2	
Patient Safety Incidents	Medication error resulting in low harm	No target	Apr-21	11	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Apr-21	16	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Apr-21	1	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Apr-21	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Apr-21	4	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Apr-21	1	
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Apr-21	70%	
RIDDOR	Number of RIDDOR	SPC	Apr-21	4	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Apr-21	0	
Serious Incidents	Number of serious incidents reported	No target	Apr-21	4	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Apr-21	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Apr-21	100%	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The positive FFT score for Inpatients is currently amber, and has stayed consistent in Q4 2020/21 and into Q1 21/22. Divisional teams are setting up patient experience groups to identify key areas for improvement and lead projects using their FFT and PALS data. The national inpatient survey scores are expected in the summer and will support the work within divisions and also corporate plans to support inpatient experience improvement.

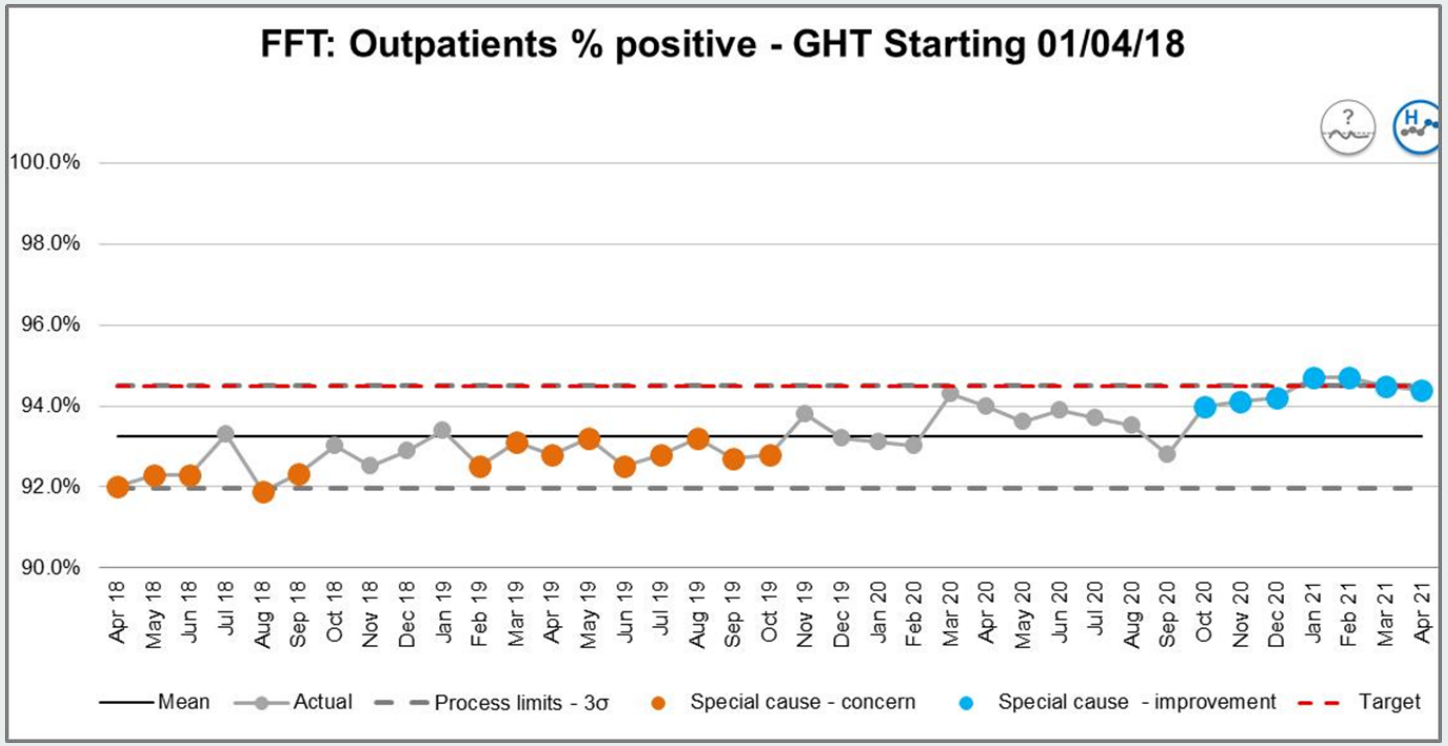
- Head of Quality

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

Outpatients FFT score has remained consistently positive (above 94%) throughout the last few months. Each department and specialty receives the data monthly to inform local improvement programmes.

- 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.
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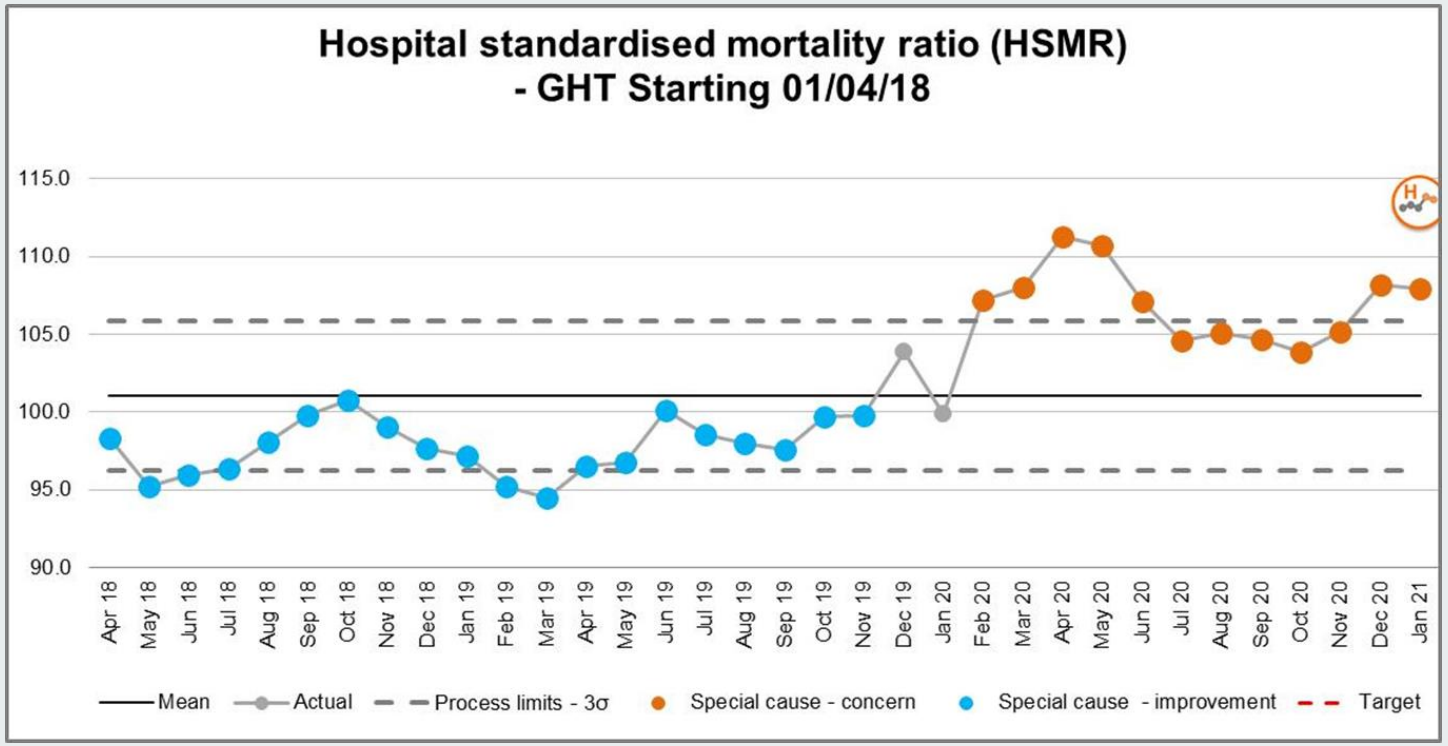
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

This has increased in January again and as described before this reflects COVID activity. Dr Fosters data shows that if you exclude COVID activity there is no increase in mortality rate in the trust. The HSMR is not able to standardize for COVID, it compares it to a normal viral pneumonia which is known to have a much lower expected mortality

- Medical Division Audit and M&M Lead

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. 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.
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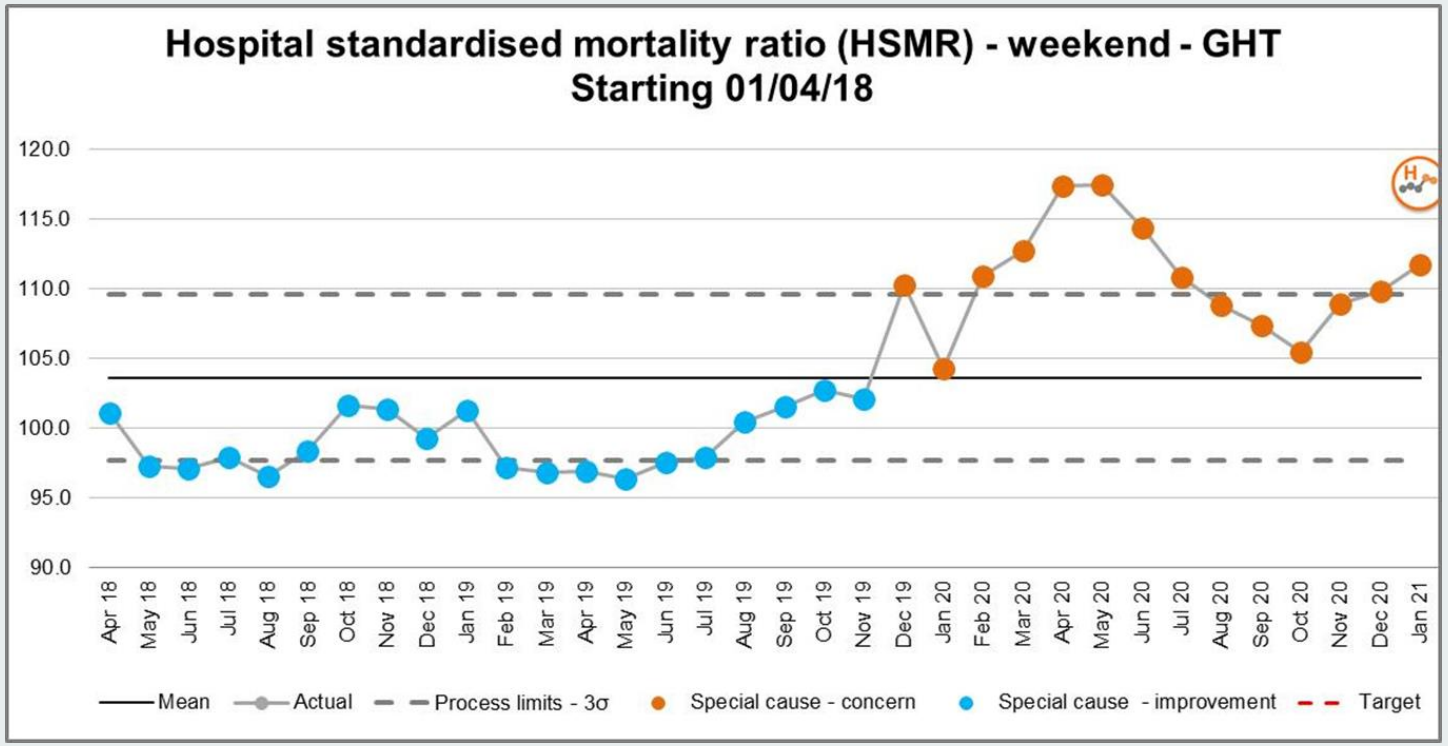
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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- 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 9 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.
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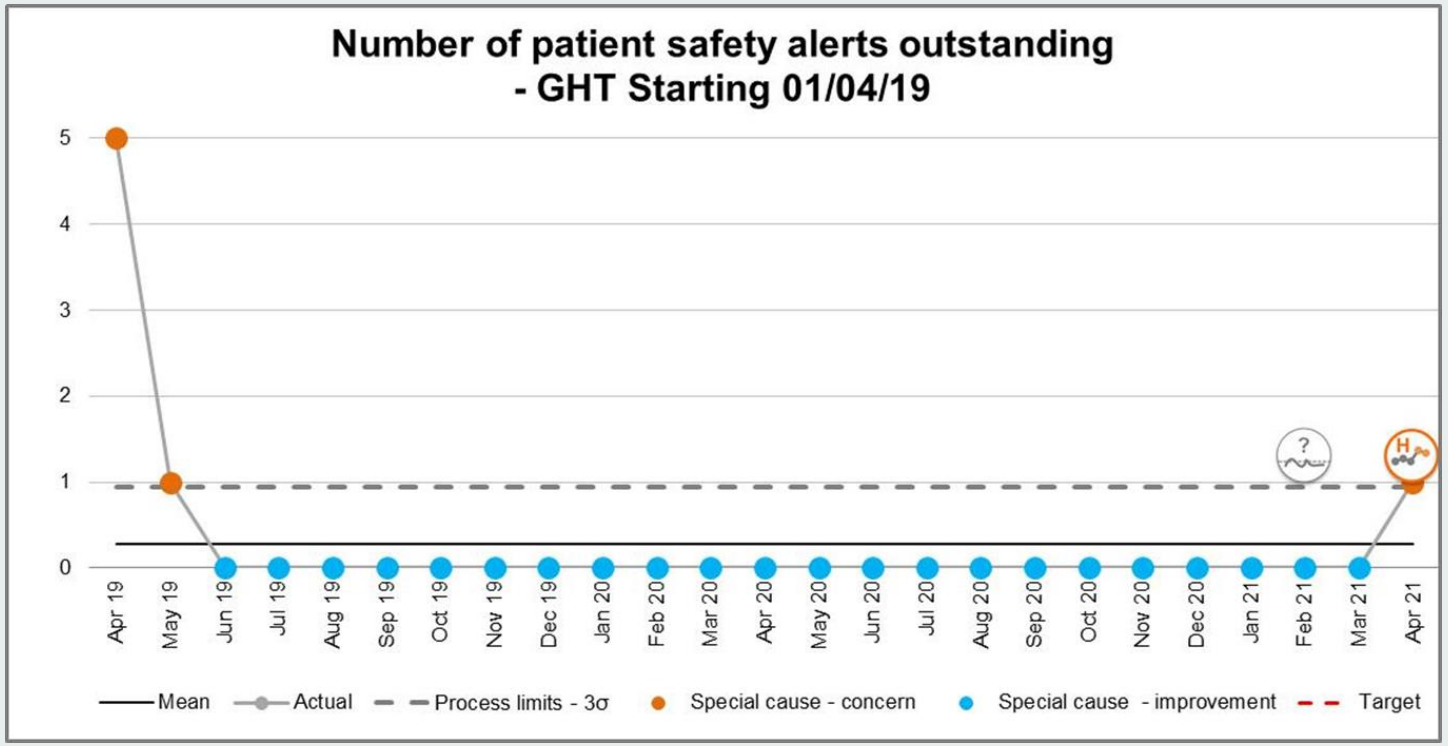
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Safety alert that is outstanding involves the tracking of patients on high dose steroids. A potential electronic alert on TrakCare is being developed but implementation will take longer than anticipated. Internal safety alerts will be issued. The aim is to design a more permanent solution into the electronic prescribing system over the next 12months. The Medicines Management Committee are overseeing the implementation.

- Quality Improvement & Safety Director

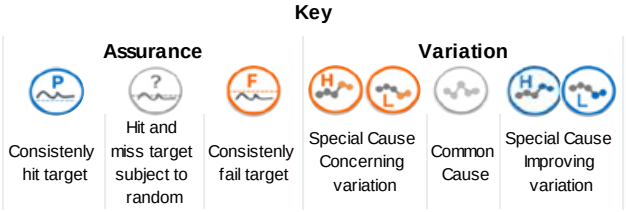
Data Observations

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

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.



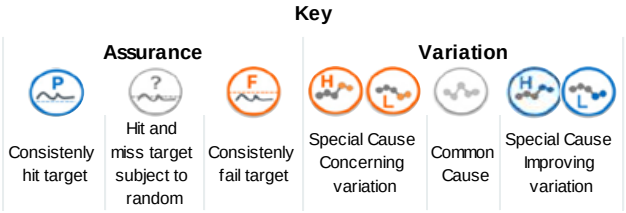
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	N/A
Finance	NHSI Financial Risk Rating		Sep-20	N/A
Finance	Capital 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

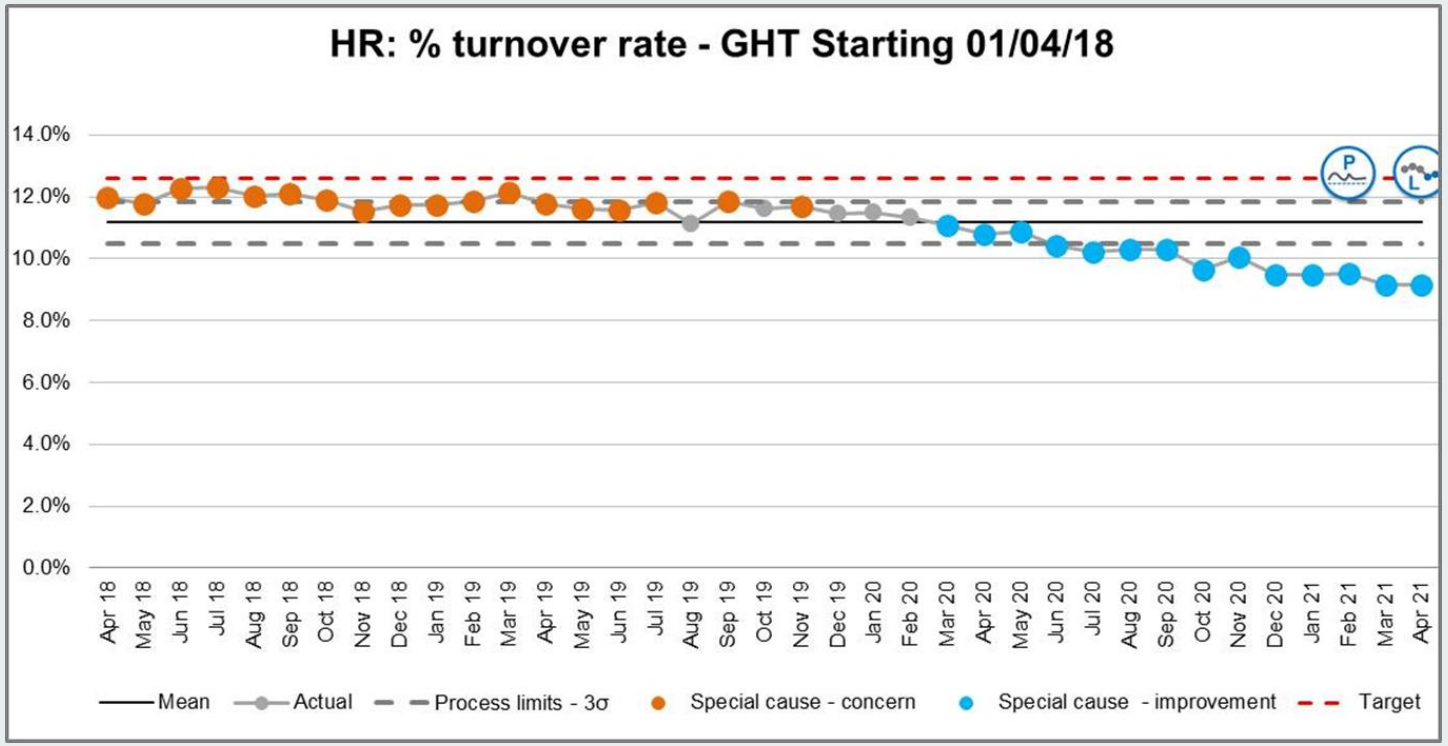
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%		Apr-21	85.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Apr-21	91%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Mar-21	93.1%	
Safe Nurse Staffing	% registered nurse day	>=90%		Mar-21	90.7%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Mar-21	101.3%	
Safe Nurse Staffing	% registered nurse night	>=90%		Mar-21	97.3%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		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	
Safe nurse staffing	Care hours per patient day total	>=8		Mar-21	9.7	
Vacancy and WTE	Staff in post FTE	No target		Apr-21	6678.31	
Vacancy and WTE	Vacancy FTE	No target		Apr-21	298.88	
Vacancy and WTE	Starters FTE	No target		Apr-21	86.69	
Vacancy and WTE	Leavers FTE	No target		Apr-21	36	
Vacancy and WTE	% total vacancy rate	<=11.5%		Apr-21	4.30%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Apr-21	1.38%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Apr-21	7.24%	
Workforce Expenditure	% turnover	<=12.6%		Apr-21	9.2%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Apr-21	8.9%	
Workforce Expenditure	% sickness rate	<=4.05%		Apr-21	3.7%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The rolling annual turnover rate shows a consistent gradual decrease since 2019, placing the Trust in the top quartile for retention when benchmarked to the Model Hospital Peer Group

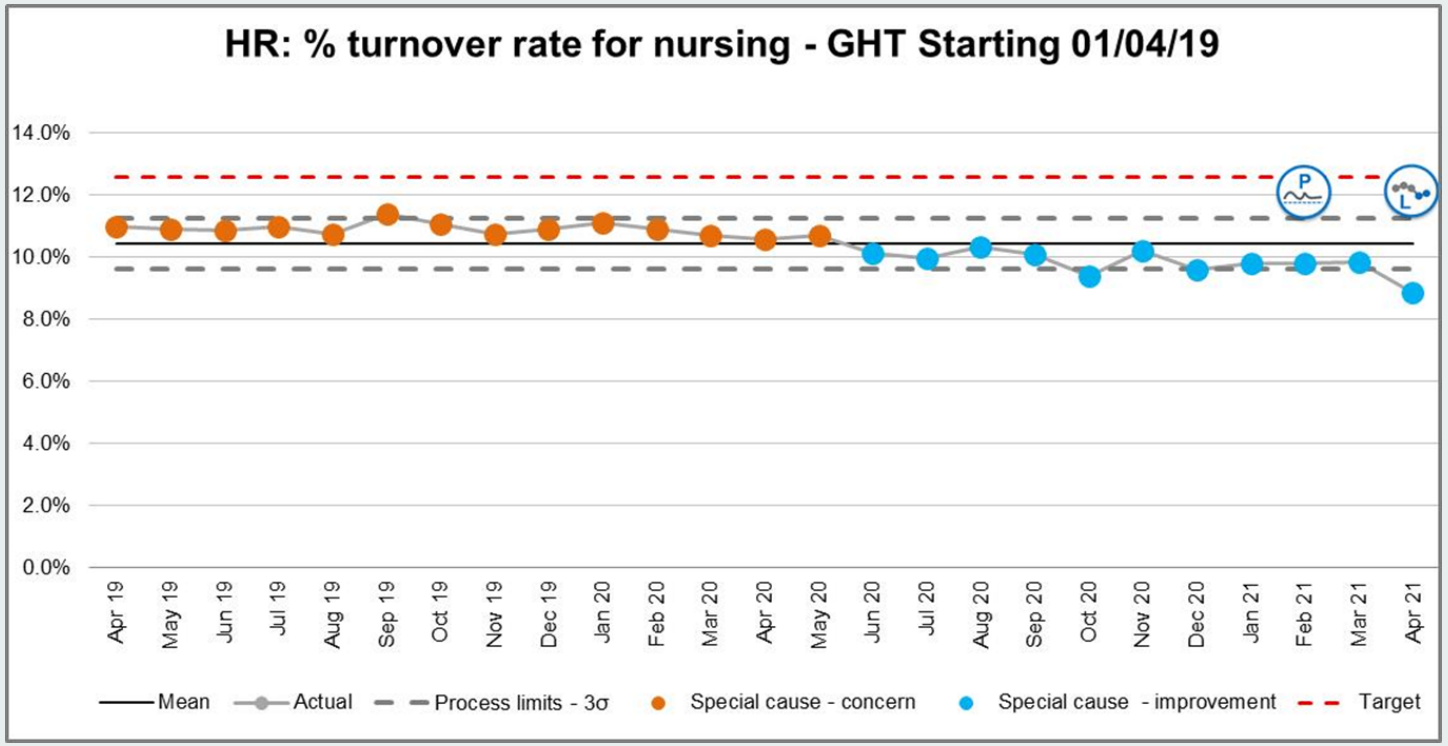
- **Director of Human Resources and Operational Development**

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 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.
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

Registered Nurse Retention figures remain consistently higher than Model Hospital Peers and show a gradual improvement during 2020

- **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 3 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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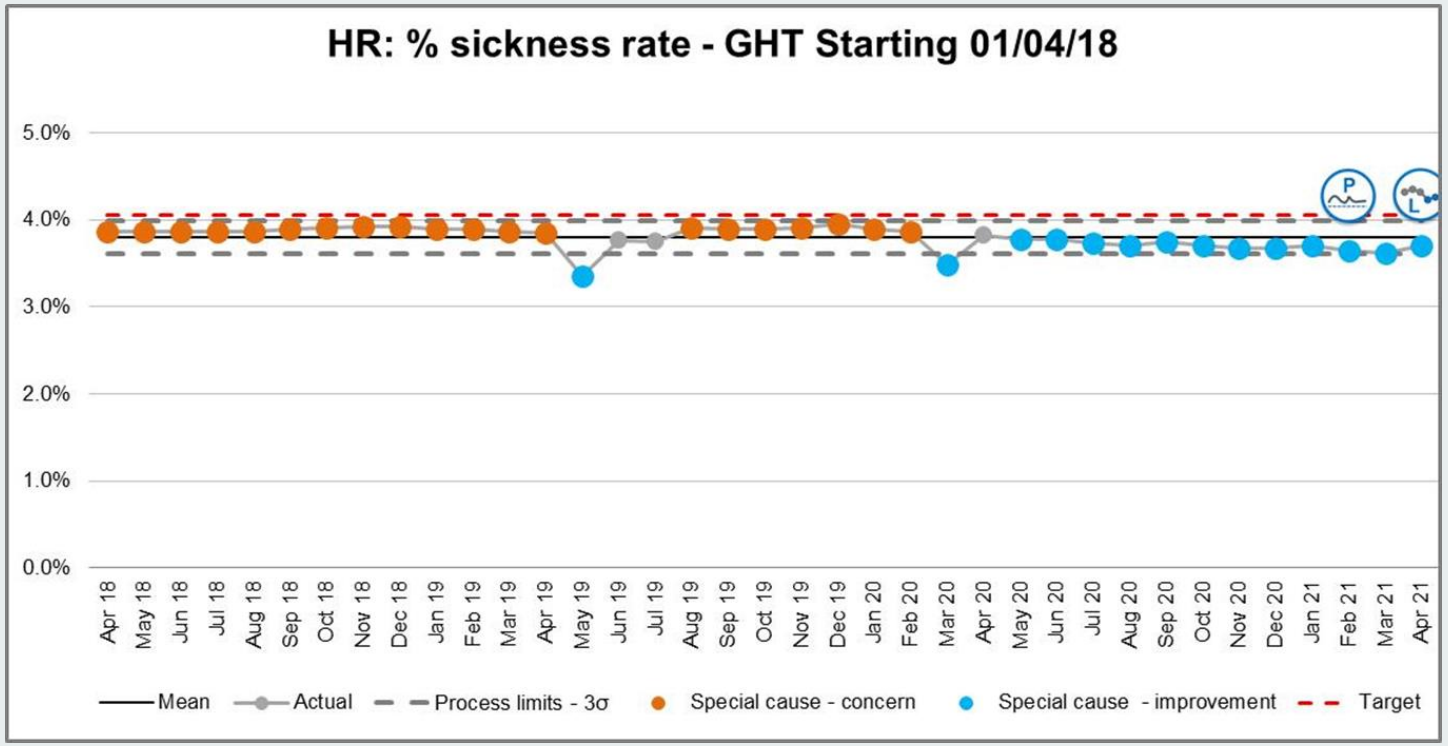
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Sickness absence rates remain stable and below that of model hospital peers

- **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
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Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – JUNE 2021

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 26 May 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
Quality and Performance Report	Comprehensive suite of papers outlining current position with key quality and performance metrics.	**Quality** Noting the recent MHRA visit to the Laboratory, were there any areas of significant concern? Concerning trends in safeguarding seen with absence of actions or plan. Focus on caring for those with dementia and/or delirium noted and an update on the butterfly project	The quality of the Quality Delivery Group exception report is continuing to improve in its ability to provide assurance to the committee on areas of focus, risk, improvement plans and ambition. Reported that the feedback was not significant and expected to be actioned within the required 28 days. Deputy Chief Nurse now leading on a task and finish group to better manage people with complex mental health issues. A suite of actions outlined which include the butterfly symbol, 'This is me'	Report back to committee through the Quality Delivery Group in July

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		requested Significant investment from NHSE/I described to support better care for people with diabetes, what does success look like and what will the key performance indicators be? What will NHSE/I expect to see? Internal audit of CQC plan at Audit and Assurance Committee noted the closed action regarding checking of resus equipment. Due to recent incident, an action for this to be reviewed in line with the new actions, can we see the update at future committee?	document and whiteboard trials. Key indicators being worked up to ensure an integrated approach to diabetes care. Assurance that this investment partially offsets the existing risk on the risk register.	To be included in future Quality Delivery Group exception reports as appropriate.
		Cancer Continued positive performance noted and commended, including national benchmarks Is there anything which will stop us continuing to achieve the standards? With the restart of elective work in theatres, would there be an issue	There are plans for increased demand, If referral patterns were to change significantly, a quick response and review of the plans would be needed. Assurance given that national prioritisation process continues to be in	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		with capacity?	place which includes care for patients with cancer.	
		Planned Care Recruitment of new team for patient communications noted, how will you measure the effectiveness of the team and their work? The validation of the data is not progressing as quickly as desired, what is the plan to change this? Are there any current concerns with harm?	Plans not finalised yet but would include numbers of contacts. Current position improved in regards endoscopy, being monitored at regional and national level. Assured none to note, monitored at executive review process and harm reviews undertaken.	Written update on mass patient communications requested for June committee, including approach and timelines.
		Maternity Internal CQC self assessment noted and new leadership role being appointed, which is part of the action plan. In line with other exception reports, a RAG rating will be useful for future updates and sight of the progress against the single cohesive plan signed off at a previous committee. How are the maternity		Written update on progress of overarching action plan to be received by committee.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		team feeling with the continued change and focus on the service?	The introduction of the maternity assessment tool had gone well and been welcomed and the new appointment is positive.	
		Unscheduled Care Four main points raised by the CQC have been actioned, considerable focus and attention from leaders, as workforce one of the key issues, what thought has there been to the 2-3-5 year solutions? High level improvement plan noted which has department focus, useful for committee to see the whole internal pathway plans with timelines	Assurance that this had been covered at the recent executive review process and Medical Director will consider and draft a report outlining position and plans.	Cross connection to People and OD Committee Consideration to what the committee needs to see for assurance at next committee
Corporate Risk Register	Reduced risk of nosocomial infections reported. Covid and duty of candour, patients across the county to be contacted soon. New patient safety training syllabus shared.	An action from the Audit and Assurance Committee was to focus on the risk regarding 8 hour waits in the emergency department. Does it take a long time for risks to be formulated? Can we link the	The Medicine Division have been asked to review all the relevant risks, with further consideration of the 8 hour issue. Agreed as an action	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		syllabus to a future board development session		
Serious Incident Report	No new never events, four x serious incidents reported, national inactivity of the PHSO to review cases continued.	Continued issue with risk assessments being undertaken, will this be picked up? Previous discussion concerned monitoring the number of non-clinical ward moves, is this or other relevant indicators being considered pre the new Quality and Performance report?	Assurance given that this is picked up at the Quality Delivery Group and through executive review process. Indicators being reviewed prior to new reporting in the Autumn	
Getting it Right First Time ((GIRFT) report	National pause due to covid now ended. A number of deep dives taken place and planned since February. Good practice and suggested areas of focus identified in the Trauma and pathology reviews. New long term (2023) programme of National Consultant Information Programme (NCIP) outlined, focussing on outcome and quality metrics. Glos is in 'fast followers' pilot nationally.	Does patients experience/qualitative data have a place in this methodology? How will the success of the NCIP programme be defined and what will patients know of it?	GIRFT data based on HES (Hospital Episode Statistics), other ways such as patient reported outcomes measures are in use. The programme will give early identification of issue and information sharing for services to review and improve. Not being considered to share wider at this point.	Report on patient reported outcome measures to future committee.
Infection,	Current position with key		Assurance received on	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Prevention and Control Quarter 4 and year end report	indicators, several with good improvements and reduction in infections in year. Focus on hand hygiene audits continue, examples of goods practice and areas to improve noted. New national cleaning standards published, being reviewed regarding local implementation. CQC report shared for information (seen at previous committee) Outline plans for 21/22 shared.	Hand hygiene % of audits being carried out in some areas lower, how does improvement feature in the plan going forward? Good to see the detail for surgical site infections rates, where the figures are red rated, how confident are you that they will improve to acceptable levels?	practices (CQC report) and reduction in numbers of several key infections through the reporting period. Confidence that supporting some areas to carry out more audits is achievable, creating the right culture key. New piece of equipment purchased to support. Good consultant engagement is key, knowing own datasets tends to drive improvement. 21/21 plan has clear focus on surgical site infection rates.	

Alison Moon
Chair of Quality and Performance Committee
28 May 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 10 June 2021
MS TEAMS commencing at 12:30

Report Title
Financial Performance Report **Month Ended 30 April 2021**
Sponsor and Author(s)
Author: Johanna Bogle, Associate Director of Financial Management Sponsor: Karen Johnson, Director of Finance
Executive Summary

Purpose

This purpose of this report is to present the Financial position of the Trust at Month 1 to the Trust Board.

Key issues to note

System Position for H1

The Gloucestershire System has submitted a balanced plan for H1 (April to September 2021). For GHFT, achieving the breakeven position will mean making £2.5m of efficiencies for the first six months. Of this value, £0.4m is not yet identified.

Month 1 overview

Month 1 reports a £13k deficit in month, compared to £3k surplus, so is £16k worse than plan in month. There are areas of concern within temporary staffing costs that are being worked through; the financial position in Month 1 includes a release of contingent reserves equivalent to £0.7m. These reserves will not be available to spend through the rest of H1 and are the release of slippage from planned investments.

Activity was down 2% month on month (although there were fewer working days in April than in March). We did, however deliver 94% of the units of activity we had delivered in the same period in 19/20, when the NHSEI baseline target was 70%. We would expect to be awarded some Elective Recovery Fund income as a direct result of the activity completed, but we will not know the value until national calculations are complete.

Conclusions

The Trust is reporting a month 1 deficit of £13k, £16k worse than the planned surplus of £3k.

Implications and Future Action Required

To continue the report the financial position monthly.

Recommendations
The Board is asked to receive the contents of the report as a source of assurance that the financial position is understood.
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	

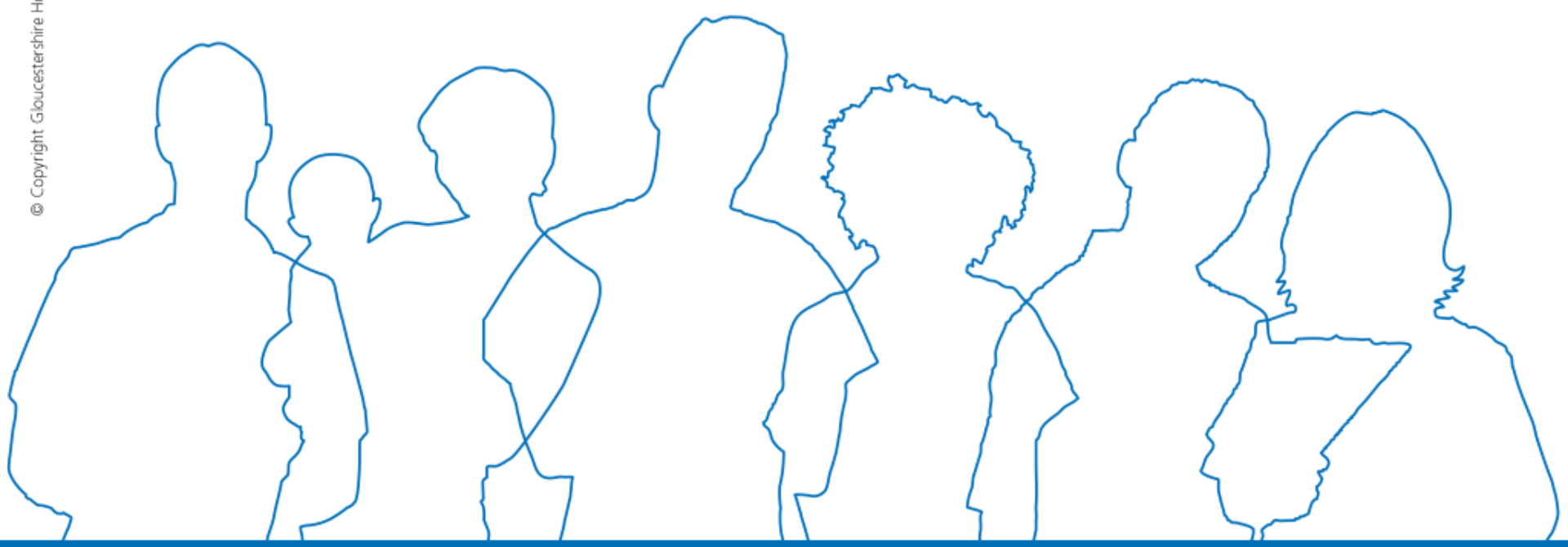
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

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)**
	27/05/2021						
Outcome of discussion when presented to previous Committees/TLT							

Gloucestershire Hospitals
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 30th April 2021



Director of Finance Summary

System Position for H1

The Gloucestershire System has submitted a balanced plan for H1 (April to September 2021). For GHFT, achieving the breakeven position will mean making £2.5m of efficiencies for the first 6 months. Of this value, £0.4m is not yet identified.

Month 1 overview

Month 1 reports a £13k deficit in month, compared to £3k surplus, so is £16k worse than plan in month.

Activity was down 2% month on month (although there were fewer working days in April than in March). We did, however deliver 94% of the units of activity we had delivered in the same period in 19/20, when the NHSEI baseline target was 70%.

Month 1 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £13k deficit		Overall YTD financial performance is £13k deficit. This is £16k worse than plan.
Income is better than plan at £55.79m YTD.		YTD £0.42m better than plan, due to Covid (outside envelope) funding and Pass-through drugs. The income position assumes £0.5m Elective Recovery Fund income will be due to us for our activity over-performance. GMS performed better than plan on income, which is offset in non-pay costs.
Pay costs are higher than plan at £35.6m YTD.		YTD £0.22m worse than plan. This is due to Covid outside envelope costs being excluded from the plan, and Medicine pay being particularly high in month, offset by vacancies in other areas and a pro-rata release of contingency budgets.
Non-Pay expenditure is more than plan at £19.61m.		YTD this is £0.20m worse than plan. This is due to both activity with related income (eg Covid outside envelope, pass-through drugs and GMS activity), as well as Gen Med costs being higher than plan. This is predominantly offset by a pro-rata release of contingency budgets.
CIP schemes are behind plan for 21/22.		The Trust has a target of £2.5m efficiencies for H1 in order that the system plan breaks even. As at Month 1, £0.4m of this remains unidentified. For the YTD, delivery is at £0.26m.
The cash balance is £82.15m		We have not yet submitted a cash flow forecast, but will be working it up over Month 2

Consolidated position M1

Gloucestershire Hospitals NHS Foundation Trust

In month 1 we had £458k of outside-envelope Covid income and cost, broadly equivalent to the gross variances in income / pay / non pay.

However, there are some issues to investigate within these numbers, particularly as there was a £0.5m overspend within Medicine in one month. This appears to be due to significantly higher use of temporary staffing compared to funding available from vacancies, and is linked to ward moves, red and green services and potentially the shift of costs categorised as Covid last year now coming under the Medicine division as the Covid cost centres become more scrutinised (i.e. costs still incurred but now moved to Division). It should be noted that due to overspends there was a pro-rata release of £0.7m contingency budgets to the bottom line in Month 1. This means that if a contingency budget is £1.2m for the full year, £0.1m has been released to the bottom line and therefore only £1.1m remains available to spend in the remaining months of the year.

Consolidated Group Summary

Month 1 Financial Position	M01 Budget £000s	M01 Actuals £000s	M01 Variance £000s	M01 Cumulative Budget £000s	M01 Cumulative Actuals £000s	M01 Cumulative Variance £000s
SLA & Commissioning Income	(48,370)	(48,217)	153	(48,370)	(48,217)	153
PP, Overseas and RTA Income	(264)	(331)	(67)	(264)	(331)	(67)
Other Income from Patient Activities	(264)	(599)	(335)	(264)	(599)	(335)
HEE Income	(2,613)	(2,799)	(186)	(2,613)	(2,799)	(186)
Operating Income	(3,853)	(3,840)	13	(3,853)	(3,840)	13
Total Income	**(55,364)**	**(55,786)**	**(422)**	**(55,364)**	**(55,786)**	**(422)**
Pay	35,386	35,606	220	35,386	35,606	220
Non-Pay	19,403	19,606	203	19,403	19,606	203
Total Expenditure	**54,789**	**55,212**	**423**	**54,789**	**55,212**	**423**
EBITDA	**(575)**	**(574)**	**1**	**(575)**	**(574)**	**1**
EBITDA %age	**1.0%**	**1.0%**	**0.0%**	**1.0%**	**1.0%**	**0.0%**
Non-Operating Costs	624	624	0	624	624	0
(Surplus) /Deficit	**49**	**50**	**1**	**49**	**50**	**1**
Fixed Asset Impairments	0	0	0	0	0	0
(Surplus) / Deficit after Impairments	**49**	**50**	**1**	**49**	**50**	**1**
Excluding Donated Assets	(52)	(37)	15	(52)	(37)	15
Control Total (Surplus) / Deficit	**(3)**	**13**	**16**	**(3)**	**13**	**16**

Month by Month Trend

Gloucestershire Hospitals NHS Foundation Trust

When looking at the run rate it is worth noting that M12 had a number of one-off items both in income and cost that distort it as an overall month (for example, the DHSC central funding and cost adjustment for the additional NHS employer's pension contribution of £16.8m).

Covid costs are coming down as expected. Outside envelope Covid costs are reimbursed on an actuals basis and include vaccination hubs, the SIREN studies and the regional testing centre. The inside envelope Covid costs are around service changes, lost income and additional staffing costs.

12 months' Consolidated Run Rate Actuals	20/21 £'000											21/22 £'000
	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	M01
Pay	32,229	32,550	31,839	33,432	34,174	33,654	33,549	33,955	33,536	33,434	58,159	34,908
Non Pay	13,855	15,843	17,418	21,004	17,569	23,324	18,709	18,766	19,614	19,101	28,985	19,164
Pay - Covid (in envelope)	1,607	1,689	1,366	476	536	154	397	1,157	1,267	1,056	870	419
Non Pay - Covid (in envelope)	2,151	1,146	968	643	1,078	537	296	(28)	180	671	634	263
Covid Costs (in envelope)	3,757	2,835	2,334	1,119	1,614	691	693	1,129	1,447	1,727	1,504	682
Pay - Covid (outside envelope)						53	49	96	283	304	274	279
Non Pay - Covid (outside envelope)						140	38	363	536	249	257	179
Covid Costs (outside envelope)						192	87	458	820	553	531	458
Non-operating Costs	991	1,072	946	1,004	129	745	767	338	750	743	(148)	639
Remove impact of Donated Asset Depreciation / impairments	(37)	(37)	(38)	(37)	(37)	(37)	3	(37)	(37)	(37)	1,158	(37)
Total Cost	50,796	52,263	52,499	56,522	53,449	58,569	53,767	54,609	56,130	55,521	90,189	55,814
Run Rate Funding / Billable Income	(49,027)	(48,452)	(48,872)	(50,748)	(48,304)	(54,113)	(54,678)	(53,767)	(55,078)	(58,828)	(89,702)	(55,343)
Covid Income (outside envelope)						(40)	(10)	(677)	(816)	(568)	(530)	(458)
Total (Surplus) / Deficit	**1,769**	**3,811**	**3,627**	**5,774**	**5,145**	**4,416**	**(921)**	**165**	**236**	**(3,875)**	**(43)**	**13**
True-up Funding	(1,769)	(3,811)	(3,627)	(5,774)	(5,145)	0	0	0				
Grand Total (Surplus) / Deficit	**0**	**0**	**0**	**(0)**	**0**	**4,416**	**(921)**	**165**	**236**	**(3,875)**	**(43)**	**13**

M1 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS Foundation Trust

Consolidated Group Summary

Month 1 Financial Position	M01 Plan £000s	M01 Actuals £000s	M01 Variance £000s	M01 Cumulative Plan £000s	M01 Cumulative Actuals £000s	M01 Cumulative Variance £000s
SLA & Commissioning Income	(48,089)	(48,217)	(128)	(48,089)	(48,217)	(128)
PP, Overseas and RTA Income	(348)	(331)	17	(348)	(331)	17
Other Income from Patient Activities	(523)	(599)	(76)	(523)	(599)	(76)
HEE Income	(2,965)	(2,799)	166	(2,965)	(2,799)	166
Operating Income	(3,439)	(3,855)	(416)	(3,439)	(3,855)	(416)
Total Income	**(55,364)**	**(55,801)**	**(437)**	**(55,364)**	**(55,801)**	**(437)**
Pay						
Substantive	33,005	31,796	(1,209)	33,005	31,796	(1,209)
Bank	1,245	2,163	918	1,245	2,163	918
Agency	719	1,193	473	719	1,193	473
Locum	407	455	48	407	455	48
Total Pay	**35,376**	**35,606**	**230**	**35,376**	**35,606**	**230**
Non Pay						
Drugs	6,487	6,608	122	6,487	6,608	122
Clinical Supplies	4,085	3,610	(475)	4,085	3,610	(475)
Other Non-Pay	8,842	9,388	546	8,842	9,388	546
Total Non Pay	**19,413**	**19,606**	**193**	**19,413**	**19,606**	**193**
Total Expenditure	**54,789**	**55,212**	**423**	**54,789**	**55,212**	**423**
EBITDA	**(575)**	**(589)**	**(14)**	**(575)**	**(589)**	**(14)**
EBITDA %age	**1.0%**	**1.1%**	**(0.0%)**	**1.0%**	**1.1%**	**(0.0%)**
Non-Operating Costs	624	639	15	624	639	15
(Surplus) /Deficit	**49**	**50**	**1**	**49**	**50**	**1**
Fixed Asset Impairments	0	0	0	0	0	0
(Surplus) / Deficit after Impairments	**49**	**50**	**1**	**49**	**50**	**1**
Excluding Donated Assets	(52)	(37)	15	(52)	(37)	15
Control Total (Surplus) / Deficit	**(3)**	**13**	**16**	**(3)**	**13**	**16**

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

HEE Income – Expected to have a higher profile in August, plan is in 12ths

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

Pay – Temporary staffing costs are worryingly high, although these do include those costs of Covid outside envelope services (offset by income). A separate piece of work is being done on the medicine m1 pay overspend.

Non-Pay – above plan, mainly due to outside envelope Covid costs.

nB Contingencies amounting to £0.7m released in month to offset high costs.

Forecast as at M01

Gloucestershire Hospitals NHS Foundation Trust

Consolidated Position	21/22 budget £'000		
	H1 Plan	H1 Forecast	H1 Forecast Variance
Income	(332,186)	(332,186)	0
Pay	212,319	212,319	0
Non Pay	114,210	114,210	0
Capital Financing	5,964	5,964	0
Total (Surplus) / Deficit	307	307	0
Remove impact of Donated Asset Depreciation	(312)	(312)	0
Grand Total (Surplus) / Deficit	**(5)**	**(5)**	**0**

Nationally, Trusts have only been asked to provide a plan for H1 (April – September 2021). This is a distinct departure from needing to submit 2- and 5-year plans, and a sign of the fluidity with which departmental planning is being undertaken.

We are forecasting a small surplus of £5k for H1, with the Integrated Care System intending to breakeven. In order to do this we need to achieve a minimum of £2.5m expenditure reduction as part of a financial sustainability agenda that is likely to only grow throughout this year. As at Month 1, this forecast remains current.

Balance Sheet

Gloucestershire Hospitals NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2021 £000	GROUP Balance as at M1 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	8,215	(65)
Property, Plant and Equipment	276,161	276,636	475
Trade and Other Receivables	6,149	6,152	3
Investment in GMS	0	600	
Total Non-Current Assets	**290,590**	**291,003**	**413**
Current Assets			
Inventories	8,933	9,304	371
Trade and Other Receivables	18,054	26,995	8,941
Cash and Cash Equivalents	77,918	82,145	4,227
Total Current Assets	**104,905**	**118,444**	**13,539**
Current Liabilities			
Trade and Other Payables	(104,034)	(110,022)	(5,988)
Other Liabilities	(8,565)	(16,712)	(8,147)
Borrowings	(3,404)	(3,401)	3
Provisions	(163)	(163)	0
Total Current Liabilities	**(116,166)**	**(130,298)**	**(14,132)**
Net Current Assets	**(11,261)**	**(11,854)**	**(593)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,485)	32
Borrowings	(37,438)	(37,317)	121
Provisions	(2,888)	(2,911)	(23)
Total Non-Current Liabilities	**(46,843)**	**(46,713)**	**130**
Total Assets Employed	**232,486**	**232,436**	**(50)**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	332,033	0
Reserves	27,976	27,976	0
Retained Earnings	(127,523)	(127,573)	(50)
Total Taxpayers' Equity	**232,486**	**232,436**	**(50)**

The table shows the M1 balance sheet and movements from the 2020/21 closing balance sheet.

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a Month 1 deficit of £13k, £13k worse than the planned £3k surplus.
- Note that the Trust needed to release £0.7m of contingency to meet its plan in month, predominantly due to temporary nursing staffing overspends in the Medicine division. This is being worked through with the Division to understand how we can mitigate to get back to plan.

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

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

Date: **May 2021**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 10 JUNE 2021

Report Title
Capital Programme
Sponsor and Author(s)
Author: Craig Marshall, Project Accountant Sponsor: Karen Johnson, Director of Finance
Executive Summary
Purpose To update the Trust Board on the funding and delivery of the 21/22 capital programme. Key Issues to Note The Trust submitted this capital plan to NHSIE on the 12 April totalling £57.5m, of which £24.4m was part of the Trust's system allocation and £33.1m was planned to be funded by National Programme PDC, donated, government grants and IFRIC 12 adjustment. c£8m of the system allocation will be subject to a successful application for Interim Support PDC.
Recommendations
The Trust Board are asked to NOTE the programme and the actions that have been taken.
Impact Upon Strategic Objectives
None.
Impact Upon Corporate Risks
The programme is prioritised on addressing highest risks identified in Trust divisional risk registers.
Regulatory and/or Legal Implications
None.
Equality & Patient Impact
Each business case within the programme will review impacts and any mitigation actions.

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

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

Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
	29 April 2021						
Outcome of discussion when presented to previous Committees/TLT							
The Committee noted the contents of the report for information.							

Author:
Craig Marshall (Project Accountant)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

2021/22 Capital Programme

LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

21/22 - Capital Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

Table 1: 2021/22 Capital Programme (in £000's)

Division	Scheme Name	March FDC	Changes	Capital Pla
System Capital				
Ring Fenced Allocation	MEF Contingency	700	0	700
Ring Fenced Allocation	General Contingency Fund	744	(265)	479
Information Technology Infrastructure	Data Warehouse	200	0	200
Information Technology Infrastructure	EPR - Allscripts Paperlite etc..	1,308	(1)	1,307
Information Technology Infrastructure	EPR - AllScripts EPR	830	0	830
Information Technology Infrastructure	EPR - Allscripts EPR - ECDS	350	0	350
Information Technology Infrastructure	EPR - Order Comms Advanced	1,000	0	1,000
Information Technology Infrastructure	EPR - EPMA Phase 2	1,500	0	1,500
Information Technology Infrastructure	EPR - EPR Upgrade	420	0	420
Information Technology Infrastructure	Imprivata Tap & Go/VDA	500	0	500
Information Technology Infrastructure	Smart Care Implementation	0	600	600
Estates Strategic Master Plan	Fit for the Future: IGIS Phase 1 - Cardiac Cath Labs	2,489	0	2,489
Surgery	Constellation VR Machine	96	0	96
Information Technology Infrastructure	End User Hardware refresh	500	0	500
NHS Gloucestershire Managed Services (Estates)	Lifecycle (Estates)	2,500	996	3,496
NHS Gloucestershire Managed Services (Estates)	Lifecycle (Estates)	0	1,108	1,108
Diagnostics and Specialties	Gamma Camera / SPECT CT *Required as part of phase 2 Cath lab instalation / IGIS	1,060	(236)	824
Surgery	GRH Refurbishment programme	1,250	0	1,250
Surgery	Light Replacements (16 theatres)	110	0	110
Surgery	UPS (14 theatres)	250	0	250
Womens and Children	Maternity Digital System	1,500	0	1,500
Estates Strategic Master Plan	Fit for the Future: IGIS Phase 1 enabling - Permanent solution for services displaced by GRH Cardiac Cath Labs	1,750	0	1,750
Information Technology Infrastructure	Clinical System Consolidation (Maces)	500	0	500
Information Technology Infrastructure	Office 365 Upgrade	300	0	300
Information Technology Infrastructure	Legacy Infrastructure Modernisation (SQL,Sharepoint,2008..etc)	200	0	200
Estates Strategic Master Plan	Fit for the Future: IGIS Phase 2 - Provision of new & 2nd IR room at GRH, including relocation of X-ray and US	1,244	(311)	933
Diagnostics and Specialties	HEE Endoscopy		700	700
Estates Strategic Master Plan	Courtyard	0	512	512
Sub Total	**Sub Total**	**21,300**	**3,104**	**24,404**
National Programme and Other				
NHS Gloucestershire Managed Services (Estates)	Energy Efficiency (Salix) - Vital			3,767
NHS Gloucestershire Managed Services (Estates)	Energy Efficiency (Salix) - GMS			3,392
Estates Strategic Master Plan	Gloucestershire Hospitals Strategic Site Development			17,602
Ring Fenced Allocation	Donated Assets			500
Information Technology Infrastructure	Digital Aspirant			2,000
Sub Total	**Sub Total**			**32,261**
IFRIC				
Corporate	Capital element of payments relating to IFRIC 12/PFI schemes			874
Sub Total	**Sub Total**			**874**
Grand Total	**Grand Total**			**57,539**

Conversations concluded within the system with regards to understanding the individual providers system capital allocations for 21/22. Gloucestershire Hospitals NHS Foundation Trust allocation was £24.4m, an increase of £3.1m to the level used for prioritisation purposes to date.

IDG approved the allocation of the additional £3.1m shown in the Table to the right. The majority of the additional allocation being assigned to Estates Lifecycle / Backlog maintenance.

The Trust submitted this capital plan to NHSIE on the 12th April.

The system capital allocation will be funded by c£16m of internally generated funds (i.e. net depreciation) and the remaining depend on the Trust being successful in securing c£8m of interim PDC.

The Trust have begun to identify these schemes with a view to begin preparing the interim PDC application in May.

Capital Programme: Risks

Gloucestershire Hospitals NHS
NHS Foundation Trust

The main risks to the 21/22 capital programme as a result of the 20/21 outturn position

- The year end position is subject to external audit. The accounts will be audited in April / May.
- Slippages and commitments that did not complete in the 20/21 financial year will need to be made available in the 21/22programme.
- Due to the regional position the Trust were able to fund the full purchase of the surgical robot from the Trust's programme. The initial plan was to fund part of the purchase from charitable fund raising in 21/22. The Trust will now switch the fund raising focus in the new year and are working with the charity to do this. The idea will be to choose something from the 21/22 capital programme to free up the allocation to complete the critical care resilience building works which were unable to be undertaken in 20/21.

Other risks to the 21/22 capital programme

- The Trust have planned for £17.6m PDC funding to support the SSD programme. Until such time as FBC, currently with NHSIE for approval, is supported then this remains a risk to the SSD programme.
- Whist we have received confirmation of the digital aspirant capital funding for 21/22 the funding as yet to have been received.

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- The Salix energy efficiency project is currently operating under an Advanced Notice Variation (ANV) within the previously approved amount of £4m.
- Timing of capital payments and drawdowns could impact on cash-flow. Work is being commenced with financial accounts team to ensure that there is drawdowns of cash are done in a timely fashion to best match the expenditure profile. This will need continually monitored throughout the year as the forecast expenditure profiles change.

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – JUNE 2021
Via MS TEAMS commencing at 12:30

Report Title
Digital & EPR Programme Report

Sponsor and Author(s)	
Author:	Anna Wibberley, Digital Programme Director Nicola Davies, Digital Engagement & Change Lead
Sponsor:	Mark Hutchinson, Executive Chief Digital & Information Officer

Executive Summary

Purpose

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

Key Issues to Note

- The new Pharmacy stock control system (EMIS) went live on Wednesday 7 April.
- Planning is continuing for the application of the latest Sunrise patch release, "Patch 69", needed to fix existing issues with EPR Tracking Boards.
- Planning activities have commenced for the recommended upgrade of Sunrise EPR to version 20 to enable full and effective implementation of electronic prescribing and medicines administration (ePMA).
- Digitising the Sepsis Pathway will be aligned with the implementation of EPR into ED.
- Hospital Discharge Service on EPR – new functionality will go live on 12 May, a new tool to support doctor's ward handover lists.
- The re-planning exercise for the implementation of electronic prescribing and medicines administration (ePMA) is progressing.
- GHT BI analysts will be working with Artificial Intelligence experts in NHSX (and their partners) to create a risk score on Sunrise EPR for every admitted patient, which will indicate the likelihood of that patient becoming a "long stayer". More detail is in the report.
- Digital Programme Office - there are currently twenty-nine new project requests in various stages of processing from receipt and triage to initiation, pending the assigning of a Project Manager.

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 Board 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**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – JUNE 2021

DIGITAL & ELECTRONIC PATIENT RECORD (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. This includes Sunrise EPR, digital programme office, business intelligence, information governance and IT. The progression of the digital agenda is in line with our ambition to become a digital leader.

2. AI Skunkworks Project NHSX

The GHT BI Team has been successful with its bid to become part of the NHSX Artificial Intelligence (AI) Skunkworks project this spring. The BI Team, joined by Mark Hutchinson and Dr 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 final 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 on Sunrise EPR 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 model proves to be accurate and effective, NHSX have plans to scale it up to implement at a national level.

3 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:

- The new Pharmacy stock control system (EMIS) went live on Wednesday 7 April.
- Planning is continuing for the application of the latest Sunrise patch release, "Patch 69", needed to fix existing issues with EPR Tracking Boards.
- Planning activities have commenced for the recommended upgrade of Sunrise EPR to version 20 to enable full and effective implementation of electronic prescribing and medicines administration (ePMA).
- Digitising the Sepsis Pathway will be aligned with the implementation of EPR into ED.
- Hospital Discharge Service on EPR – new functionality will go live in mid-May, including the addition of ward handover lists. Engagement and testing with clinicians underway.
- The re-planning exercise for the implementation of electronic prescribing and medicines administration (ePMA) is progressing.
- Order Comms will be delivered into Theatres, Endoscopy and some Outpatients areas during June.
- GHT BI analysts will be working with Artificial Intelligence experts in NHSX (and their partners) to create a risk score on Sunrise EPR for every admitted patient, which will indicate the likelihood of that patient becoming a "long stayer". More detail is in the report.

3.1 EPR High Level Programme Plan

The programme plan below details the EPR functionality being delivered this year. *This table is correct as of 1 May 2021.*

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	March 2021
Pharmacy Stock Control –	April 2021	April 2021
HDS (ward handover list)	May 2021	May 2021
Sepsis/deteriorating patients	Moving to coincide with ED in GRH	

Order Communications (theatres)	June 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 2021/22. Upgrade to Sunrise EPR v20 may impact this.	

3.2 EPR project summaries and status updates

This section provides the latest status on EPR projects currently reporting through the EPR Programme Delivery Group.

3.3 EMIS Pharmacy Stock Control

EMIS Pharmacy Stock Control system went live on Wednesday 7 April. Implementation was successful, with a number of snagging issues resolved in the first week of go live.

Two elements originally planned to be delivered were broken out into a separate phase; CIVAS and Electronic Medicines Management. Planning of this phase is ongoing.

The implementation of this modern integrated Pharmacy system supports the Trusts long term EPR strategy replacing the legacy system which had been in use since the 1990s. The new system is integrated with Allscripts Sunrise EPR System, with further integration to existing systems interfacing with TrakCare, Pharmacy robot and Finance systems. The solution is also compliant with the dm+d (Dictionary of Medicines and Devices) standard.

3.3 Hospital Discharge Service

Working closely with clinical leads, we are launching additional functionality within Sunrise EPR that will allow us to improve the quality of information shared on ward handovers, and meet national reporting requirements.

A solution has been developed and is being tested with a range of consultants and juniors, that will allow us to fully implement the Hospital Discharge Services (HDS) Policy and the recording of Medically Optimised For Discharge (MOFD) or ‘Criteria to Reside’. By recording this data in EPR we will know that:

- All patients will have a decision and plan at board round/ward round. Are they MOFD or not? If not why not and if they are what is the pathway for them.
- OCT will be able to view this data and support referrals to the Transfer of Care Bureau and discharge planning earlier.
- The site team will be able to view who is MOFD so will know which simple discharges to chase and support again earlier in the day.

- We should see a reduction in phone calls between teams as a result of having a central point of information that everyone can view.

Engagement is underway, led clinically by Eve Olivant (nursing) and Dr Kate Hellier. Demonstrations have been given to a group of interested clinicians from across the hospital – this group is acting as a feedback and testing group. The EPR team is engaging juniors across both hospital sites.

Go-live planning is underway, with a launch date of 12 May. Floor walking support will be provided and senior clinicians are being asked to be visible during the first week, to encourage use of the new tool; signposting to use EPR during board rounds and ward rounds. Compliance data for all wards and specialities will be provided back to divisional and service line Tri's to monitor progress.

3.4 EPR Programme RAG Status Updates

Title:	**Order Communications – Theatres**	
Current Project RAG Status:	**A**	**Scope:**
RAG Status against Programme:	**G**	**All Theatre locations at GRH, CGH and SMH**

RAG Status	Workstream	Update
G	Benefits & Comms	Benefits have been baselined and signed off. Communications will begin to inform IPS users of the eventual switch to Sunrise EPR for viewing results.
G	Config	Unit Testing is planned to end on 04/05/2021, subject to a progress review on 27/04/2021. The Clinical Systems Safety Group has reviewed the SOPs and agreed the future state. Theatres are scheduled to approve at the Surgical Board on 26/04/2021 and Endoscopy Team to review at a business meeting on 28/04/2021. . Endoscopy SOPs are also pending approval with a meeting scheduled for 28/04/2021.
A	Testing	Testing is currently behind schedule. Re-planning activities are taking place and due to deliver 4th May.
G	Training	The final clinical approval of SOPs for Theatres (26/04/2021), Endoscopy (28/04/2021) and Radiology (TBC) will enable training scope and content to be finalised.
G	Site Readiness	Decision has been made to place an order for 19 x Bytec carts rather than shelving/desks. The BCP audit is complete (excluding Radiology).
G	Cutover	Planning will commence during May.
Overall Status:		

The overall status is Amber. Progress has been slower than planned with the configuration of the Histopathology module in TCLE/SCM. Obtaining feedback from testers in order to progress this development has been challenging and so dedicated Test management resource has been recruited in order to drive progress and deliver daily updates.

Title:	Order Communications – Outpatients	
Current Project RAG Status:	**A**	**Scope:**
RAG Status against Programme:	**G**	• **All Outpatient locations that use phlebotomy services at CGH and GRH** • **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 follow-on meetings scheduled to enable comparison work.
A	Config	All future state items have been agreed with the exception of those for the CGH Pre-Admissions Day Unit. 8 configuration items out of a total of 11 have been completed (with Care Provider Review, Label Configuration and the Take-away form for Phlebotomy outstanding). Completion expected 28/04/2021.
A	Testing	The Test scope and approach is being re-scheduled and is due to be delivered 28/04/2021, subject to completion of unit testing.
G	Training	A review of the scope of Training is underway, to be completed by 28/04/2021.
G	Site Readiness	Phlebotomy site readiness audits have been completed. The review of CGH Pre-Admissions Day Unit (an additional area) is scheduled.
G	Reporting	BCP machines requirements in Phlebotomy have been determined. Requirements for CGH Pre-Admissions Day Unit are pending.
RG	Cutover	Planning will commence during May.

Overall Status:

The overall status is Amber. Testing has been delayed by the late delivery of configuration items. However, time-scales are still within tolerance and the project is expected to deliver to time-scale.

Title:	TCLE Implementation – Replacement Lab System	
Current Project RAG Status:	A	Scope:
RAG Status against Programme:	G	Implement TCLE and Retire IPS within all GFHT labs

RAG Status	Workstream	Update
G	Benefits	An initial meeting has been held with the Benefits Manager. Benefits articulation and baseline to enable measurement are being developed.
A	Config	Configuration tasks are behind plan but expected to complete on 4th May. Obtaining feedback from some testers in order to progress this development has been challenging and so dedicated test management resource has been recruited in order to drive progress and deliver daily updates.
R	Testing	Completing testing work has been extremely challenging for the team. Extra resource including a dedicated test manager has been provided to the project to assist with this task. Progress is being managed closely and reported on daily in order to ensure time-scales are met.
G	Training	Plans are being drawn up to deliver comms and training to colleagues across the Trust and the wider ICS to ensure that delivery of results continues without interruption post-go-live.
G	Site Readiness	All end-user requirements are complete. .
A	Integration	Issues with SCM to TCLE messaging are ongoing but under active management. All downstream interfacing has been built with the exception of ICNet, which is not due until 11/05/2021.
G	Reporting	A Reporting Workshop was held on 20/04/2021 and Labs confirmed that all operational reporting requirements can be met by TCLE reporting functionality Logic to duplicate the COSD (Cancer Outcomes and Service Dataset) extract within the Date Warehouse is being built with advice from ISC. A test plan to ensure that data migration does not impact Labs reporting is underway. A solution to identify cancer pathway patients for Histology cancer reporting has been agreed.
G	Cutover	Planning will commence during May.
Overall Status:		

This is rated Amber.. The Histology and Blood Transfusion configurations are behind plan. Although extra resource has been provided through the Digital Teams, feedback from some testers in order to enable swift turn-around of configuration issues has been and continues to be a challenge.

Title:	EPR in GRH ED	
Current Project RAG Status:	G	Scope:
RAG status against programme:	G	• Implement Follow Me Desktop in ED locations • Implement EPR in ED in GRH

RAG Status	Workstream	Update
G	Benefits	Work has commenced pulling together the information required for time in motion studies and observers are being resourced.
A	Config	Scoping meetings have now taken place with ED and a clearer understanding as to what is to be built has now been reached, with work underway to build this into the plan. Twice weekly meetings are being scheduled with the clinical team for sign off of the build. Mode of Arrival has been added as a change request to ISC.
G	Testing	Work on the plan is underway with Allscripts and the Team.
A	Training	A meeting to discuss training needs and configuration has been scheduled. 65% of all ED Staff have completed training and ED has been asked to rotate ED staff through CGH for training needs. A meeting has been scheduled with Specialty teams to understand their scope. Delivery of training for additional functionality that has been confirmed as essential has yet to be approved by ED clinical team.
G	Site Readiness	A Citrix milestone has been added to the plan and is on track to complete 07/05/2021. The required patch release has been added to the plan. Bytec carts have now been delivered and delivery of static carts is outstanding. Imaging of Igels and PCs has commenced as has the setting up of zebra printing and the Bytec carts. Follow Me Desktop licences are being reviewed. Resources are required to enable trials to take place in both CGH and GRH. A decision also needs to be reached as to which modes will be used in ED for the Igels.

G	Integration	Not required.
G	Reporting	BI has been working on the plan to ensure that core dates are in place. A meeting with Configuration and BI will ensure that timescales are mirrored in the plan. Data Quality Dashboard dates have been added to milestones.
G	Cutover	A review of go live support needs and floorwalker resource is planned to take place w/c 4th May.
Overall Status:		
The overall project status is Green. Great progress has been made by the EPR configuration team and the ED clinical team. The success of this project relies on the correct clinical engagement, which is being closely managed by the project team.		

Title:	**EPMA**	
Current Project RAG Status:	**G**	**Scope:**
RAG Status against Programme:	**A**	• **Implement EPMA in Adult Inpatient areas** • **Implement EPMA in other areas**

RAG Status	Workstream	Update
G	Benefits	Benefits will be monitored as an ongoing activity together with EPR Benefits Lead.
G	Config	Worklist Manager Views have been completed and the Basic Order Form was discussed at the work-stream meeting (13/04) and approved.
G	Testing	Testing was will commence when configuration is in place.
G	Training	Training plan is awaiting sign off of the overall project plan.
G	Site Readiness	Equipment and infrastructure will need to be delivered in line with the future states once agreed.
G	Integration	The design specification for ePMA integration is currently being reviewed.
G	Reporting	This will be monitored as an ongoing activity. Discussions are currently underway with Pharmacy and BI to define these requirements.
G	Cutover	The plan is awaiting sign off.
Overall Status:		

Detailed project plan and brief has been scrutinised by the Programme Delivery Group. Activities are being tracked against plan. There is a dependency on the Upgrade of SCM to version 20 and the impact of this will be discussed at the next meeting.

3.5 Activity planned for next period

- The EMIS Phase 1 project will move into BAU.
- The EMIS Phase 2 project plan will be reviewed and approval sought to proceed.
- The HDS project will go live.
- The TCLE, Theatres and Outpatients projects' configuration activities will complete and training, cutover planning activities will commence and testing will continue to be completed, tracked and reported on daily.
    - The GRH ED project will continue work to deliver planned work across all work-streams – including Follow Me Desktop improvements.
    - Sepsis/Deteriorating patients' development in line with ED.
- A workstream within the GRH ED project will deliver the application of "Patch 69".
- Detailed planning activities will commence for the upgrade of SCM in order to ensure that a major dependency for the ePMA project is met.

3.6 Risks

Current major risks to the project timeline and successful outcomes:

- An upgrade to version 20 of Sunrise EPR is needed to implement ePMA which in turn will negatively impact the ePMA implementation timeline if delivered late.
- The testing approach previously adopted by the Trust is not thorough enough for EPMA and could cause a delay to project timeframe or data quality, or patient harm could result.
- Lack of engagement from some areas within the pathology department threaten to impact the successful and timely delivery of the TCLE project and delivery of Order comms into Theatres, Endoscopy and Outpatients.

3.7 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. Clinical engagement is key to the successful delivery of this programme of works.

4. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). Since the last report two projects have been completed and closed and two projects have gone into closure.

There are currently twenty-nine new project requests in various stages of processing from receipt and triage to initiation, pending the assigning of a Project Manager.

Key issues to note:

- The MDT Video Conferencing and N3 to HSCN Migration Countywide projects have been closed.
- Office 365 (N365) migration project is continuing, with engagement beginning at operational level.

- The decommissioning of legacy telephony equipment to complete the Next Generation Telephony project will commence with the cessation of the remaining single circuit.
- The Data Centre Refurbishment project is in initiation.
- The Viewpoint 6 Upgrade is waiting to go into closure.
- Four projects are either in closure or have been closed during the last period.

4.1 Office 365 Project Update

From 31 October 2021, The Office 2010 product installed on all 7,000 Trust computers, used by more than 10,000 staff, is no longer being supported by Microsoft. GHT has signed up to be part of the newly formed N365 product offering, a specially developed Microsoft Office 365 product for the NHS; developed by Accenture, Microsoft and NHS Digital. Office 365 means moving to web based products, which is a significant change for the organisation, but avoids increasing annual costs of providing the full Microsoft Office suite to every member of staff.

We have committed to providing only essential users (approximately a third of staff) with full Microsoft Office and work is underway to identify those users. Stakeholder engagement has started, with service and departmental reps now attending project sessions.

The project stakeholders (listed below) will be an integral part of the planning and feedback loop. Lead stakeholders are being asked to nominate if they themselves are unable to participate. Meetings are happening throughout May to set the scene and expectations.

Although headline messaging has been agreed, communications have not yet started in earnest across the organisation. This will not begin until the business analysis work is complete and there is clear messaging on what this change means for each area.

Project update:

- An investigation into the clinical systems interoperability with Microsoft Office is making good progress.
- Progress has been made with NHS Digital and Accenture on the issue of migrating the local e-mail archive files into the on-line archive for all users.
- A new tool to support the transition from desktop to web browser, and make it easier for users, is being scoped.
- Engagement with the operational leads is underway; this will ensure we identify how colleagues use Microsoft Office currently and tailor the new solution so that they are able to continue to complete their normal duties without interruption.
- Work is ongoing to identify how data will be managed and utilised in the Microsoft Cloud instead of within the on-premise environment.
- User scenario scripts are being drafted to determine how applications can be best deployed to users.

Key Stakeholders identified at start of project, or representatives:

Name	Role
Thelma Turner	Associate Chief Information Officer / IG and Health Records
Felicity Taylor-Drewe	Director of Planned Care / Deputy COO
James Brown	Director of Engagement, Involvement & Communications
Craig MacFarlane	Head of Communications

Ian Quinnell	Associate Director of Strategic Planning and Transformation
Chantal Sunter	Head of Research and Development
Dan Corfield	Head of Business Development & Planning
Vivien Mortimore	Divisional Director of Quality, Nursing and Midwifery (Women & Children)
Margaret Coyle	Chief of Service (Surgery)
Eve Olivant / Nominee	Acting Director of Operational Nursing and Deputy Chief Nurse *Divisional Director of Quality & Nursing (Surgery)*
Ian Shaw	Chief of Service (Medicine)
Alison McGirr	Director of Unscheduled Care & Medicine & Deputy COO
Gavin Hitchman	Divisional Director of Quality & Nursing
Sandra Attwood	Deputy Director of Quality & Nursing for Medicine
Rachael Mantel	Deputy Director of Quality & Nursing for Medicine
Alex Matthews	Deputy Director of Medicine
Anna Blake	Deputy Director - Unscheduled Care & Flow (Medicine)
Dr Kate Hellier	Diagnostic & Specialties Chief of Service
Judith Hernandez	Divisional Operations Director (Diagnostic & Specialties)
Jo Harvey	Divisional Director of Quality and Nursing (Diagnostic & Specialties)
Nicola Turner	Divisional Director for Allied Health Professionals (Diagnostic & Specialties)
Rachel De Caux	Emergency Planning, Resilience & Response Accountable Officer & COO
Dickie Head	Emergency Planning
James Curtis	GM Cancer Services
Sian Middleton	Lead Cancer Nurse
Roger Blake	Associate Director Planned Care
Sam White	Lead Nurse for Specialist Palliative and End of Life Care
Dee Gibson-Wain	Associate Director of Education & Development
Mel Murrell	Associate Director of Resourcing
Alison Koeltgen	Operational Director of People and OD
Suzie Cro	Deputy Director of Quality
Craig Bradley	Associate Chief Nurse / Deputy DIPC
Carole Webster	Deputy Chief Nurse
Lynne McEwan-Berry	Safeguarding, Adults
Vivien Mortimore	Safeguarding Children
Mark Hutchinson	Senior Information Risk Owner (SIRO) Exec Chief Digital & Information Officer
Mark Pietroni	Caldicott Guardian Medical Director
Caroline Pennels	Data Protection Officer/FOI
Dr Alex D'Agapeyeff	Deputy Medical Director
Victoria Collins	Safety & Quality Improvement Manager
Alex Gent	Head of Shared Services
Edward Taylor	Head of Procurement
Hayley Harper-Smith	Head of Payroll & Payments
David Cooper	Site Management, Capacity & Flow GM
Sarah Hammond	Associate CIO & Head of BI
Steve Perrins	Director of Operational Finance
Johanna Bogle	Associate Director of Financial Management
Terry Hull	GMS

4.2 Areas of Concern & Mitigating Actions

SQL Migration & Windows 2003 Upgrade

Following escalation regarding a lack of engagement and with commitment received a re-planning exercise is underway to accommodate resource availability and project dependencies to outline the approach required to successfully deliver the last, problematic, elements of the project.

GHT N365 Transition and Change

A number of issues have arisen during the investigation phase of this project. These are primarily focused on 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, with an expectation that the project will return to Green within the next few weeks.

N365 for the GCCG

Following the loss of the technical lead the first tranche roll-out across 14 sites has been placed on hold whilst a new support resource is confirmed. A replacement is at present split across a number of projects and the split and availability for this project has yet to be determined. This is expected to the clarified shortly and progress will re-commence and the project will return to Green.

4. Countywide IT Service (CITS) monthly report

To report on the monthly performance of the countywide IT service for March 2021.

Key issues to note

- The CITS team continue to experience increasing demand to support 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 March shows 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 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. We saw increases due to software deployment issues with MS Teams via SCCM.
- We have reduced the number of open deployment incidents; as deployment of equipment is organised and managed in much quicker timescales.

5. 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.

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 UK General Data Protection Regulation (UK 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. This is a small decrease in numbers in comparison with last financial year.

A summary of the incidents, including lessons learned, will be included in the Trust's annual report.

46 Confidentiality incidents have been reported on the Trust internal Datix incident reporting system during March 2021.

6. Cyber Security

This section highlights cybersecurity activity for March 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.

- Cyber Security Risks moved from Red to Amber following remediation activity.
- Cyber Response Table Top Exercise pencilled in for 4th June, with support from NHSD and Police.
- One High Severity CareCERT Advisory received during the reporting period, affecting only GHC (single instance of Exchange 2016), which was closed in short order via patching.
- CC-3772, received in February, was addressed by VMware partner, Lima, on 28th March. Reported here for assurance.

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

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – June 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 27 May 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
Digital Programme Report	Comprehensive report on project status. Key points: • Pharmacy stock control went live in April • Successful deployment of latest Sunrise patch release • New functionality of Hospital Discharge Service on EPR went live on May 12th • Progress of collaborative effort with NHSX on length of stay risk assessment • Commencement of revised planning approach for electronic prescribing and medicines administration	What resilience testing has taken place? Does the change in Emergency Department levels in Cheltenham impact the EPR timeline? Does the Trust comply with NHS cyber security standards?	Deployment of the recent upgrade has presented an excellent opportunity to test ahead of the much larger upgrade planned for the autumn. This has provided an opportunity for system assurance ahead of the deployment in Gloucester later in the year.	A special review has been scheduled for July. Proposed that the team give consideration to risk appetite to ensure the correct approach particularly in the light of gaps in national guidance
OFFICE N365	Paper presented covering the rollout planned for Autumn 2021 of the specially	Are GMS staff included in the plans?	Yes they will be	Documentation needs to reflect the inclusion of GMS

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	developed Microsoft Office 365 product developed by Accenture, Microsoft and NHS Digital. Key feature is a web-based approach giving the opportunity to reduce licencing costs. Stakeholder engagement has started and tools to help transition for users being scoped,	Discussion stressed the need for a robust and equitable approach to the approval process for granting licences to individual users	Process under development	
Integrated Care System Update	Report on the ICS Digital programme. Highlighted: • Digital workforce staff numbers low compared to other localities • Prioritisation and identification of funding requirements underway • Overall programme status currently assessed as amber acknowledging resourcing gaps		Acknowledged to be work in progress	
Outcome of Intolerable Risk, Cost Pressure and Investment Process	Detailed report on the process followed and outcome which had resulted in 52 out of 199 projects receiving approval	Did the process include reasonability checks after the basic scoring had been undertaken?	The report demonstrated a robust and thorough process. Executives stressed that there had been repeated checks to ensure the correct prioritisation had been applied	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Financial Performance Report	Report covered: • The submission of a balanced plan for the ICS for the first half of 21/22 • Month 1 for the Trust which reported a £13k deficit versus a planned £3k surplus • The month's result included a one-off release of contingent reserves of £0.7 million • Activity levels at c. 94% of the 19/20 level compared to the NHSI target of 70% in month 1 – the resulting Elective Recovery Fund income will not be known until national calculations are completed	Have budget holders signed off their budgets? Is there a concern with payments from SABA?	A clear and comprehensive report Division directors have signed off their budgets. Individual cost centre managers have yet to do so – the delay results from the timing of the national planning process. No concern – the delay is the result of VAT technicalities. These are being monitored	
Capital Programme Report	The report covered the approved 21/22 expenditure plan of £57.5 million comprising 4 core categories of expenditure – System Capital (£24.4m), National Programme (£19.6m), IFRIC 12 (£0.9m) & Government Grant/Donations (£12.7M) Month 1 spending was £1.8	The committee reinforced the need to avoid spend that was heavily weighted to the end of the year and stressed the importance of early business case finalisation		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	million			
Update on Working Budgets vs ICS Financial Planning	Explanation of the overall process to agree and input to the ICS balanced first half plan. Detail explained of the income and expenditure assumptions applied to achieve the break-even position	Is there clear ownership by executives of their specific contribution to the plan and its improvement requirements?	Yes	
Quarterly Procurement Review	Report presented providing assurance that the Procurement service had: • Met national performance targets • Operated in accordance with national standards • Supported the delivery of the Cost Improvement Programme • Represented value for money	How well are the divisions equipped with contract management resources?		This is an opportunity – Finance Director to progress and report back to the Committee
GMS Business Plan	In accordance with the schedule of reserved matters the Committee reviewed and approved the financial section of the GMS business plan	Is this plan consistent with the Trust consolidated planning submissions?	Yes – there has been very good liaison between the finance teams	
Financial Sustainability	Comprehensive report on the progress of the new arrangements drive financial sustainability combining cost reduction and quality		Examples were quoted indicating the good engagement with the new approach that divisions are demonstrating.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	improvement initiatives. Project breakdown of the detailed programme of work to achieve the £2.5 million savings incorporated in the first half plan – to date £2.1 million has been identified	Is Financial Sustainability covered in the Trust's induction programme?	Yes - a video presentation from the finance director does include the topic	Review the material in the light of the changed emphasis

Rob Graves
Chair of Finance and Digital Committee
3 June 2021

Gloucestershire Hospitals
NHS Foundation Trust

MAIN BOARD – JUNE 2021
Via MS Teams commencing at 12:30

Report Title
Patient Experience Improvement in Response to Board Stories
Sponsor and Author(s)
Authors: Katie Parker-Roberts, Head of Quality and Freedom to Speak Up Guardian Sponsor: Steve Hams, Director of Quality and Chief Nurse
Executive Summary

Purpose

To provide an update on the patient experience improvement work that has been initiated in response to the stories presented to Board from November 2020 to May 2021

Key issues to note

In September 2020, a decision was made to alternate the Board story between a staff and patient perspective at each Board. Each story is told by an individual, who chose to come to Board, to tell us their story from their own perspective. The stories provide us with an opportunity to understand their experience of the care they have received – what was good, what did not meet their needs and what could be done to improve their experience.

We use patient stories: -

- To get a better understanding of individuals' experiences and perspectives on a specific issue or service.
- Alongside other data sources to gain powerful insight into what is happening with our services and/or systems.
- To improve our services.
- To enable Board members to step into the shoes of the patient and see our care and working environment through the eyes of our patients and colleagues.

Patient experience improvement must be the golden thread throughout any improvement work that is undertaken in our Trust and patient and staff experience insights should be an improvement measure in most if not all of our quality improvement projects. As a Trust we are committed to using the patient voice and their insights to drive our improvement priorities. Fundamental to the principle of quality improvement is an understanding that those closest to the patients (front line staff) are often best placed to find the solutions for improvement.

Conclusions

The pandemic has changed the world and we now are developing new ways of working. Some improvement programmes have been stopped, some have been paused and others have seen new and innovative ways of working to improve our staff and patients' experiences.

Recommendations
The Board are asked to note the contents of this report.
Impact Upon Strategic Objectives
The stories and improvement work provide insight into how the organisation is delivering our

strategic objectives

- Outstanding care
- Compassionate workforce
- Quality Improvement
- Involved people

Impact Upon Corporate Risks

Listening to stories helps identify our risks and where improvements can be made.

Regulatory and/or Legal Implications

None.

Equality & Patient Impact

Improvement work being carried out in response to stories.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

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

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

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

Outcome of discussion when presented to previous Committees/TLT

Gloucestershire Hospitals
NHS Foundation Trust

MAIN BOARD – JUNE 2021

PATIENT EXPERIENCE LEARNING AND IMPROVEMENT IN RESPONSE TO BOARD STORIES

1. Patient Experience Learning and Improvement

The aim of this paper is to provide the Board an update on the patient experience improvement work that has been initiated in response to the stories that were presented to Board from November 2020 to May 2021.

People who come to Trust Board to tell their story provide us with evidence that gives us confidence that services are being delivered effectively, or conversely, they can highlight some areas that need improvement by telling us that certain aspects are ineffective or there are gaps that need to be addressed. Whatever we hear we will always strive to make sure that quality improvement is at the heart of everything we do.

2. Patient Experience Stories

December 2020

Lucy Mathieson shared the story of her husband Alan, which was to form part of the Trust's new induction programme to ensure focus on patient experience and the compassionate culture from day one.

Lucy conducted an exercise to ask board members to share what mattered to them in terms of care for themselves and their family and used this to demonstrate that the same things matter to staff and patients.

The Board were played an audio file of Alan's story which described his experiences of being admitted following a heart attack during the first wave of COVID-19 and other admissions that followed. Alan's story demonstrated the difficulties patients have in hearing what is said to them, especially when they have hearing difficulties, and how this can be compounded by the use of Personal Protective Equipment (PPE), different accents and also the fear from not knowing what is happening to them or how they are provided with information. Lucy advised that neither she nor Alan wanted to complain as they were grateful for the care but had been left feeling disappointment at times.

The Board members recognised that people can feel "othered" and that through "walking in their shoes" and providing a kind word and a smile staff can make a dramatic difference to how patients feel cared for. The new approach to induction would provide that focus on the patient experience and the connection to the Trust values.

Learning/Actions to date:

- This patient story, “Walk in my shoes” is now integrated into our Trust induction, following the positive feedback from the Board
- The story provokes reflective discussion with participants, and connects back to our Trust values
- This has received positive feedback from participants in the induction, and will be reviewed annually, with feedback provided through the People and OD Delivery Group

February 2021

There was no patient story at the February 2021 Board.

April 2021

Molly Bradshaw delivered a presentation on people who use drugs (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. Molly 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.

Molly and Pippa were joined by Pete, a person who has use drugs previously, who shared his story and experiences of using our services, and highlighted how the care has not always been as empathetic because of his drug use.

The Board discussed that this was a topic where the ICS could all work together through the health inequalities group, and encouraged the team to publish their findings and pursue this new role.

Learning/Actions to date:

- Pippa and Molly have sourced job descriptions for a Specialist Drugs Liaison Nurse role from other Trusts, and these are being reviewed to develop a Gloucestershire role with support from Jim Welch and Jeanette Welsh. The post will come under the Mental Health Liaison Team and will be for 15 months, with 3 months to write a summary of activity and benefits to go to the next board for sign-off as a recurrent post.
- The team are looking to submit a poster at the Royal College of Psychiatrists Addiction faculty regarding their research and the introduction of this role
- There is also ongoing work to introduce point of care drug testing for PWUD who present at our emergency department

Recommendation

The Patient Experience Improvement Team are working with several people to prepare them ready to provide stories to the Board either by joining via Teams or by providing a video story.

Author: Katie Parker-Roberts, Head of Quality and Freedom to Speak Up Guardian

Presenter: Steve Hams Director of Quality and Chief Nurse