Gloucestershire Hospitals
NHS Foundation Trust

AGENDA

Meeting: **Public Trust Board meeting**

Date/Time: Thursday 12 August 2021 at 12:30

Location: Microsoft Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies	Chair		12:30	
1.	Patient /Staff story		Information		
2	Declarations of interest	Chair		13:00	
3.	Minutes of the previous meeting	Chair			YES
4.	Matters arising	Chair	Approval		
5.	Chief Executive Officer's report	Deborah Lee	Information	13:05	YES
6.	Trust risk register	Deborah Lee	Information		YES
ESTATES AND FACILITIES					
7.	Assurance report of the Chair of the Estate and Facilities Committee	Mike Napier	Assurance	13:20	YES
AUDIT AND ASSURANCE					
8.	Assurance report of the Chair of the Audit and Assurance Committee	Claire Feehily	Assurance	13:30	YES
	BREAK			13:40	
QUALITY AND PERFORMANCE					
9.	Guardian report on Safe Working	Mark Pietroni / Jess Gunn	Assurance	13:50	YES
10.	Learning From Deaths	Mark Pietroni	Assurance	14:05	YES
11.	Quality and Performance report	Steve Hams / Qadar Zada / Mark Pietroni	Assurance	14:15	YES
12.	Cancer Services Annual Report	Qadar Zada / James Curtis	Information	14:25	YES
13.	Journey to Outstanding visits	Steve Hams	Assurance	14:35	YES

14.	Assurance report of the Chair of the Quality and Performance Committee	Claire Feehily	Assurance	14:45	YES
FINANCE AND DIGITAL					
15.	Finance Performance and Capital Report	Steve Perkins	Assurance	14:55	YES
16.	Digital report	Mark Hutchinson	Assurance	15:05	YES
17.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	15:15	YES
STANDING ITEMS					
18.	Governor questions and comments	Chair		15:25	
19.	New risks identified	Chair			
20.	Any other business	Chair			
CLOSE				15:30	

Date of the next meeting: Thursday 9 September 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 (CEO) 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 & Deputy CEO Emma Wood, Director of People and OD & Deputy CEO Qadar Zada, Chief Operating Officer
Associate Non-Executive Directors	
Rebecca Pritchard Roy Shubhabrata	

GLOUCESTERSHIRE ACADEMY

Bristol Medical School

Undergraduate Office

University of
BRISTOL


University of BRISTOL
Worcester
Stratford-Upo
Pershore
Hereford
Great Malvern
Evesham
M50
Tewkesbury
Cheltenham
Gloucester
Brecon Beacons National Park
Abergavenny
Ammanford
Merthyr Tydfil
Ebbw Vale
M4
Stroud
Cirencester
Morriston
Bargoed
Pontypool
Dursley
Aberdare
Llanelli
Neath
Cwmbran
M5
Kingswood
Swansea
Port Talbot
Caerphilly
Newport
Stoke Gifford
Swindon
Chipping Sodbury
Wootton Bassett
Bridgend
Llantrisant
Portishead
Ely
Cardiff
Mangotsfield
Chippenham
Porthcawl
Barry
Penarth
Clevedon
Bristol
Neston
Bath
Devizes
Weston-Super-Mare
Trowbridge
Ilfracombe
Minehead
Frome
Warminster
Exmoor National Park
Bridgwater
Street
Braunton
Barnstaple
Salisbury
Taunton
Yeovil
Sherborne
Wellington
Tiverton
Blandford
South

GLOUCESTERSHIRE ACADEMY

Bristol Medical School

Undergraduate Office

Students	
Year 2	46
Year 3	96
Year 4	72
Year 5	39
	273

University of BRISTOL

GLOUCESTERSHIRE ACADEMY

Bristol Medical School

Undergraduate Office

University of BRISTOL

Finance

HEFCE	£200,000
MUT	£2.5 million

£670 per student per week

GLOUCESTERSHIRE ACADEMY

Bristol Medical School

Undergraduate Office

University of BRISTOL

<u>Staff</u>

Dean

3 Admin staff

2.2 WTE consultant staff

6 teaching fellows

2 clinical skills trainers


GLOUCESTERSHIRE ROYAL HOSPITAL

69% survey response rate

NSS

39

Univers
and alt
provide

Survey

21

	Agree (%) 2020	Agree (%) 2021	Rank (out of 31) 2021
Overall satisfaction	**96**	**97**	**1**
The teaching on my course	**94**	**96**	**1**
Staff are good at explaining things	96	97	
Staff have made the subject interesting	97	97	
Course is intellectually stimulating	97	98	
Course has challenged my to achieve my best work	88	93	
Learning opportunities	**94**	**95**	**1**
Course has provided opportunities to explore ideas or concepts in greater depth	90	90	

'overall – I am satisfied with the quality of the course.'

75% of students agreed with this statement

332,500 students responded


University of BRISTOL
Academy of Year
Gloucestershire
University of BRISTOL
Best Nurse Teacher
Hannah Chant, Gloucestershire
University of BRISTOL
Academy staff member of the Year
Gloucestershire
Katy Lee

WELCOME TO

UNIVERSITY OF WORCESTER

THE THREE COUNTIES

MEDICAL SCHOOL

> *"Our healthcare professional graduates already make a hugely beneficial impact on the health and wellbeing of our local communities. The opportunity to expand this further across the counties of Worcestershire, Herefordshire and Gloucestershire, through the creation of a new Medical School, will make a transformative contribution to the region's health workforce."*

Professor Sarah Greer

Deputy Vice Chancellor and Provost
University of Worcester, and Chair
Three Counties Medical School Project

University of Worcester


GLOUCESTERSHIRE ROYAL HOSPITAL

Gloucester academy as a student

ALISON BROWN

Personal experience

Preparing for professional practices (PPP)

Acute medicine:	Ward based	Primary care
•A&E •AMU •DCC/critical care	•Bibury ward – endocrine at the time	•Stow surgery

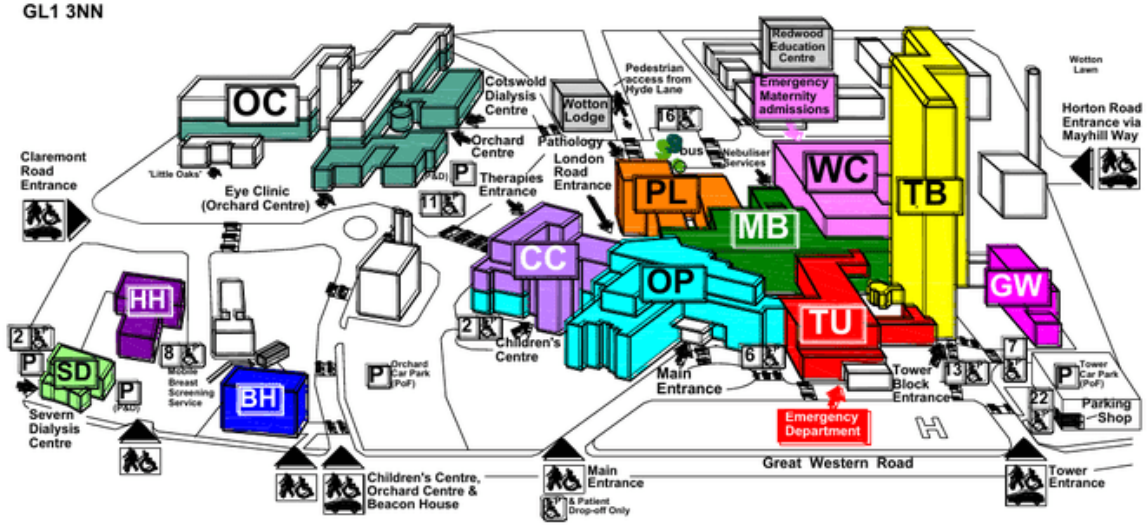
<u>Exams</u>:
PSA
SJT

Caps logbook – clinical skills
EPAs to complete
Mini-cex
CBDs

Gloucestershire Royal Hospital

Great Western Road
Gloucester
GL1 3NN

Gloucestershire Hospitals NHS
NHS Foundation Trust



There are designated drop-off points at all principal building entrances

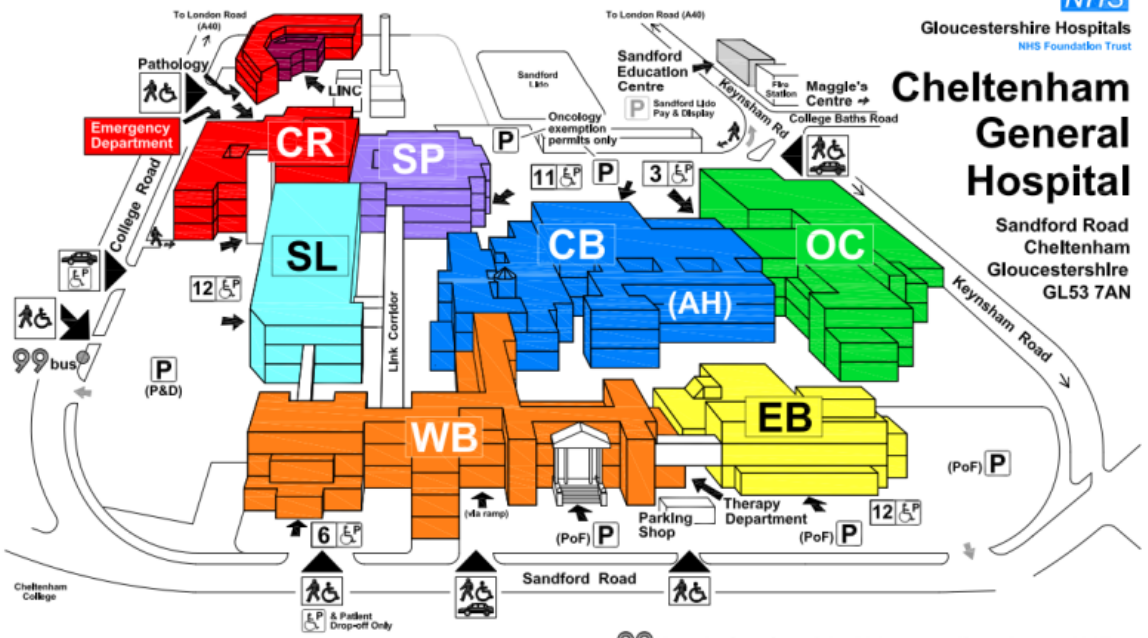
P Parking is provided either on a 'pay on foot' basis, shown as PoF or 'Pay & Display' shown as P&D

Blue Badge holders park for free in designated parking bays only (Charges apply for any vehicle occupying a standard parking bay)

Cheltenham General Hospital

Sandford Road
Cheltenham
Gloucestershire
GL53 7AN

NHS
Gloucestershire Hospitals
NHS Foundation Trust

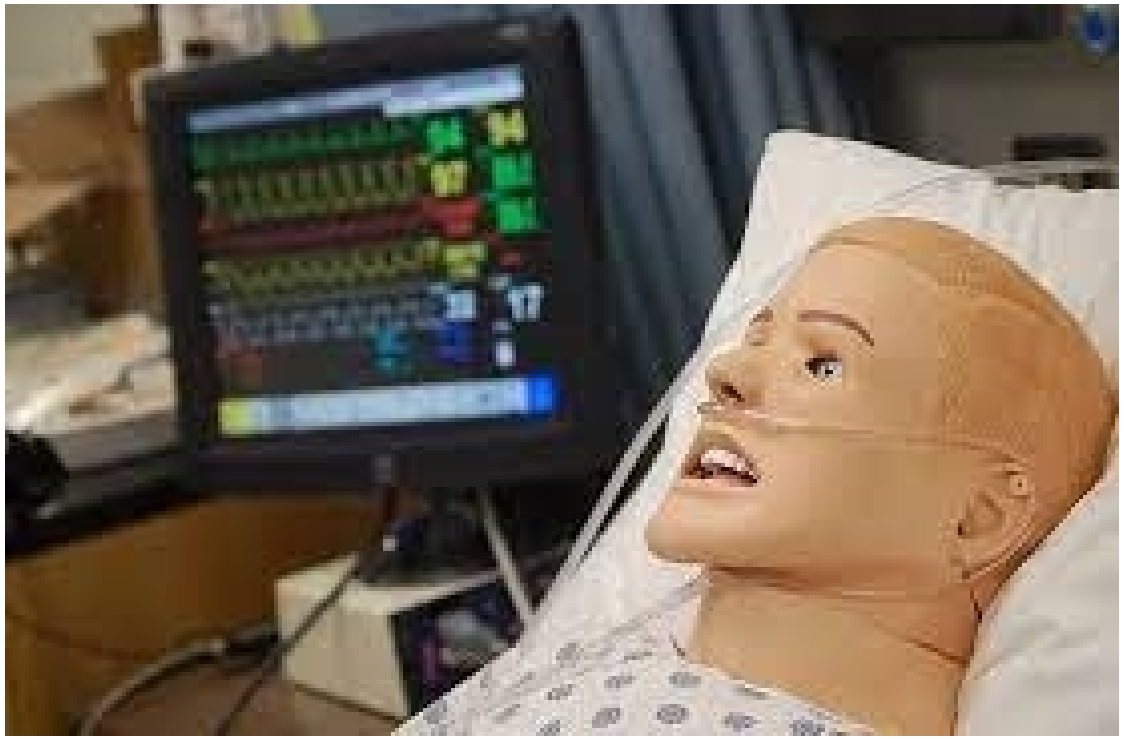


Arrow denotes building entrance

99 Note the location of the 99 bus stop (from August 2017)

P Parking is provided either on a 'pay on foot' basis, shown as PoF or 'Pay & Display' shown as P&D

Blue Badge holders park for free in designated parking bays and also in standard parking bays



University of BRISTOL

Teaching

Canteen and student area

Gloucester - Foster's restaurant

Cheltenham – Blues spa

Acommodation

Cheltenham – Cadeceus house; flats of 4-5 students

Gloucester – new modern flats of 2-4 students

Gloucestershire and socials

WEEKLY CHALLENGE

STRAVA

Overall – great academy!

Gloucestershire Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD VIA MICROSOFT TEAMS THURSDAY 08 JULY 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
Claire Feehily	CF	Non-Executive Director
Marie-Annick Gournet	MAG	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
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
Qadar Zada	QZ	Chief Operating Officer
IN ATTENDANCE:		
James Brown	JB	Director of Engagement, Involvement & Communications
Sim Foreman	SF	Trust Secretary
Kate Hurley	KH	Senior Specialist Nurse Organ Donation (Item 124/21)
Mark Haslam	MHa	Clinical Lead – Tissue Donation (Item 124/21)
Amy Lawson	AL	Trust Psychologist (Staff Story – Item 116/21)
Ian Mean	IM	Chair – Organ Donation (Item 124/21)
Trudie Neveu	TN	Specialist Nurse Tissue Donation (Item 124/21)
Eve Olivant	EO	Deputy Chief Nurse
Lizzie Partridge	LP	Specialist Nurse Tissue Donation (Item 124/21)
Steve Perkins	SP	Deputy Director of Finance
Rebecca Pritchard	RP	Associate Non-Executive Director
APOLOGIES:		
Steve Hams	SH	Director of Quality and Chief Nurse
Karen Johnson	KJ	Director of Finance
Roy Shubhabrata	RS	Associate Non-Executive Director
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were five Governors, two members of the public and one member of staff present.		

ACTION

116/21 STAFF STORY

EW introduced AL and reminded the Board of the Trust's focus on health and wellbeing and psychological support for staff and the initiatives introduced to support this.

AL explained her background had originally been in a mental health trust and outlined how the last year had seen a shift from scoping and understanding needs to implementing compassion focused ideas that

put psychology at the front line of support. AL provided examples of how this had been used, with the 2020 Hub, to ensure colleagues received the right support and care. AL added and stressed the importance of the Hub as an embedded single point of entry that allows the Trust to spot clusters and those teams/managers/colleagues who are struggling and need extra support.

AL delivered a presentation on "Compassion Focused Intervention For Staff Support" and invited questions and comments from the Board.

DL referred back to the work with Professor Michael West on compassionate leadership which highlighted the importance of meeting people's basic needs i.e. toilet breaks and meal breaks. and asked if this was a theme AL had seen. AL confirmed it was. She added most people doing a job can cope, but there are occasions when small pressures and "threats" can build and build and tip people over the edge. There is a genuine need to 'soothe' as humans cannot survive on drive alone; the work will always be there but it won't get done if you don't take care of yourself which includes having breaks.

AM recognised that people are different, but asked if there were groups of staff who felt an increased personal response and professional duty, but who didn't ask for support. AM asked how the Trust could proactively reach out to this group and asked about the scalability of the support available. AL noted the team managed away days to cascade message via managers and provided small team support. She added training for managers on holding wellbeing conversations was also underway. The question of scalability was tricky as there were only three people in her team although another two were joining by September. The key was the embeddedness of the Hub and the team within it as having someone on the phone who can listen, and then signpost..

CF noted that when a person was in crisis and threat response mode, it was not necessarily the appropriate time to practice and learn and asked what resources were place to support and mandate managerial competence. EW and AL advised the compassionate leadership module was mandatory adding that the People and OD Delivery Group (PODDG) were looking at what else was needed to build resilience and develop teams. DL added that if the support in the Trust was mapped as a reasonable proxy to clinical support then it would be closer to social work but just called something different.

MN referenced his own experiences of managing people and the importance of giving choices in working life. He observed that stress did not feature in the bubbles shown in the presentation and asked if it was part of the toolkit. AL affirmed it was restating the need to balance the "soothe and drive" elements.

In response to a question from DL, AL confirmed that she was not part of the compassionate leadership training that was being delivered, however she had worked closely with Paul Wain in developing the content. AL and EW noted work was underway to develop more detailed, in-depth modules and there were plans for AL and her team

to be involved in smaller workshops to help cascade and spread the learning.

The Chair thanked AL for presentation and invited her to return in nine months to provide an update on progress. **SF**

117/21 DECLARATIONS OF INTEREST

SP and RP declared interests in Gloucestershire Managed Services (GMS) item at 133/21. SP as a director of GMS and RP as a person being proposed to become an interim GMS non-executive director.

RESOLVED: The Board NOTED the declarations of interest.

118/21 MINUTES OF THE PREVIOUS MEETING

EWa confirmed that Minute 105/21 should state that the Green Plan was coming to the Estates and Facilities Committee (EFC) in July 2021 and not the Board as shown.

RESOLVED: The Board APPROVED the minutes of the meeting held on Thursday 10 June 2021, subject to the correction above.

119/21 MATTERS ARISING

There were no matters arising.

120/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL presented the report and provided the operational context and the Gloucestershire perspective on wider national and system issues.

COVID-19 community transmission rate had increased from 203.5 per 100k to 233.5 per 100k and was increasing exponentially with the growth of case going down through age bands. This impacted parents with childcare responsibilities. The profile of admissions has changed from a peak of 20 earlier in the week dropping to current level of 11 (11-12 cases are normal). However all admission must be considered as potential COVID-19 cases as the 19 July 'Freedom Day' was imminent and its impact on the NHS unknown.

Both hospitals were very busy and it was expected would get busier with many patients coming in via Emergency Departments (ED) who could have presented at a Minor Injuries Unit (MIU). DL was proud of how teams were responding and how they were being led and in particular, commended the progress of recovery activity reaching 2019/20 activity levels. Two Week Waits (2WW) for breast cancer were best in South West Region.

90.4% of staff had been vaccinated against COVID-19 and work continued with the remaining 9%

The final report from the Care Quality Commission (CQC) had been received with the GOOD rating retained for Gloucestershire Royal

Hospital (GRH) but noting required improvement in unscheduled and emergency care (UEC). DL advised additional accommodation had increased capacity within the department through changes to layout but there was still a focus on balancing the waiting times in ED. The report included lots of praise and commentary on the quality and safety of care delivered and acknowledged risks were at the busiest times.

DL also highlighted a number of key points from the rest of the report;

- NHS Improvement had formally approved the £44.5m business case for the Strategic Site Development (SSD) on both sites;
- The Electronic Patient Record (EPR) had been rolled out in ED at GRH the previous day; and
- A new laboratory system (TCLE) had been rolled out on 23 June which was more complex and challenging however the team continued to work through resolving issues.

EWa noted virtual outpatients accounted for 33% of appointments and asked for a sense of how sustainable this was for the future and any feedback on how patients were feeling about it. DL confirmed the Trust was exceeding the national ambition of 25% and that most of these appointments related to follow up care (80%). MH added that there was certainly more that could be done to support virtual appointments and even more that could facilitate remote care of patients and self-care.

CF remarked that the CQC report felt like a judgement on a provider trust which is the front door to a wider system and asked how the report would be reviewed in the Integrated Care System (ICS). DL advised the report referenced system work and this would be needed to drive improvements. The formal report would be presented to both the ICS Board and ICS Executive meetings,

AM followed on from this commenting that it felt like there was no respite for staff or in terms of demand. She noted the number of patients attending ED that could be seen at an MIU and asked if communications were adequate and getting through to ensure people attended the right places. She asked if patients were being asked to go an MIU or just waited to be seen in ED. DL believed that communications needed to be more targeted and that current demand was primarily being driven by patients who were unable to get face to face appointments in primary care. In response to the question of whether people are turned away, MP explained a key issue was the expectation of the people presenting that there were more services on offer in the acute trust, and they were prepared to wait for them. Clinicians also found it professionally difficult to turn people away and it was often easier to see the patient and send them home than suggest they go elsewhere. The Chair commented that system communications still did not appear to put enough effort into finding out what is driving peoples' behaviour and that gaining this deeper insight from patients would be beneficial.

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

ACTION

121/21 TRUST RISK REGISTER

EW presented the Trust Risk Register (TRR) report and advised one safety risk has been added (**C3223COVID -** The risk to safety from nosocomial COVID-19 infection through transmission between patients and staff leading to an outbreak and of acute respiratory illness or prolonged hospitalisation in unvaccinated individuals) with the score reflecting the risk to unvaccinated people.

One risk score had been reduced (**C3295COO -** The risk of patients experiencing harm through extended wait times for both diagnosis and treatment) due to there being no evidence to support major harm on a weekly basis. The harm score had been reduced but the overall score meant it remains on the TRR.

The Board also heard that the agreed changes to the risk framework meant that risks with a consequence of 5 and likelihood of 1 would no longer appear on the TRR and would be managed at a divisional level.

EW also reported that the last RMG had received an excellent report from the Medicine Division relating to a recent quality and risk summit focused on the unscheduled and emergency care (UEC) pathway and the risks which have been noted would be presented to Quality and Performance Committee at the end of the month.

EWa commented on the seven risks that had dropped off the TRR noting that some were longstanding. She asked for assurance on how these were reviewed with ”fresh eyes”. EW confirmed and assured they still received divisional scrutiny with the triumvirate. EW added that some risks had been treated and were presented at committees where relevant. EWa asked whether these 5 x1 risks would still be reported to board committee. *[POST MEETING NOTE: 5 x1 risks will not go committees, unless specifically requested but managed by Divisions. These are also presented at delivery groups to ensure ongoing management and review i.e. People and OD Delivery Group, Quality Delivery Group etc. and they feature in the Risk Management Group (RMG) report as part of the Corporate Risk Register.]*

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

122/21 EQUALITY DIVERSITY AND INCLUSION (EDI) ACTION PLAN: ONE YEAR ON

EW presented the report highlighting the positive work and progress made by the Trust over the past year in relation to EDI. EW updated on “The Big Conversation” conducted by DWC Consulting and the subsequent monitoring by the People and OD Committee (PODC). She noted the engagement with the Board in setting the Trust’s ambition and programmes of work. Most of the 28 objectives set by the Board had been delivered with Divisions embracing and embedding compassionate culture and behaviours into their areas. The Board would receive the final report from DWC in September 2021 with a review of findings scheduled for the PODC in August.

EW updated that work on compassionate leadership and wellbeing was starting to feature in ICS planning and the Trust was developing an exciting cultural barometer that was being promoted nationally so others can share the learning. This will allow the Board to assess the outcomes of initiatives in "moving the staff experience dials" in a contemporary manner.

RG noted the role of PODC in terms of reviewing and monitoring initiatives but felt it would good for updates to come to Board in future.

BH was pleased to see the report and expressed her pride in the leadership shown to deliver work that stands out. She noted her observation that people can speak about EDI issues freely and that this programme was not tokenistic. BH reinforced her view that this linked to leadership and the benefit of consistent messages trickling through the organisation.

DL advised the progress was great to hear and she commended communication and leadership at all levels. The Board noted a new animation had been developed to help bring the work to life and extended thanks to EW and JB for this. DL stated that staff believed the Trust had listened and acted, and the changes were starting to make a difference.

MN also noted wonderful progress and it was pleased to see four new recruits into the EDI team. He asked how these were funded and EW confirmed three had been taken as a cost pressure in budget setting and the fourth was a fixed term appointment funded through Health Education England.

RESOLVED: The Board RECEIVED the report as assurance that progress with the EDI agenda had been made.

123/21 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE

BH summarised the key points from the report as follows:

The Committee had reviewed a new risk related to supervision for trained doctors but this was not considered significant.

The Trust was ahead on NHS England and Improvement (NHSE/I) inclusive recruitment and promotion practices due to the work taking place under the Equality Diversity and Inclusion programme already.

Colleagues from Diagnostics and Specialities Division had delivered a powerful presentation on sustainable workforce with a particular focus on radiology where the division had adapted to a more innovative approach to train and develop staff for vacancies that they had found difficult to recruit to.

The Committee had been assured on progress in research despite COVID-19 and also heard good progress was being made with the

University Hospital status application through seeking grants and awards. A system application was not possible as yet so it had been agreed to proceed with this on a Trust basis, rather than an ICS and noted there would be valuable feedback from applying this year.

An update on the People and OD strategy had included details on sustainable workforce and the use of digital solutions in support of this.

Discussion on the quarantine risk from children had shown that the remote and flexible working arrangements in the Trust kept this risk at a low level but it would continue to be monitored.

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

124/21 ANNUAL ORGAN DONATION REPORT

MP introduced IM, MHa, LP, TN and KH to present the annual organ donation update and highlighted his pride that the Trust and Gloucestershire continued to "punch above its weight' in respect in this agenda.

IM had been chair of the Gloucestershire Committee for seven years and recently appointed as a regional chair covering 12 trusts. IM advised that despite COVID-19 and a fall of 20%-25% in donations, Gloucestershire exceeded the number of transplants in the period July 2020 to June 2021 thanks to the work of a small, agile team.

There were currently 18 people on the waiting list for transplants in Gloucestershire with 466,470 registered donors from a population of 673k (73%). This was an incredibly high proportion which rose 1% in the past year and continued a six year trend of improvement. By way of comparison London has 31% registered donors for its population.

MHa advised the numbers spoke for themselves and as stated, despite pressures and the impact COVID-19, the Trust has continued to honour the choice and decisions made by patients to offer organ donation where clinically appropriate. Over the past year the Trust achieved the same number of donors (nine) but delivered 25 lifesaving transplants (up from 23). MHa felt this was a credit to the people of Gloucestershire and testament to the courage of families saying yes and the work of ITU nurses building up trust to help them do make these decisions. This was reflected by a 79% consent rate (10% higher than national average).

LP and TN delivered a presentation on tissue donation. There was a recognised need to increase tissue donation and Gloucestershire was chosen as a national pilot site for this work. LP and TN were employed as two specialist nurses providing a single presence in the Trust. This was an unique opportunity to become a centre of excellence.

There is a drive to increase awareness and knowledge for tissue

donation and it was noted one donor can help up to 50 people. The Board heard that the process and information shared with families by staff in the Trust has helped increase referral rates. LP and TN also provided a patient story of a member of staff (Paula) who had received corneal transplants in Cheltenham General Hospital (CGH).

IM reported that Gloucestershire was a trailblazer for this work and members of the national committee of organ donation chairs. He expressed thanks to the Board for its ongoing support and highlighted that there were few organs available so the need to spot opportunities was greater than ever. IM also explained that seeking organ donors from BAME backgrounds continued to be a challenge.

CF was overwhelmed by this work, adding that it was the ultimate example of compassion and altruism. She asked in relation to the BAME community challenge what the Trust might do to change things. MHa advised this was both a local and national issue, affecting a group who were more likely to need organ donation but for whom traditionally consent levels were lower. Hospital faith leaders do provide support and when asked our consent rates have been good (although numbers are low) but there is a need to reach out further in a sensitive way. KH added that it was complex and she saw it every day in other matters such as COVID-19 vaccination where there are fears amongst BAME communities based on historic medical trials. KH explained there had only been four or five approaches over 11 years and they continued to work with faith leaders to create an open forum for people to engage with the Trust and bust some myths. MHa advised it comes down to trust, and nursing staff who can build this helps with consent rates.

AM thanked the presenters and stated she continued to be impressed and commended their work and dedication. On the matter of tissue donations, AM referenced the 1000 deaths in hospital each year, as well as those across the county, and asked how the Trust can give non-specialists the skills and competence to have the conversations about tissue donation at a difficult time. LP confirmed the referral model was nursing led and team members train staff to approach families after a patient death to give information to them in case they are contacted by the national referral centre who can explain options.

Linked to AM's question, EO asked what the team expected to happen over the next two years on tissue donation and what support they might need. LP advised they continued to work with more new areas to increase their reach and build a strong link nurse network. LP noted the benefits of the work on the electronic records pathway which would mean all deceased patients could be considered, making the process of identification much quicker and easier, as it would be automated.

The Chair thanked all for the presentation, questions and answers and noted the national recognition bestowed on Gloucestershire for this work.

RESOLVED: The Board SUPPORTED Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as the Trust searched to minimise missed donation opportunities.

125/21 CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)

EO presented the report which provided assurance on how the maternity service had met the ten key standards of the CNST and which allowed financial recovery of an element of the insurance premium paid by the Trust. EO advised that the Board was being asked to approve the submission on the key standards and explained that the detailed full data set had been presented by SH to the NEDs after a recent Quality and Performance Committee (QPC). Additional evidence had been gathered and feedback provided to the maternity team based on NED feedback. AM confirmed as chair of QPC, she was content to support the submission for approval.

RESOLVED: The Board APPROVED the submission to NHS Resolution, and delegated the CEO to sign the submission on behalf of the Board.

126/21 QUALITY ACCOUNT

EO presented the Quality Account which had been approved in draft by the Quality and Performance Committee. Positive feedback on the report had been received from the Clinical Commissioning Group (CCG), Health Overview and Scrutiny Committee (HOSC), Health Watch and Governors. The report was presented in the final design version for approval.

RESOLVED: The Board APPROVED the final designed version of the Quality Account to be sent to NHS England and Improvement for publication and for uploading onto the Trust webpages.

127/21 ANNUAL MEDICAL REVALIDATION AND APPRAISAL REPORT

MP presented the report and described that doctors were required to undergo an annual appraisal and formal revalidation every five years and there was a statutory requirement to report upon this to the Board.

The Board heard that there had been some disruption to the appraisal process due to COVID-19 but only for a short time as most clinicians were keen to continue with the process. MP advised there was now an increased focus on wellbeing within the appraisal and that a new cohort of Responsible Officers (ROs) had been appointed to support him with the appraisal and revalidation work. MP advised that once approved, the report would be submitted to the national team.

RESOLVED: The Board RECEIVED the report as a source of assurance regarding the quality of medical appraisal and revalidation throughout the Trust and APPROVED for submission to the national team.

128/21 QUALITY AND PERFORMANCE REPORT

MP referenced the current performance issues covered in DL's earlier CEO report and highlighted that cancer care in Gloucestershire was

excellent and ahead of other centres in the region and nationally. The struggle with UEC was noted but recent data has shown the Trust's comparative performance was no worse than the regional average and although ambulance waits were improving, the current position was not where the Trust wished to be.

EO reported that there were some concerns about Clostridium Difficile (C.Diff) with cases rising across the South West although there was no change in the position at the Trust. The Trust was about to commence an NHS England/Improvement collaboration for C.Diff to take a system focus on anti-microbial steward and ward rounds.

EO also provided assurance that the vent cleaning programme in the Tower had continued despite COVID-19.

QZ reported there were currently 11 COVID-19 cases in the Trust and advised that based on similar community infection rates this would have been over 200 patients last year. He added that the cohort of patients was not coming from younger age groups and this was compounded by the increase of Respiratory Syncytial Virus (RSV) infections in young children. There was one patient in the Trust with RSV. QZ informed the Board that complex winter planning was underway to manage the expected demand from COVID-19, RSV and the usual increased seasonal activity. In response to a question from the Chair, he advised a meeting was planned for 22 July for all system partners to discuss the plan together and offer organisational responses,

QZ praised the teams involved in the EPR roll-out in ED and advised they were coping well despite the pressures they were facing.

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.

129/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

AM confirmed there had been a wide ranging discussion at QPC and highlighted the following;

The Committee were pleased to see the Quality Delivery Group (QDG) had a particular focus and challenge related to sepsis, and the role QDG were playing in pushing back to Divisions for further detail.

Mental health metrics had been reviewed and the Committee noted the high levels of children self-harming.

End of life care work would be reported to a future QPC.

The Committee heard that all of the work relating to maternity was being pulled together into a single action plan. The Committee sought assurance that the actions were the right ones, it considered how they could be expedited and explored how staff were feeling.

The Chair thanked NED colleagues on QPC for the additional work on the CNST standards, adding this reflected the strength of the Committee and the follow up on feedback to staff.

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

130/21 FINANCE REPORT

SP presented the Finance report for Month 2 (M2) and confirmed the reported forecast positon for the ICS was £11k surplus for Half 1 (H1). As part of this the Trust was planning to deliver a £5k surplus, although the current M2 positon was £51k deficit with the main driver being additional operational costs for Mental Health Nursing. As shown in the report there was a timing issue for the receipt of Elective Recovery Funding (ERF) flowing from commissioners. SP advised NHS England was aware of this delay.

In respect of ERF, SP confirmed the Trust was in a strong position to achieve additional funds and it was hoped the M1 performance would be rewarded in mid to late July. The Board noted the extended lag period and noted NHSEI were also discussing threshold levels for ERF.

The balance sheet was showing high cash balances with the main drivers being the timing of capital payments and the level of provisions held.

Capital spending was £4m behind Year To Date (YTD) and work was ongoing with schemes leading to get back on track. SP confirmed that the ICS was working together to deliver five year capital plans.

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

131/21 DIGITAL REPORT

MH presented the report and referenced the table showing the EPR work and the key enabling schemes from Trak such as e-obs and Order Comms. MH explained that his team had initiated a number of recent “go lives” which included pharmacy stock control, CGH Minor Injuries and Illness (MIIU) to ED and GRH ED the previous day. These go lives had been agreed in order to have a decompression period for staff to take leave over the summer ahead of the next phase of work.

MH was heartened by comments from a clinical colleague earlier in the day comparing the ease of using EPR to that of an Apple iPhone. He believed familiarity with EPR would be a key tool in making progress across the ICS and believed this would be instrumental

MP commented that he has visited GRH ED to see how the go live was going and acknowledged although it had been tough, the acute medics

were excited by EPR and pleased to move away from paper.

RESOLVED: The Board NOTED the digital report.

132/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

RG presented the report and reinforced the "big picture" assurance attained by the committee from both the Finance and Digital reports. He added there has been focus on how to prioritise between digital and physical assets.

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

In response to a query from the Chair on any emerging headlines on the financial position for the second half of the year (H2), DL advised that full details were not expected until September but efficiencies were required for financial sustainability and this would be a challenge for the whole system. DL added that Elective Recovery Funding (ERF) was going well but indications were that the thresholds for funding may increase and the drive and incentive to do more felt at odds with the messages related to staff health and wellbeing.

133/21 GMS BOARD APPOINTMENTS

SF presented the paper proposing the appointment of an interim Chair and interim NED for GMS, confirming this had been supported through the relevant governance routes in accordance with the Reserved Matters.

DL wished to record thanks to Kathy Headdon, the retiring GMS Chair for her work over the past four years and these sentiments were echoed by the Board.

RESOLVED: The Board APPROVED the appointment of Kaye Law-Fox as GMS Interim Chair and Rebecca Pritchard as GMS Interim Independent NED with effect from 10 July 2021.

134/21 COMMITTEE TERMS OF REFERENCE

RESOLVED: The Board APPROVED the revised Committee Terms of Reference for the PODC and QPC.

135/21 COUNCIL OF GOVERNORS MINUTES HELD 21 APRIL 2021

RESOLVED: The Board NOTED the minutes of the Council of Governors Meeting held on 21 April 2021.

136/21 GOVERNOR QUESTIONS AND COMMENTS

Alan Thomas (AT), public governor for Cheltenham and Lead Governor commented on the EPR go live and the work to progress the digital

agenda across the Trust and advised there had been an excellent training session for governors where Dr Kate Helier had talked about how it helped her as a clinician.

AT also remarked that system communications need to be improved about people presenting at ED and asked when the system would do this. He also repeated previous points expressed at board relating to public representation on the ICS and frustration caused by the inability to speak to system colleagues directly and hoped that this would be picked up by NHS Providers at their "Governor Focus" conference.

AT referenced DL's comment that corridor care had been "largely eliminated" and asked if there were still instances occurring. DL explained that there might be some very few instances on occasion where patients awaiting radiology queue in a corridor but the historic practice of corridor care had gone.

AT also asked about the risk related to nosocomial infection of patients and staff and whether there was an increased risk to or from unvaccinated staff. DL advised that less than 10% of staff were unvaccinated and conversations were ongoing to deploy staff differently where required. DL reminded that double vaccination did not mean people were immune to catching COVID-19. In respect of the specific risk from staff, DL advised COVID-19 was the greatest risk to the Trust at present but nosocomial infections were not new and all tracked to patient-to-patient transmission. MP stated that staff wore Personal Protective Equipment (PPE) and masks which also greatly reduced their risk of transmission.

137/21 NEW RISKS IDENTIFIED

There were none.

138/21 ANY OTHER BUSINESS

The Chair updated on the desire to return to physical face-to-face Board meetings as soon as possible, but that this could not yet be finalised for August The Board would be advised once a decision had been taken.

There were no other items of any other business.

DATE AND TIME OF THE NEXT MEETING

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

[Meeting closed at 15:30]

Signed as a true and accurate record:

Chair
12 August 2021

PUBLIC BOARD – AUGUST 2021
CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 In the four weeks since my last report I have had the (huge) benefit of two weeks annual leave. This has enabled me to connect with the distinction in leave that is primarily about recovery – the few days or week model – and the leave which moves on to being restorative – two weeks + model. Whilst a challenge for many teams and individuals to achieve, I shall be leading conversations about the distinction between leave that supports "recovery" and that which goes on to be "restorative". Nothing feels more important as we go into the winter months.

Operational Context

2.1 In the four weeks since my last report, community rates of COVID-19 continued to rise peaking at 382.8 cases per 100,000 population in late July, with the greatest prevalence in the 15-19 year group with rates. However, positively infection rates appear to have now plateaued and are starting to fall. At the 4th August 2021, infection rates for Gloucestershire are c20% below the South West and England average at 252.2 per 1,000 population; again the highest rates are within the younger and largely unvaccinated population. The Government's announcement this week to accept the recommendation of the Joint Committee of Vaccination and Immunisation (JCVI) with respect to commencing vaccination of 16 and 17 years has been welcomed in many quarters. It is also now clear that there will be a vaccination booster programme in the Autumn which is likely to include the most at risk groups including NHS and social care staff. This booster campaign will be distinct from the flu vaccination campaign which will be delivered through our tried and tested model of peer vaccination.

2.2 The numbers of patients in our hospitals remains low and plateaued in a range of 18-22 patients and at one time, and with no more than three requiring critical care at any one time. Our local picture adds to the increasingly strong evidence that the vaccination programme is limiting transmission but most importantly it appears to have significantly weakened the all-important link between the virus and the severity of the disease and thus requirement for hospitalisation and associated mortality. Currently, those admitted reflect a younger cohort of patients than in surge 2 (49 years on average compared to 66 years in the second surge) and more than 85% have had no or just one vaccine.

1.2 COVID-19 aside, we remain very busy with our urgent and emergency care services being especially challenged, alongside the impact of our efforts to treat as many patients as possible who we were unable to operate upon, or see in outpatients, during the pandemic. As a result of these pressures, waiting times for many services are much longer than we would wish,

despite the considerable efforts of all to make improvements. Positively, there has been a slight easing of demand and operational pressures in the first week of August.

1.3 Finally, despite the efforts of many including our system partners, the numbers of patients whose discharge from hospital is delayed has risen significantly in the last month to c125 and this is making improvements in flow, and thus A&E waiting times, very difficult to achieve as well as not reflecting the optimal experience for our patients and their families. Of particular note however, is the pressure that the South West Ambulance Trust is under across their region and a number of escalatory actions are being considered both regionally and nationally; locally we are managing ambulance delays well and as such any regional initiatives are unlikely to apply to Gloucestershire unless the position deteriorates.

1.4 Despite the emergency pressures, teams continue to undertake significant amounts of elective and diagnostic activity and we remain one of the top performing Trusts in the South West (by value) and fourth out of 15 Trusts in respect of those waiting over 52 weeks which has reduced further to 3.4% of those waiting for treatment having waited more than 52 weeks, from 3.7% last month. Again positively, the Trusts performance in respect of the Elective Recovery Fund stands at 100.4% against an access standard of 95% and a regional average of 90.6%.

1.5 Finally, our biggest weapon in the battle against COVID-19 and its impacts is the vaccination programme. In Gloucestershire, we have now vaccinated 88.1% of the adult population with their first dose and second dose uptake remains high alongside positive uptake from within the younger age groups. 93.6% 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 and 91% of staff are now vaccinated; uptake amongst BAME staff has also increased and stands at 87%. The work to address vaccine hesitancy in community settings is being over seen by the *One Gloucestershire* health inequalities work stream. Finally, it appears increasingly likely that a COVID vaccination booster programme will proceed and is likely to commence next month, and will include NHS and social care staff. The programme will be distinct from the flu vaccination programme which will be mobilised through our usual peer vaccinator model. In respect of vaccinating those aged 16 and 17 in our workforce, this has already been part of our vaccination offer to staff and will continue to be so.

2 Key Highlights

2.1 Given the context above, it has never been more important to celebrate success and recognise the contribution and achievement of colleagues and the wider NHS although my recent leave means I have less to report than is often the case. I remain delighted with the number of patients who continue to write to me personally to express their gratitude and commend our staff for the standard of care that they have received. These thanks come from across the range services we provide and very positively from some of our busiest and most challenged areas. I continue to showcase these acknowledgements in the weekly global emails which appear to be appreciated by all staff.

2.2 Our ICS partners have been doing a number of deep dives into common services across member organisations and the most recent one was into safeguarding services.
All safeguarding teams are clearly high performing in our system and well regarded by the colleagues they serve but I was especially proud of the feedback on our own team, led by Jeanette Welsh. Jeanette and the team have some of the most challenging issues to deal with and the support they provide to colleagues was described in glowing terms. Huge thanks to the whole team and the wider organisation who have embraced working so closely with our Safeguarding Hub.

2.3 I've talked before about the innovation associated with robotic surgery. I was delighted therefore, to hear that our general surgical team have been asked to be a European demonstration site for the recently acquired Versius robot at GRH, whilst our robot at CGH undertook its first ever day-case prostatectomy; a procedure that not very long ago would have resulted in several nights in hospital and a prolonged recovery. The advances in robotics and our part in bringing this to the fore in patient care have been the subject of a number of national media and scientific journal articles.

2.4 In a similar vein, the Trust is set to become one of a handful of pilot sites for a new technology that will significantly reduce the need for endoscopy in patients who are at risk of developing cancer. The technology which uses a "sponge on a string" to gather cells from the gastrointestinal tract will be able to be delivered by suitably trained nurses and, in time, is likely to be available in primary care and may even go on to wider applications. Given the pressure on endoscopy services and the scale of backlogs in this area, this is a hugely welcome initiative and one that myself and ICS Designate Chair, Gill Morgan will be seeing in action early next month.

2.5 The Trust has heard much over the last year or so about the achievements of our organisation during the pandemic and I was therefore proud to read the very positive article in the Financial Times which included contributions from our Medical Director and a number of key staff from critical care and respiratory services. It painted the organisation and many of our staff in a hugely positive light. To further add to this positive coverage the Trust has also been shortlisted for a national award for our Respiratory High Care service which was developed between critical care and respiratory services, during the second wave of the pandemic and led to a huge reduction in the numbers of patients needing to be admitted to the Critical Care Unit.

2.6 Whilst I was on holiday, I was delighted to learn that Dame Gill Morgan has been confirmed as the Chair (designate) for the Gloucestershire Integrated Care System. Whilst this was not a surprise, it is good to have Gill's appointment formally confirmed and gives her a mandate to take forward the next steps recently outlined to the member Boards including the appointment of the Accountable Officer role. Gill will be joining the August meeting of the Council of Governors to hear and share views on how public involvement will evolve and be reflected in the new governance arrangements for the ICS.

2.5 Having welcomed Qafar Zada to the Board last month, this month we will (hopefully) be recruiting our future Director of People as Emma Wood prepares to move on to her new role in Bristol and Weston. We have been fortunate in attracting a strong field and will be interviewing three candidates, all of who are currently operating at Board level in other NHS organisations. In other people news, this month we have also said goodbye to Felicity Taylor-Drewe who is leaving us to take up her first Board role as Chief Operating Officer at neighbouring Trust, Great Western Hospitals in Swindon. Felicity has been a familiar face around both Committee and Board tables and I'd like to record my personal thanks for her huge contribution to the organisation. Positively, we remain a Trust attracting the best and I am pleased to confirm that Neil Hardy-Lofaro has been appointed to the vacancy left by Felicity and has already taken up the post of Deputy Chief Operating Officer following a national recruitment process. I look forward to welcoming him to future meetings.

Deborah Lee, Chief Executive Officer
5th August 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 August 2021
MS TEAMS – Commencing at 12:30

Report Title
TRUST RISK REGISTER (TRR)
Sponsor and Author(s)
Author: Lee Troake, Corporate Risk, Health & Safety Sponsor: Deborah Lee, CEO
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. A Risk Management Group (RMG) meeting was held on the 4 August 2021. **KEY ISSUES TO NOTE** There have been NO changes made to the TRR since the Board report of 8 July 2021.
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	X
Human Resources	X	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 4 August

Outcome of discussion when presented to previous Committees
Risks discussed and decisions made to include on Divisional risk registers and to refer some to committees for further discussion.

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Title of Assurance Committee / Board	Review date	Operational Lead for Risk	Approval status
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.	Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR. Winter summit business case. Development of and compliance with 90% recovery plan, CQC action plan for ED	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Emergency Care Board, Trust Leadership Team	31/03/2021	Anna Blake	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts.. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 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.	To review and update relevant retention policies. Devise a strategy for international recruitment. 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	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	People and OD Committee, Quality and Performance Committee, Trust Leadership Team	30/04/2021	Evelyn Olivant	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
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		31/05/2021	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	Service Review Meetings	31/05/2021	Joseph Mills	Trust Risk Register
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.	Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Complete CQC action plan. Compliance with 90% recovery plan. 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	Trust Leadership Team	17/06/2021	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. Demand and Capacity model for diabetes	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Trust Leadership Team	25/06/2021	Laura Greenway	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. 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. re educate trainees that if femoral head if not out/guide wire not within 20 mins, requirement to request senior help. 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. work with HR to develop recruitment and retention plan for trauma nursing. review feeback from nursing education programme. Review and update transfusion policy post surgery. Review post op transfusion policy for NOF patients.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. Investigate options to Increase out of hours ortho geriatric cover	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk		25/06/2021	Will Mason	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value £60m), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment of core equipment and/or buildings.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI; 4. All opportunities to apply for capital made; 5. Finance and Digital Committee provide oversight for risk management/works prioritisation; 6. Trust Board provide oversight for risk management/works prioritisation; 7. GMS Committee provide oversight for risk management/works prioritisation; 8. Prioritisation of Capital managed through intolerable risk process 2019-20 – Complete 30/4/19 and revisited periodically through Capital contingency funds; 9. On-going escalation to NHSI for Capital Investment requirements – Trust recently awarded Capital Investment for replacement of diagnostic imaging equipment (MR, CT and mammography) in October 2019, SOC for £39.5 million Strategic Site Development on GRH and CGH sites approved September 2019, Trust recently rewarded emergency Capital of £5million for 19/20 from NHSI.	1. Prioritisation of capital managed through the intolerable risks process for 2019/20. escalation to NHSI and system. To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	GMS Board, Trust Leadership Team	30/06/2021	Akin Makinde	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients. 6. Use of telephone follow up for patients - where clinically appropriate 7. Additional capacity (non recurrent) for Ophthalmology to be reviewed post C-19 8. Adoption of virtual approaches to mitigate risk in patient volumes in key specialties 9. Review of % over breach report with validated administratively and clinically the values 10. Each speciality to formulate plan and to self-determine trajectory. 11. Services supporting review where possible if clinical teams are working whilst self-isolating.	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 speciaiiities to support f/u clearance of backlog	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Trust Leadership Team	30/06/2021	Felicity Taylor-Drewe	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. share microteaches and workbooks to support react 2 red	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Leadership Team	30/06/2021	Craig Bradley	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	Quality and Performance Committee, Trust Leadership Team	30/06/2021	Felicity Taylor-Drewe	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	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	Quality and Performance Committee	30/06/2021	Craig Bradley	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Patient Falls Policy 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6.Falls link persons on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Falls management training package	Discussion with Matrons on 2 ward to trial process. Develop and implement falls training package for registered nurses. develop and implement training package for HCAs. #Litle things matter campaign. Review 12 hr standard for completion of risk assessment. Alter falls policy to reflect use of hoverjack for retrieval from floor, review location and availability of hoverjacks Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR. Discuss flow sheet for bed rails on EPR at documentation group	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Quality and Performance Committee, Trust Leadership Team	30/06/2021	Craig Bradley	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	Trust Leadership Team	30/06/2021	Tom Hewish	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	Write risk assesment. Agree enhanced checking and verification of Theatre ventilation and engineering. 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 Update busines case for Theatre refurb programme. 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. Five Year Theatre Replacement/Refurbishment Plan	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Quality and Performance Committee, Trust Leadership Team	01/07/2021	Candice Tyers	Trust Risk Register
C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	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. 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	COVID T&F Group to develop Recovery Plan to minimise harm	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Trust Leadership Team	26/07/2021	Felicity Taylor-Drewe	Trust Risk Register

C3084P&OD	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	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	Finance and Digital Committee, People and OD Committee, Trust Leadership Team	30/08/2021	Lee Troake	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		31/08/2021	Akin Makinde	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		01/10/2021	Jonathan Lewis	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		01/10/2021	Linford Rees	Trust Risk Register
C3223	The risk to safety from nosocomial COVID-19 infection through transmission between patients and staff leading to an outbreak and of acute respiratory illness or prolonged hospitalisation in unvaccinated individuals.	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	safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Quality and Performance Committee, Trust Leadership Team	01/08/2021	Craig Bradley	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	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	Quality and Performance Committee, Trust Leadership Team	31/12/2021	Ben King	Trust Risk Register

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – August 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 22 July 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	Customer Satisfaction survey results had been received by the GMS Board.	Are there any areas of concern for the GMS Boards?	There are areas for improvement around switchboard performance, Apparently, the results were skewed by "only a couple of comments". There are no performance issues reported in the contractual KPIs.	
	It was reported that there are increasing instances of GMS staff moving to GHC	Is this an issue for GMS? Ideally, this should not happen within the same ICS.	The movement out of GMS has not caused any operational issues to date. The situation is being monitored and would be raised with the Trust for discussion at the ICS HR Forum if it becomes an issue.	
Contracts Management Group Exception Report	It was report that all monthly KPIs for May '21 were met with the exception of programmed maintenance for medical devices and equipment. Reason provided is due to an ongoing		These thermometers are being subjected to increased calibration as per manufacturer's advice and associated MHRA Medical Device Alert (MDA/2020/009). This issue is recorded on the	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	externally attributable issue with the Cardinal Health Genius 2 & 3 Tympanic Thermometers.		Corporate E&F Risk Register	
	Performance standards for cleaning services remain at target performance levels for consecutive months. The number of cleaning audits required to determine performance levels have been stable overall.	The average failure rate for audits appeared to indicate that the Trust is not on track towards Outstanding.	It was explained that the cleaning scores were based on more than 50 individual elements and any one element could result in a poor score. Overall, the scores were tracking well and there are no underlying issues revealed.	
	It was reported that the number of Violence and Aggression (V&A) incidents had increased from 113 to 318 quarter-on-quarter, coupled with increasing severity of incident.	How is this being monitored and analysed, with what improvement plans?	The incidents are becoming more frequent and more complex (it was also reported that this is a national trend). There are no signs that the situation is likely to improve in the near future. This area was also the subject of an internal audit that reported issues around governance that have since been addressed with a series of actions. One action is to establish a new V&A Group reporting to People and OD Committee.	As an area of growing concern which spans a number of Board committees (Q&P, People and OD, Estates and Facilities), it was suggested that this was a topic to be raised with the Trust Chair for a deeper discussion at the Board.
GMS Business Plan 2021/22 (Year 4) Progress	The MD of GMS presented a progress report showing a RAG report for each of the key elements of the Plan.	Do the colours provide a true reflection of progress, as the picture portrayed is fairly	Assurance was provided that the report was possibly over-cautious, but it is being monitored by the GMS Board	This report will return to the Committee every other meeting.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Most areas were shown as amber or red.	pessimistic?	on an ongoing basis.	
Risk Management Process	The report was presented to Committee to provide an update on progress against actions identified in the March 2021 presentation. Considerable progress has been made across most risks.	The effectiveness of the security management group was raised, as there were risks in this area that showed limited progress.	The security management group reports into the Health and Safety Committee, for which assurance is sought from the People and OD Committee.	It was agreed that a report on the recent security management group proceedings would be presented in September to provide assurance on actions being taken against the respective risks.
Estates Strategy Update	The Strategic Site Development Plan's Full Business Case had now been signed off by the Department for Health and Social Care. Kier, as main contractors, were planning to mobilise on Monday 26 July. The P22 contract will be signed in September. There will be an open day at both sites on 8 September to allow public and staff to view the plans.	What project controls are in place to oversee progress and delivery?	There is an Implementation Group which reports into the Strategic Estates Oversight Group.	It was requested that a high-level report from these groups be presented regularly at this Committee to provide assurance on effective project management and control processes, including monitoring of key risks. The key programme risks would also be revisited to understand which ones had been closed and which were being carried forward.
Governor's Comments	The Governor observer (Sarah Mather) asked whether the impact on portering services from increasing V&A incidents was being monitored and assessed.			MD of GMS committed to investigate further.

Mike Napier
Chair of Estates and Facilities Committee
5 August 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO MAIN BOARD – August 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 27 July 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 Management Report	Regular assurance report confirming: • Changes to register • Two new risks, relating to 8 hour waits in ED and Covid. • Location of each risk in terms of assurance Cttee oversight • Existing/planned mitigations and controls • Continued improvement in in risk KPIs.	• What is the spread of performance across Divisions? • Can future reporting take the Cttee closer to divisional variations, particularly in the light of some of the observations from the BDO report relating to divisional governance and risk? • Can KPI data be extended to include relative as well as absolute performance to enable comparisons to be made? • What is the arrangement within wider ICS to examine mitigations and controls that are outside the Trust's control e.g. ED waits?	Regularly discussed at Executive reviews. Yes. Yes and to be adopted in future reports. More development needed within ICS. COO leading.	Further discussion required within ICS as to how this integrated approach to risk will be

				undertaken.
External Audit Report	Progress report re outstanding work required to complete GMS and Charity audit of accounts. Training with Trust's finance team scheduled for October 2021. Discussion re future Cttee oversight of Audit plan for 2021/22 accounts.	• What is the progress on the Value for Money statement? • Request that FD and Deloitte undertake a reflection on lessons learned from the 2020/21 audit (to include Cttee members' feedback) prior to the Sept Cttee and bring a report to that meeting.	Going to plan. Letter to be drafted in August for discussion at September Audit Cttee. Agreed	
Internal Audit progress report **Divisional Governance Audit (Surgery) presented**	Good progress reported on 2021/22 audit plan. Positive report with substantial assurance.	• Identification of some points that had not always come through to Q&P Cttee eg context for a Quality Board being established.	Executive Review will exercise oversight of progress.	
Information Commissioner's Office (ICO) Assurance Report	This was the first such report presented to the Cttee and provided good evidence of the Trust's arrangements and performance.	• Discussion of quality of relevant training • Timing / scope of future ICO audit to provide assurance to ICO of Trust's compliance with data protection legislation.		

Losses and Compensations	13 ex gratia payments made in period to patients for loss of property on wards.	• Does there appear to be any reduction in the frequency of these losses, especially as the policy is being re-examined?	No	Report on revised policy and implementation progress to be made Sept Cttee.

We were joined for this meeting by the Audit Chairs from the CCG and from GHC as part of NED initiatives to extend understanding of system partners' Audit Cttee arrangements and approaches.

We were also pleased to welcome the Interim Chair of GMS as an observer.

Claire Feehily
Chair of Audit and Assurance Committee
August 2021

Gloucestershire Hospitals NHS Foundation Trust

PUBLIC TRUST BOARD - 12 August 2021

Report Title									
Guardian for Safe Working – Quarterly Report									
Sponsor and Author(s)									
Author: Dr Jess Gunn, Guardian for Safe Working Sponsor: Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO									
Board Members		Regulators		Governors		Staff		Public	

Executive Summary

Purpose
This report covers the period of 1st April 2021 to 30th June 2021.

Key issues to note
There were 104 exception reports logged.
There were no fines levied.
No correlation with Datix clinical incident reports for this period.

Conclusions
The number of exceptions has increased this quarter but is comparable with the same quarter of 2020.

Implications and Future Action Required
The Guardian for Safe Working will continue to monitor exception reports and assist divisions and specialities where these arise to ensure improved compliance

Recommendations

The Board should be ASSURED that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly

Impact Upon Strategic Objectives

Managing Junior Doctor hours and ensuring compliance with National Terms and conditions ensures colleagues have the rest and recuperation necessary for their own wellbeing and to deliver safe care. Safe working therefore assists the Trust in achieving its objectives, specifically around compassionate workforce and Outstanding Care.

Impact Upon Corporate Risks

Ensuring working hours are reasonable and in line with national terms and conditions assists in reducing the risk of errors, poor decision making or poor care due to tiredness and fatigue.

Regulatory and/or Legal Implications

Under the 2016 terms and conditions of service (TCS) for junior doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the board of compliance

with safe working hour's limits.
Equality & Patient Impact
There is a risk that tired staff can make errors and this could be detrimental to patient care and outcomes. Ensuring Junior Drs have a similar experience across divisions and specialities in terms of working hours provides an equitable experience during training.

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

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

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Trust Leadership Team**	**Other (specify)**
					N/A
Outcome of discussion when presented to previous Committees/TLT					
N/A					

Gloucestershire Hospitals
NHS Foundation Trust

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

For Presentation to the Main Board
Thursday 12 August at 12.30pm

1. Executive Summary

1.1 This report covers the period of 1.4.21 – 30.6.21. There were 104 exception reports logged.

1.2 During this period, 0 fines were levied.

2. Introduction

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

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

High level data

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

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1-2 &GPT**	**IMT & ST3-8**	**Additional training and trust grade vacancies**
ED	0	0	6*	0	*** 4x ST1/2** *** 2x ACCS ST1/2**
Oncology	0	0	1*	1*	***1x IMT1** ***1x GP Trainee**
T&O	0	0	0	0	**1 Trust Dr** **3 x Trust Dr (ST1)**
Surgery	0	0	0	0	**1x Surgical Education Fellow** **1x Ophthalmology Clinical Fellow**
General Medicine	0	0	0	3*	***1x Renal IMT2** **1x Cardiology Clinical Fellow** ***1x Cardiology IMT** **1x COTE Clinical Fellow** ***1x COTE IMT1** **4x General Medicine Clinical Fellows**
Paeds	0	0	0	1*	***1x Paediatric ST4**
Obs & Gynae	0	0	0	0	
Haematology	0	0	1*	0	***1x ST1**
Total Junior Doctor Vacancies across all grades and departments					**25**

(vacant post to which tabulated numerical value corresponds)*

4. Locum Bookings

4.1 Data from finance team:

The total expenditure on junior doctor locum cover, across all specialties', over the last quarter was £137,164.00. The breakdown of this expenditure, i.e. grade of doctor and department covered is not available at the time of submission.

5. Exception Reports

	Exceptions Raised		
Specialty	**Working Hours**	**Educational Opportunities**	**Service Support Available**
General/GI Surgery	6	3	5
Urology	0		0
Trauma/ Ortho	13		0
ENT	0		0
MaxFax	0		0
Ophthalmology	0	0	0
Orthogeriatrics	0	0	0
General Medicine	33	6	2
Geriatric Medicine	8	0	1
Neurology	0	0	0
Cardiology	0	0	0
Respiratory	1	0	0
Gastro	0	0	0
Renal	8	2	0
Endocrine	0	0	0
Acute medicine/ ACUA	0	0	0
Emergency Department	2	0	0
Obstetrics and Gynaecology	4	0	0
Paediatrics	4	0	0
Psychiatry	2	1	0
Anaesthetics	0	0	0
Oncology	2	1	0
Haematology	0	0	0
GP	0	0	0
Total	**83**	**13**	**8**

6. Fines this Quarter

6.1 This quarter there have been no fines levied.

7. Issues Arising

7.1 There were 6 reports listed as 'immediate safety concern' relating to general medicine, geriatric medicine, renal medicine and general surgery.

No specific incidents occurred; these were related to degree of patient workload compared to the number of staff which was felt to be very high and a clinical risk. These were escalated to the supervising teams. A common theme throughout was the perception amongst trainees that known vacant shifts had not been advertised through the locum portal.

It is also acknowledged that trainees and juniors are fatigued at present, as a consequence of the unprecedented demands placed on them over the last 12-18 months of pandemic response. This fact has been acknowledged by the medical director during the latest junior doctor monthly catch up. The medical director has also expressed thanks to this cohort of colleagues on behalf of himself and the wider trust for all their help, support and hard work over this difficult time.

8. Actions Taken to Resolve Issues

8.1 As above.

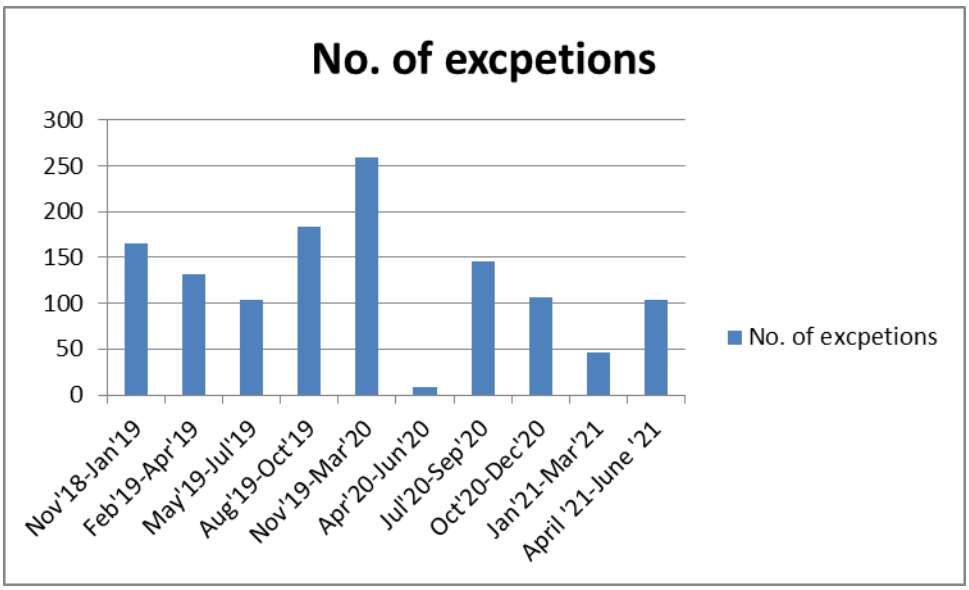
9. Correlations to Clinical Incident Reporting

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

10. Junior Doctors Forum

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

11. Trajectory of exception reports



The graph shows the number of exception reports per quarter.

12. Summary

11.1 A total of 104 working hour's exception reports have been made from the beginning of April '21 to the end of June '21. No fines were levied. The overall rate of exception reports has increased this quarter although is comparable to the same quarter last year (i.e. 2020).

Author: **Dr Jess Gunn, Guardian of Safe Working Hours**

Presenting Director: **Prof Mark Pietroni**

Date 27.7.21

Recommendation

- To endorse
- To approve

Appendices

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

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 AUGUST 2021

Report Title
Learning from Deaths Quarterly Report – Q3 & Q4
Sponsor and Author(s)
Author: Andrew Seaton, Quality Improvement & Safety Director Sponsor: Prof Mark Pietroni, Director for Safety & Medical Director

Executive Summary

Purpose

To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

Key issues to note

- All deaths in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.
- All families meet with the bereavement team and have the opportunity to feedback any comments on the quality of care which are fed back to wards for their learning.
- The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. Timeliness of review through SJR is challenging and will be reviewed by the Hospital Mortality Group, the current rate has improved this quarter.
- All serious incidents have action plans based on the identified learning which are monitored to completion.
- HSMR for the period March 2020 – February 2021 is now showing to be within the expected range:
  - HSMR is now 104.9 from the previous reported position of 103.9.
  - SMR has now increased to 110.1 from the previous reported position of 103.6 which is statistically significant.
  - SHIMI for period Jan 2020 - Dec 2020 remains in the expected range at 101.77 from 106.83.

The Dr Foster team have created a new methodology for reviewing COVID deaths to allow comparison with other Trusts and shows that the Trusts mortality rate against a range of parameters were within normal variation.

Conclusions

- All deaths are reviewed in the Trust through the Medical Examiner, other triggered deaths are further reviewed through the Trust structured judgement process, SI investigation and national programmes driving local learning, feedback and system improvement.

Implications and Future Action Required

To ensure actions have desired impact and embed learning from good care driving change.

Recommendations
Quality and Performance Committee are asked to note the Learning from Deaths Quarterly Report.
Impact Upon Strategic Objectives
This work links directly to our Trust objectives to achieve outstanding care and continuous quality improvement.
Impact Upon Corporate Risks
Understanding the themes from mortality reviews will inform Trust risks
Regulatory and/or Legal Implications
National requirement to report to Trust Board.
Equality & Patient Impact
Reviews of children and patients with Learning difficulties

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

TRUST PUBLIC BOARD – 12 AUGUST 2021

LEARNING FROM DEATHS REPORT

1. **Aim**

1.1 To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

1.2 With the exception of mortality data the period covered reflects Oct-March 2020-21 and is an update from the previous report, the next report will revert to a quarterly period.

2. Learning From Deaths

2.1 The main processes to review and learn from deaths are:

a. Review by the Medical Examiners and family feedback collected by the bereavement team on all deaths and provided to wards.

b. Structured judgment reviews (SJR) for deaths that meet identified triggers completed by clinical teams, providing learning through presentation and discussion within specialties. (Appendix 1)

c. Serious incident review and implementation of action plans.

d. National reviews including Learning Disability Reviews, Child Death Reviews, Perinatal Deaths and associated learning reports and national audits.

2.2 All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners. These deaths are entered on to the Datix system to support the SJR process.

2.3 All families are given the opportunity to provide feedback to the bereavement team on the quality of care. The feedback is overwhelmingly positive and is routinely shared with the relevant ward area. The data in this report has been affected by COVID restrictions which temporarily stopped the usual feedback mechanism.

2.4 The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings at Specialty level. The rate of reviews within 3 months reached 72% in Q3 but then dropped in Q4 to 61% linked to the COVID increase.

2.5 All serious incidents have action plans based on the identified learning which are monitored to completion. High level learning themes are fed into expert Trust groups. Summary reports on closed action plans are included in the report.

3.0 Mortality Data (Appendix 3)

3.1 HSMR for the period March 2020 – February 2021 continue to be within the expected range:

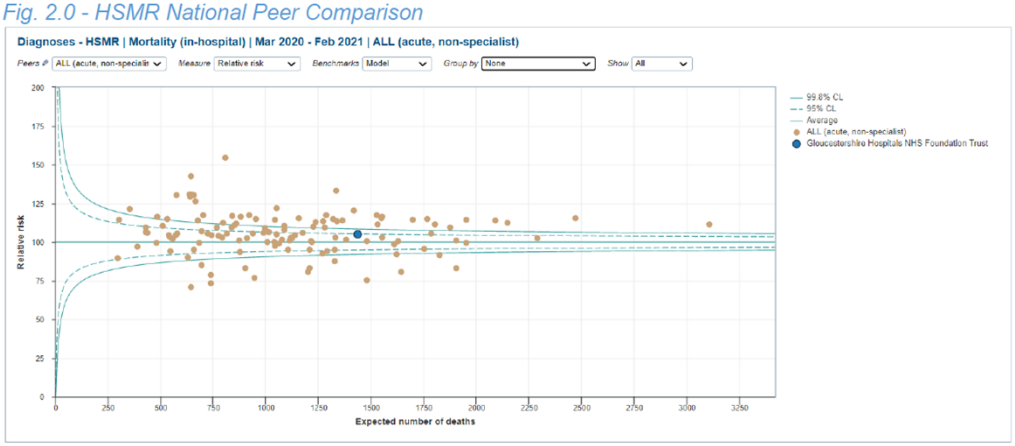
- HSMR is now 104.9 from the previous reported position of 103.9.
- SMR has now increased to 110.1 from the previous reported position of 103.6 which is statistically significant.
- SHIMI for period Jan 2020 - Dec 2020 remains in the expected range at 101.77 from 106.83.

3.2 HSMR

Peer Comparison

The HSMR for the Trust remains within the expected range using 99.8% control limits.

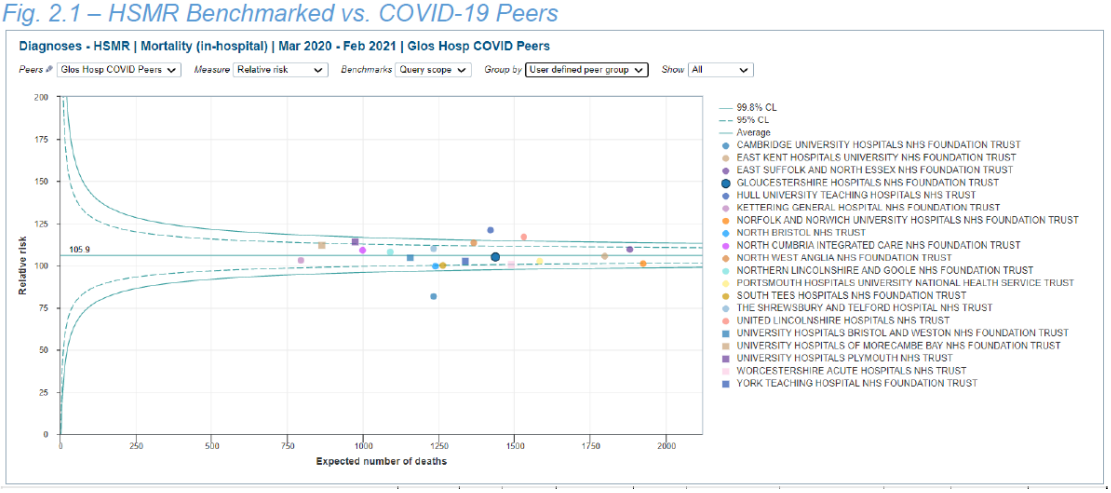
Fig. 2.0 - HSMR National Peer Comparison



3.3 COVID mortality

To aid the interpretation of mortality indicators over the Coronavirus pandemic period, we created peer groups of trusts that saw a similar cohort of patients, had a similar number of COVID-19 spells and had similar baseline capacity. Fig. 2.1 below shows the HSMR for the Trust benchmarked against their COVID-19 peer group. The Trust's HSMR using this peer group benchmark (rather than the usual national benchmark) is 99.1 (94.1 – 104.2), this is within the expected range using 95% confidence intervals.

Fig. 2.1 – HSMR Benchmarked vs. COVID-19 Peers



3.4 SMR Increase

The increase in the Standardised Mortality Rate appears to be connected to COVID, when COVID deaths are removed the remaining picture returns the rate to normal variation against peers.

Peer Comparison

The SMR for the Trust remains statistically significantly higher than expected using 99.8% control limits.

Fig. 8.0 - SMR National Peer Comparison

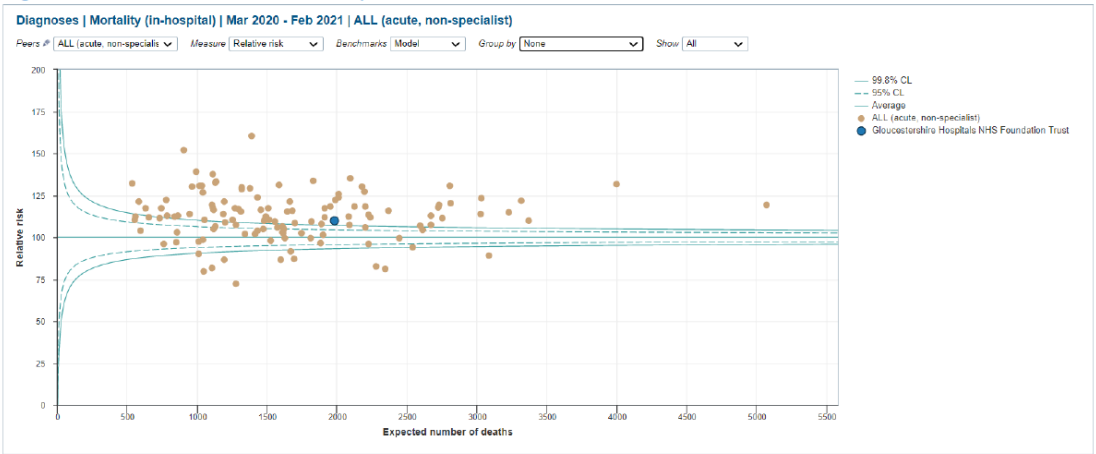
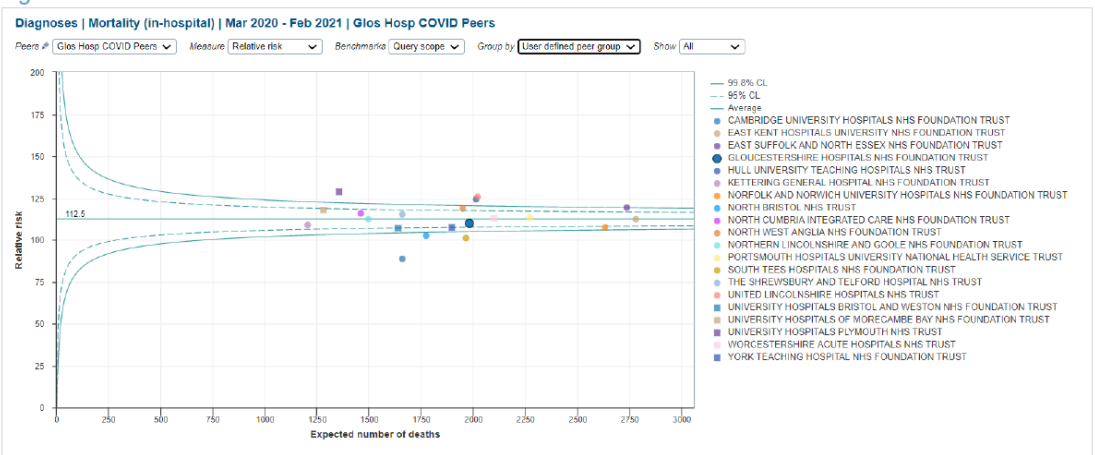


Fig. 8.1 below shows the SMR for the Trust benchmarked against their COVID-19 peer group. The Trust's SMR using this peer group benchmark (rather than the usual national benchmark) is 97.9 (93.8 – 102.1), this is within the expected range using 95% confidence intervals.

Fig. 8.1 – SMR Benchmarked vs. COVID-19 Peers



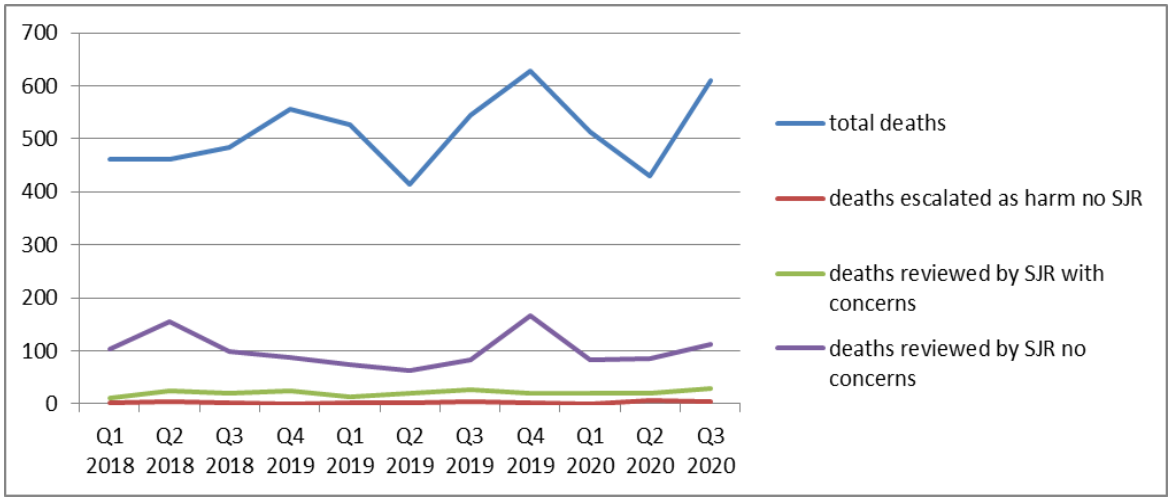
4. Structured Judgement Review Process

4.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They have now managed to ensure all deaths are recorded in real time.

4.2 Deaths identified for review

Mortality Quarterly Dashboard Trust wide: Quarter 3 (Oct-Dec 2020)

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
610	431	**5**	6	**29**	20	**113**	86	135(22%)	101 (23%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
1557	2104	**11**	12	**68**	80	**282**	355	335(22%)	416 (20%)	**0**	6



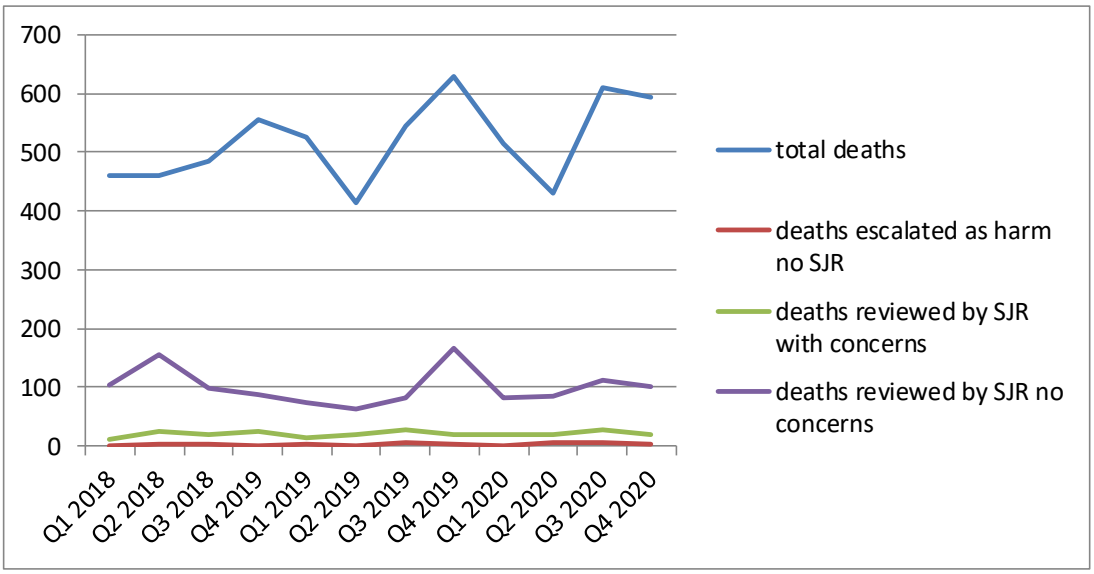
Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		**Score 2 – Poor Care**		**Score 3 – Adequate Care**		**Score 4 – Good Care**		**Score 5 – Excellent Care**		**Deaths escalated to harm review panel following SJR**	
This Quarter	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**
0	0	**4**	6	**26**	67	**59**	138	**22**	54	**0**	1

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 09/05/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
12 (41%)	6 (29%)	**81 (72%)**	52 (65%)	**1 (33%)**	1 (50%)	**81 (60%)**	61 (60%)	**20 (15%)**	14 (14%)
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year

18 (26%)	14 (17.5%)	**186 (66%)**	110 (31%)	**3 (43%)**	12 (63%)	**199 (59%)**	12 (63%)	**45 (13%)**	18 (4%)

Mortality Quarterly Dashboard Trust wide: Quarter 4 (Jan-Mar 2021)

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
593	610	**4**	5	**21**	29	**100**	113	119(20%)	135(22%)	**1**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
2150	2104	**15**	12	**89**	80	**382**	355	454(21%)	416 (20%)	**1**	6



Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		**Score 2 – Poor Care**		**Score 3 – Adequate Care**		**Score 4 – Good Care**		**Score 5 – Excellent Care**		**Deaths escalated to harm review panel following SJR**	
This Quarter	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**	**This Quarter**	**This year (YTD)**
0	0	**4**	6	**26**	67	**59**	138	**22**	54	**0**	1

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (14/07/2021) (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
12(57%)	12 (41%)	**62 (61%)**	81 (72%)	**3 (60%)**	1 (33%)	**61 (51%)**	81 (60%)	**26 (22%)**	10 (7%)
This	Last	**This**	Last	**This**	Last	**This**	Last	**This**	Last Year

Year	Year	**Year**	Year	**Year**	Year	**Year**	Year	**Year**	
30 (34%)	14 (17.5%)	**248 (65%)**	110 (31%)	**9 (64%)**	12 (63%)	**260 (57%)**	12 (63%)	**45 (10%)**	8 (2%)

4.3 Feedback on progress is provided to the Hospital Mortality Group. The SJR approach continues to embed within all divisions; deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty.

4.4 The Performance against standard tables above illustrates the general performance. Timeliness of the review to improve local learning and escalation to SI status still requires improvement but is showing a consistent improvement from Q1 last year at the start of first wave of COVID; however COVID is still impacting this year as teams attempt to catch up on a range of issues such as complaint responses. Access to notes remains a delaying factor in general.

5. Family Feedback from Bereavement team

5.1 Positive comments

83% (last report 85%) of all comments received were positive with a further 2.7% mixed comments (containing positive and negative). Staff and the care provided was described as caring, fantastic, marvellous and excellent.

5.2 Negative comment

9% (last report 12.5%) of comments received were negative with a further 2.5% mixed comments. Two families were signposted to PALS. Acquisition of COVID, visiting time restrictions and communication were mentioned most frequently.

5.3 Conclusion

There has continued to be a significant reduction in comments received from families during this period. Despite the difficulties experienced during this time feedback has remained mostly positive at 83%. Learning from the feedback reflects the learning from COVID where better support from PALS and use of technology to communicate where implemented.

6. Learning from Deaths

6.1 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through the speciality and divisional processes, this approach although improving is still inconsistent.

All specialties now receive monthly individual monthly data on SJR performance.

6.2 The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some common themes continue to be identified which are in common with known areas of quality, as in previous months these are in particular the complex management of the deteriorating patient (monitored by Quality Delivery Group).

6.3 Serious incidents that result in death all have action plans. A summary of the individual closed actions plans and learning in the past 6 months is attached for information (Appendix 2).

Deaths by Special Type –	Apr-Jun 20		July- Sept 20		Oct-Dec 20		Jan-Mar 2021	
Type	*Number*		*Number*		*Number*		*Number*	
Maternal Deaths (MBRRACE)	0		0		0		1 (W&C)	
Coroner Inquests with SI	1		2		3		3	
Serious Incident Deaths	3		7		9		6	
Learning Difficulties Mortality Review (Inpatient deaths)	6		8		3			
Perinatal Mortality	Neonatal <8 days	2*	Neonatal <8 days	4*	Neonatal <8 days	1*	Neonatal <8 days	4 (but only 1 at GRH)
	Still births	4	Still births	2	Still birth	5	Still birth	5

*1 in Bristol

6.4 LeDeR (excerpt from annual report)

The GHFT Lead for Safeguarding Adults has attended every LeDeR quality assurance panel throughout the year. There were 22 in-hospital deaths of patients with LD during the year. This averages less than 2 a month and therefore is within normally expected numbers. However, of these 8 who died of COVID – 3 in April and May 2020 (peak 1) and 5 in January 2021 (peak 2). All of the in-hospital deaths were graded as either 2 (good) or 3 (adequate), with an average rating of 'good'. This is extremely positive feedback, especially as ward staff were under extreme pressure for most of 2020/2021 with high numbers of COVID patients.

LeDeR processes will be changing fundamentally in June 2021 and therefore there will be no LeDeR reviews undertaken in Q1 of 2021/2022. The deaths that occur in that quarter will be reviewed once the new system is running.

Restoring the Learning Disability Steering Group to shape and monitor a learning Disability Improvement Plan was a priority for 2020/2021. That has been achieved and the Improvement Plan written and agreed. Improvements are planned under headings of:

- Data
- Patient experience
- Family/carer experience
- Staff experience

Woven into these are all the learning points raised in LeDeR reviews, which are around nutrition and hydration, communication with non-verbal patients, communication with relatives and carers and use of Hospital passports (to be known as Health Passports going forward)

6.5. Monthly updates are provided to QDG from the Safeguarding lead on LeDeR, action is taken forwards on the Safeguarding meeting.

7. Mortality Dashboard (Appendices)

7.1 The Trust reporting requirements can be found below:

Appendix 1
a) SJR dashboard & Divisional Performance

Appendix 2
a) Summary reports from Serious Incidents

Appendix 3
a) Mortality indicators – Dr Foster report

9. Conclusions

9.1 All deaths are reviewed within the Trust via the bereavement and the Medical Examiner approach.

9.2 There is good progress on local learning from problems in care and ensuring these are being reflected on within specialties. Identified themes will feed in to the Learning from Concerns report and Specialty quality data reports.

9.3 Timeliness and completion rate have shown continual improvement for SJRs, COVID is still impacting on consistency of approach across the Trust.

9.5 Mortality indicators across most parameters are showing a general decrease and are within expected ranges with the exception of SMR which appears to have been impacted by COVID.

9.6 Using a new Dr Foster approach mortality from COVID is currently within normal variation in comparison to our peers.

10. Recommendations

10.1 The Committee is asked to note the Learning from Deaths Quarterly Report and approve in advance of it going to Trust Main Board.

Author: Andrew Seaton, Quality Improvement and Safety Director

Presenter: Prof Mark Pietroni, Director for Safety & Medical Director

July 2021

Gloucestershire Hospitals NHS Foundation Trust

Appendix 1

Divisional SJR Q3 Oct-Dec

Surgical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
89	71	**0**	3	**7**	6	**27**	25	**30 (34%)**	29 (41%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
239	398	**3**	4	**18**	21	**68**	98	**78 (33%)**	114 (29%)	**0**	3

	Total number of deaths	**Deaths presented to harm review panel (No SJR undertaken)**	**Total number of deaths selected for review under SJR methodology (% of total death)**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Critical care	**31**	**0**	7	**0**	**0**	**5**
T&O	**21**	**0**	17	**0**	**0**	**1**
Upper GI	**13**	**0**	3	**0**	**0**	**0**
Lower GI	**14**	**0**	2	**0**	**0**	**0**
Vascular	**0**	**0**	0	**N/A**	**0**	**0**
Urology	**2**	**0**	0	**N/A**	**0**	**0**
Breast	**0**	**0**	0	**N/A**	**0**	**0**
ENT	**3**	**0**	1	**0**	**0**	**0**

OMF	**0**	**0**	0	**N/A**	**0**	**0**
Ophthalmology	**0**	**0**	0	**N/A**	**0**	**0**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 09/05/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
3 (43%)	3 (50%)	**16 (59%)**	17 (77%)	**N/A**	0 (0%)	**24 (80%**	20 (69%)	**4 (13%)**	1 (3%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year(YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
6 (33%)	3 (14%)	**43 (63%)**	24 (24%)	**0 (0%)**	4 (57%)	**58 (74%)**	83 (73%)	**7 (9%)**	0

Reason for SJR not being undertaken	**This Quarter**	**Last Quarter**
Notes unavailability	**0**	**0**

Medical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
503	342	**5**	3	**19**	14	**84**	56	**100(20%)**	67 (19%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
1159	1584	**8**	6	**46**	50	**202**	222	**241**	264	**0**	3

								(21%)	(17%)		

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Acute medicine	**90**	2	6	**0**	**1**	**0**
Cardiology	**31**	0	10	**0**	**0**	**0**
Emergency Department	**56**	0	54	**0**	**2**	**10**
Gastroenterology	**16**	0	3	**0**	**0**	**1**
Neurology	**11**	0	0	**0**	**N/A**	**N/A**
Renal	**38**	0	4	**0**	**0**	**0**
Respiratory	**64**	0	5	**0**	**0**	**0**
Rheumatology	**0**	0	0	**0**	**N/A**	**N/A**
Stroke	**30**	0	1	**0**	**0**	**0**
COTE	**142**	3	16	**0**	**0**	**3**
Diabetology	**15**	0	1	**0**	**0**	**0**
Endoscopy	**0**	0	0	**0**	**N/A**	**N/A**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 09/05/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
7 (37%)	3 (20%)	**62 (74%)**	32 (62%)	**0 (0%)**	1 (100%)	**53(53%)**	38 (57%)	**14 (14%)**	13 (19%)
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year

(YTD)		(YTD)		(YTD)		(YTD)		(YTD)	
10 (22%)	8 (16%)	**124 (61%)**	77 (35%)	**2**	11 (92%)	**129 (53%)**	172 (65%)	**37 (15%)**	17 (6%)

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**0**	**0**

Diagnostic and Specialties

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
18	18	**0**	0	**2**	0	**3**	5	**5 (28%)**	5 (28%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
55	112	**0**	2	**4**	9	**11**	35	**15 (27%)**	38 (34%)	**0**	0

	Total number of deaths	Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)	Total number of deaths selected for review under SJR methodology	Deaths investigated as serious or moderate harm incidents. Following SJR (total)	Number of SJRs with very poor or poor care	Number of SJRs with excellent care
Lead Specialty						
Oncology	**12**	**0**	**3**	**0**	**0**	**2**
Clinical haematology	**6**	**0**	**2**	**0**	**1**	**0**
Performance against standards for review						

Deaths with concerns reviewed within 1 month of death		Deaths with no concerns reviewed within 3 months of death (% of total requiring review)		2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)		Completion of Key Learning Message (% of total requiring review)		Deaths selected for review but not reviewed to date 09/05/2021 (% of total requiring review)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
1 (50%)	N/A	**3 (100%)**	3 (60%)	**1 (100%)**	N/A	**4 (80%)**	2 (40%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
1 (50%)	3 (33%)	**9 (82%)**	N/A	**1 (100%)**	**N/A**	**11 (73%)**	N/A	**0**	0

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**0**	**0**

Maternity and Gynaecology

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of in hospital deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
0	0	**0**	0	**0**	0	**0**	0	0	0	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
1	2	**0**	0	**0**	0	**1**	0	0	0 (0%)	**0**	0

	Total number of deaths	Deaths presented to harm review panel	Total number of deaths selected for	Deaths investigated as serious or	Number of SJRs with very	Number of SJRs with

		(Prior to SJR/SJR not undertaken)	review under SJR methodology	moderate harm incidents. Following SJR (total)	poor or poor care	excellent care
Lead Specialty						
Gynaecology	**0**	**0**	**0**	**0**	**0**	**0**

Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 09/05/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
N/A	N/A	**N/A**	N/A	**N/A**	N/A	**N/A**	N/A	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
N/A	N/A	**0 (0%)**	N/A	**N/A**	**N/A**	**0 (0%)**	N/A	**1 (100%)**	0

Gloucestershire Hospitals
NHS Foundation Trust

Divisional SJR Q4 Jan-Mar 2021

Surgical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
101	89	**3**	0	**6**	7	**23**	27	**26 (26%)**	30 (34%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
340	398	**6**	4	**24**	21	**91**	98	**104 (31%)**	114 (29%)	**0**	3

	Total number of deaths	**Deaths presented to harm review panel (No SJR undertaken)**	**Total number of deaths selected for review under SJR methodology (% of total death)**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Critical care	**37**	**0**	5 (13%)	**0**	**0**	**1**
T&O	**24**	**2**	13 (54%)	**0**	**0**	**2**
Upper GI	**16**	**0**	3 (19%)	**0**	**0**	**0**
Lower GI	**13**	**1**	3 (23%)	**0**	**0**	**0**
Vascular	5	0	0 (0%)	N/A	N/A	N/A
Urology	**2**	**0**	2 (100%)	**0**	**0**	**0**
Breast	0	N/A	N/A	N/A	N/A	N/A

ENT	**5**	**0**	0 (0%)	**0**	**0**	**0**
OMF	0	N/A	N/A	N/A	N/A	N/A
Ophthalmology	**0**	**N/A**	N/A	**N/A**	**N/A**	**N/A**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 14/07/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
3 (50%)	3 (43%)	**12 (63%)**	16 (59%)	**N/A**	N/A	**16 (61%)**	24 (80%)	**5 (19%)**	4 (13%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year(YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
9 (38%)	3 (14%)	**55 (60%)**	24 (24%)	**2 (0%)**	4 (57%)	**74 (71%)**	83 (73%)	**9 (9%)**	0 (0%)

Reason for SJR not being undertaken	**This Quarter**	**Last Quarter**
Notes unavailability	**0**	**0**

Medical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
474	503	**0**	5	**15**	19	**73**	84	**89(19%)**	100(20%)	**1**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year

1633	1584	**8**	6	**61**	50	**275**	222	**330 (20%)**	264 (17%)	**1**	3

	Total number of deaths	Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)	Total number of deaths selected for review under SJR methodology	Deaths investigated as serious or moderate harm incidents. Following SJR (total)	Number of SJRs with very poor or poor care	Number of SJRs with excellent care
Lead Specialty						
Acute medicine	**127**	0	31 (24%)	**1**	**0**	**1**
Cardiology	**21**	0	5 (24%)	**0**	**0**	**0**
Emergency Department	**23**	0	22 (96%)	**0**	**1**	**8**
Gastroenterology	**18**	0	1 (6%)	**0**	**0**	**1**
Neurology	**7**	0	1 (14%)	**0**	**0**	**0**
Renal	**39**	0	4 (10%)	**0**	**0**	**0**
Respiratory	**65**	0	8 (12%)	**0**	**0**	**0**
Rheumatology	**0**	0	N/A	**0**	**N/A**	**N/A**
Stroke	**22**	0	1 (5%)	**0**	**0**	**0**
COTE	**132**	0	11 (8%)	**0**	**1**	**3**
Diabetology	**20**	0	5 (25%)	**0**	**0**	**1**
Endoscopy	**0**	0	N/A	**0**	**N/A**	**N/A**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 14/07/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
9 (60%)	7 (37%)	**46 (59%)**	62 (74%)	**2 (50%)**	0 (0%)	**42 (47%)**	53 (53%)	**21 (24%)**	6 (6%)

This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
19(31%)	8 (16%)	**170 (62%)**	77 (35%)	**4 (44%)**	11 (92%)	**171 (52%)**	172 (65%)	**36 (11%)**	8 (3%)

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**0**	**0**

Diagnostic and Specialties

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
17	18	**0**	0	**0**	2	**3**	3	**3 (18%)**	5 (28%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
72	112	**0**	2	**4**	9	**14**	35	**18 (25%)**	38 (34%)	**0**	0

	Total number of deaths	Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)	Total number of deaths selected for review under SJR methodology	Deaths investigated as serious or moderate harm incidents. Following SJR (total)	Number of SJRs with very poor or poor care	Number of SJRs with excellent care
Lead Specialty						
Oncology	**16**	**0**	**1 (6%)**	**0**	**1**	**0**
Clinical haematology	**2**	**0**	**2 (100%)**	**0**	**0**	**1**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 14/07/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
N/A	1 (50%)	**3 (100%)**	3 (100%)	**1 (100%)**	1 (100%)	**3 (100%)**	4 (80%)	**0 (0%)**	0 (0%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
1 (50%)	3 (33%)	**12 (86%)**	N/A	**2 (100%)**	**N/A**	**14 (78%)**	N/A	**0 (0%)**	0 (0%)

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**0**	**0**

Maternity and Gynaecology

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of in hospital deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
1	0	**1**	0	**0**	0	**0**	0	1 (100%)	0	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
2	2	**1**	0	**0**	0	**1**	0	1 (50%)	0 (0%)	**0**	0

	Total number of	Deaths presented to	Total number of	Deaths investigated	Number of	Number of

	deaths	harm review panel (Prior to SJR/SJR not undertaken)	deaths selected for review under SJR methodology	as serious or moderate harm incidents. Following SJR (total)	SJRs with very poor or poor care	SJRs with excellent care
Lead Specialty						
Gynaecology	**0**	**0**	**0**	**0**	**0**	**0**
Maternity	**1**	**1**	**0**	**N/A**	**N/A**	**N/A**

Deaths with concerns reviewed within 1 month of death		**Deaths with no concerns reviewed within 3 months of death (% of total requiring review)**		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date 09/05/2021 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
N/A	N/A	**1 (100%)**	N/A	**N/A**	N/A	**N/A**	N/A	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
N/A	N/A	**0 (0%)**	N/A	**N/A**	**N/A**	**0 (0%)**	N/A	**0**	0

Appendix 3

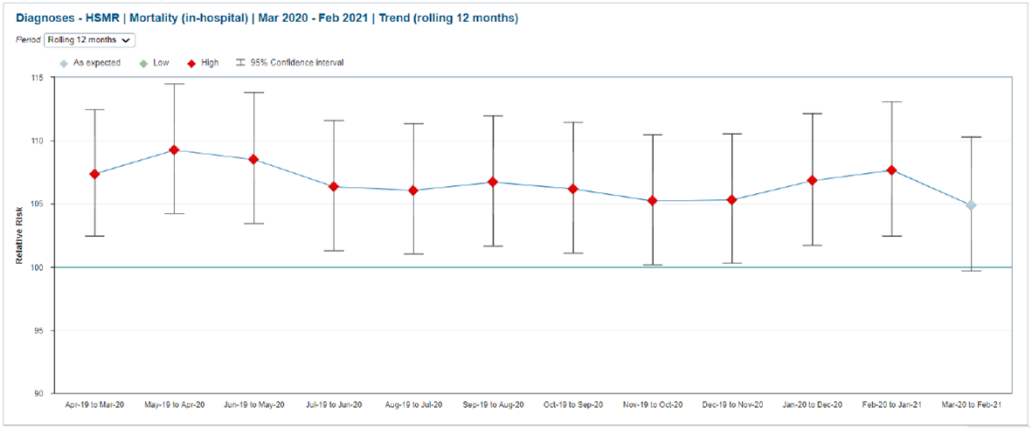
Dr Foster Summary Report – June 2021 Report

Results Summary

Metric	Result (arrows in brackets indicate change vs. previous reported time period)
HSMR	Trust – 104.9, within the expected range (↓) Cheltenham General – 72.4, statistically significantly lower than expected (↓) Gloucestershire Royal – 111.4, statistically significantly higher than expected (↓)
HSMR for Emergency Weekend/Weekday Admissions	Weekday – 103.1, within the expected range (↓) Weekend – 112.1, statistically significantly higher than expected (↑)
Trends in Coding for HSMR Basket (20/21 FY to date)	Palliative Care Coding Rate (non-elective spells): 4.16 (↓), national rate is 4.63% Charlson Comorbidity Upper Quartile Rate: 21.9% (↑), this is 87 as an index of national
SMR	Trust – 110.1, statistically significantly higher than expected (↑) Cheltenham General – 73.8, statistically significantly lower than expected (↓) Gloucestershire Royal – 117.5, statistically significantly higher than expected (↓)
New Relative Risk Alerts	Influenza Excision of skin
New CUSUM Alerts	Residual codes, unclassified (7th alert)
Mortality Patient Safety Indicators	Both within the expected range
SHMI (January to December 2020)	101.77, within the expected range using NHS Digital's 95% control limits adjusted for over dispersion (↓)
New Early Warning Mortality Relative Risk Alerts	No new data

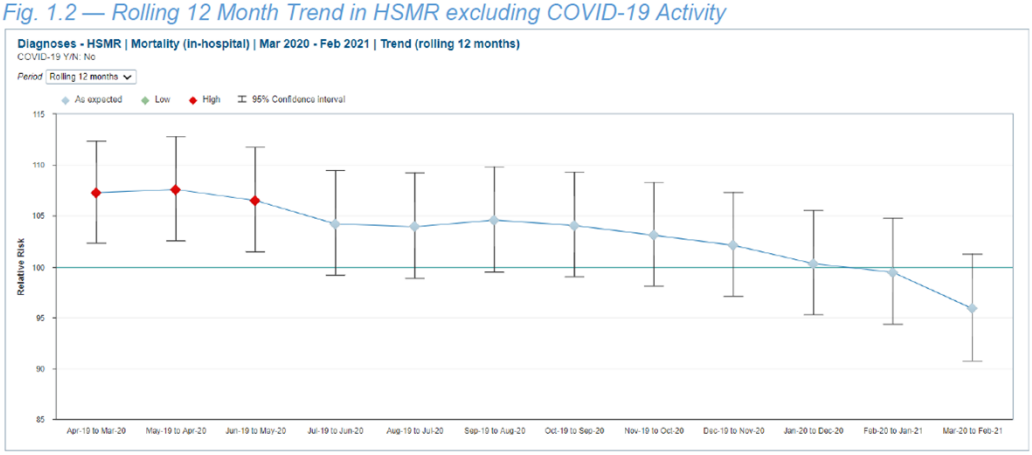
To provide a slightly longer term view of performance, Fig. 1.1 shows the rolling 12 month trend in HSMR where each point on the graph represents 12 months of data. Overall, the linear trend shows a slight decrease.

Fig. 1.1 – Rolling 12 Month Trend in HSMR



If COVID-19 activity is removed from the HSMR (where it is in a secondary diagnosis position), it reduces to 95.9 (90.7 – 101.2) for the latest 12 month period, this is within the expected range. The rolling 12 month trend shows a gradual decrease from the Oct-19 to Sep-20 period onwards.

Fig. 1.2 — Rolling 12 Month Trend in HSMR excluding COVID-19 Activity



Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 AUGUST 2021

Report Title
QUALITY AND PERFORMANCE REPORT
Sponsor and Author(s)
Author: Katie Parker-Roberts, Head of Quality, and Felicity Taylor-Drewe, Deputy Chief Operating Officer and Director of Planned Care Sponsor: Steve Hams, Chief Nurse
Executive Summary

Purpose

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

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

Quality

There has been one hospital onset health care associated MRSA bacteraemia within the renal speciality in June 2021. Initial findings suggest this is related to an invasive device specifically an peripheral venous cannula. Further investigation via the post infection review process is due to be completed. Furthermore, in line with the IPC annual strategy 2021-2022 a point prevalence audit will be performed across the trust of invasive devices to assess indication, care of the device and documentation. A report will be created and remedial actions identified and implemented to address issues that arise

In June 2021 there were 7 community onset - health care associated (CO-HA) cases and 4 hospital onset - health care associated (HO-HA) cases. All HO-HA cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re-review.

Three of the HO-HA cases are associated with Prescott ward and identified as part of an outbreak. Since May 2021 there have been 6 HO-HA cases associated with Prescott ward identified as part of C. difficile outbreak (ribotyping for 3 of the cases are the same which indicates likely patient to patient transmission). Three multidisciplinary outbreak meetings have been held and an action plan to address the suspected causes and any lapses in care has been implemented. Upon identification of the sixth positive patient the ward was completely closed to admissions and transfers on 22/6/2021. Before that bays had been sequentially emptied and closed to allow red cleaning (Fuse and HPV). The ward was re-opened on 29/6/2021 after all active CDI patients were moved off the ward prior to opening and completion of whole ward cleaning (which was reviewed by the IPCT prior to opening).

In light of the increased number of period of increased incidences and an outbreak of C. difficile across the trust a new trust wide C. difficile reduction plan will be created to address issues identified from post infection reviews and PII/ outbreak meetings. A meeting will be held to engage essential stakeholder in the creation of the reduction plan and assurance of action completion will be monitored through the Infection Control Committee. The ICS also met with NHSE/I on their region wide CDI improvement collaborative to agree upon 3 key improvement areas which includes antimicrobial stewardship, optimisation of CDI treatment and management and environmental cleaning/ CDI IPC bundle; this work will be progressed through the collaborative.

As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominately identified lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Joint cleaning standard audits undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning will continue which more frequency, with any issues being addressed the point of review.

Furthermore, Nurse-led C. difficile ward rounds continue thrice weekly to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients.

Number of falls per 1,000 bed days
We are recovering from a spike in the number of in-patient falls, reaching 8.6 per 1000 bed days in January 2021, performance has improved since and is now comparable and in most cases better than trusts in the South West.

Number of deep tissue pressure ulcers acquired as in-patient
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. Factors have been, lack of repeat assessment of risk and length of stay. There is an increase of prevalence of pressure ulcers on ward that have more HCAs than registered nurses on duty.

% of adult inpatients who have received a VTE risk assessment – need info from Andrew
The VTE committee met for the first time and discussed the data available and two investigation reports. As previously reported the plan to increase percentage of risk assessments for VTE sits with the development of the EPR. The committee did review the serious incidents and have identified areas for improvement with missed drugs administration and recording of mechanical prophylaxis.

% breastfeeding (initiation)
The service use BFI Standards across maternity and neonatal services with an aim to ensure sustained improvement. Progress is monitored through Maternity Delivery Group.

% Massive PPH > 1.5 litres
Specialty Director is liaising with Southmead about their QI projects which reduced their PPH rates, to inform QI projects within our services.

ED and Maternity Services are both developing patient experience improvement plans, which incorporate FFT data alongside complaints, concerns, national surveys and engagement with service users to identify priority areas for improvement. These are monitored within division, including through the ED patient experience group, with oversight and assurance to Quality Delivery Group and Maternity Delivery Group.

Performance

There remains significant focus and effort from operational teams to support performance recovery and restoration and to maximise activity within existing resources.
In June 2021, the trust performance against the 4hr A&E standard was 69.55%, system wide 78.36%.

In respect of RTT, we are reporting 74.45% for June 2021 un-validated, whilst this is below the national standard; this is within the context of the Covid-19 recovery 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 for the 2 week standard at 92.7% (un-validated) for June. Cancer 62 day Referral to Treatment (GP referral) performance was not met for June was 78.4% un-validated.

Key issues to note

The key areas of focus remain the assurance of patient care and safety during this time. Teams across the hospital continue to support each other to offer the best care for all our patients. Further details are provided within the exception reports.
Quality delivery (with the exception of those areas discussed) remains stable, with exception reporting from divisions through QDG for monitoring and assurance.

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

Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.

Impact Upon Corporate Risks
Continued poor performance in delivery of the two national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators.

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

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period June 2021

Presented at July 2021 Q&P and August 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 continue 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 continues into May and June and currently meets the gateway targets for elective activity.

During June, 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 June was 69.55%. The system did not meet the delivery of 90% for the system in June, at 78.36%.

The Trust did not meet the diagnostics standard for June at 11.39% but this was an improving position. 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 not meet the standard for 2 week wait cancer at 92.7% or for the 62 day cancer waits standard at 78.6% in June, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 74.65% (un-validated) in June, work continues to ensure that the performance is stabilised & patients are treated in clinical order. 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 2,047 in June. 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		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	88	78	166	140	152	166	333	286	262	362	316	262	253
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	5	1	36	21	42	95	440	336	219	382	237	85	117
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	89.94%	90.05%	83.26%	82.34%	80.20%	79.66%	77.04%	77.82%	78.62%	80.02%	78.28%	76.34%	78.36%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.17%	85.90%	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%	85.79%	85.79%	85.79%
	Actual	85.07%	84.46%	73.53%	71.74%	68.96%	69.41%	65.41%	68.81%	69.50%	69.77%	64.55%	61.53%	69.55%
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	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.35%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	694	1037	1233	1279	1285	1411	1599	2234	2640	3061	2657	2263	2047
% 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	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%
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	98.00%	96.50%	90.80%	95.20%	96.00%	91.80%	93.60%	90.20%	97.10%	97.00%	94.80%	95.30%	92.70%
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	95.70%	96.30%	95.90%	93.30%	97.10%	85.20%	91.80%	71.80%	98.00%	99.00%	93.60%	96.50%	90.60%
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	97.00%	98.10%	97.10%	97.90%	100.00%	98.30%	97.50%	97.00%	99.20%	99.00%	96.50%	98.30%	98.80%
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	98.90%	100.00%	100.00%	98.90%	100.00%	100.00%	99.30%	100.00%	99.40%	100.00%	100.00%	100.00%	99.10%
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	90.70%	96.70%	98.70%	99.00%	100.00%	97.50%	99.10%	100.00%	100.00%	98.50%	98.10%	97.70%	100.00%
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	91.30%	90.50%	86.00%	98.20%	100.00%	98.60%	100.00%	96.20%	97.20%	97.60%	90.00%	95.50%	95.50%
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	66.70%	66.70%	77.80%	100.00%	100.00%	96.90%	100.00%	93.10%	88.00%	89.70%	84.10%	90.60%	97.00%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	73.70%	92.30%	92.30%	92.00%	86.40%	65.40%	80.60%	78.40%	93.30%	76.70%	90.80%	65.40%	68.80%
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	80.60%	85.90%	88.60%	82.20%	86.00%	81.90%	87.10%	86.40%	82.20%	84.80%	82.50%	76.50%	78.60%

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	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	% change from previous year: Monthly (Jun)	% change from previous year: YTD
GP Referrals	6,582	8,411	7,348	8,798	9,155	7,940	7,199	6,861	7,157	8,945	8,503	8,385	8,797	33.7%	84.1%
OP Attendances	40,650	44,360	39,210	50,027	52,473	52,939	47,526	45,539	46,036	57,806	50,325	51,022	54,535	34.2%	60.5%
New OP Attendances	12,055	13,887	12,573	16,232	17,490	17,253	14,412	13,616	13,530	17,933	15,971	16,264	17,051	41.4%	76.8%
FUP OP Attendances	28,595	30,473	26,637	33,795	34,983	35,686	33,114	31,923	32,506	39,873	34,354	34,758	37,484	31.1%	54.0%
Day cases	2,758	3,487	3,145	4,421	4,593	4,449	4,003	3,288	3,173	4,383	4,195	4,552	4,747	72.1%	122.2%
All electives	3,289	4,260	3,999	5,378	5,651	5,344	4,652	3,630	3,608	4,989	5,045	5,421	5,698	73.2%	121.2%
ED Attendances	9,819	10,957	11,636	10,904	10,279	9,475	9,309	8,289	8,021	10,687	11,063	11,930	11,975	22.0%	36.6%
Non Electives	3,527	3,671	3,896	4,116	4,175	3,791	3,759	3,569	3,383	4,108	4,019	4,396	4,659	32.1%	40.8%

Trust Scorecard - Safe (1)

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

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission	1,395	9	5	4	18	48	224	193	444	112	29	3	6	15	24	24	No target	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	265	1	1	0	1	3	57	71	42	11	3	0	3	13	16	16	No target	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	192	2	1	0	0	0	55	48	41	5	1	0	0	2	2	2	No target	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	188	1	1	1	0	0	57	56	30	3	2	0	1	1	2	2	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days														3.9	1.4	1.4	Zero	
Number of trust apportioned Clostridium difficile cases per month	75	2	7	0	4	8	4	4	4	11	8	3	14	11	28	28	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	1	2	6	1	1	2	1	2	5	3	3	7	4	14	14	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	1	5	6	3	7	2	3	2	6	5	0	7	7	14	14	<=5	
Clostridium difficile – infection rate per 100,000 bed days	22.7	9.9	30.3		15.7	29.2	15.8	15.2	19.2	21.8	30.9	13.5	60.2	42.6	39.2	39.2	<30.2	
Number of MSSA bacteraemia cases	18	3	1	1	0	1	1	4	1	2	3	1	2	2	5	5	<=8	
MSSA – infection rate per 100,000 bed days	6.4	14.9	4.3	4		3.6	3.9	15.2	3.8	5.9	11.6	4.5	8.6	7.7	7	7	<=12.7	
Number of ecoli cases	30	2	4	3	0	6	3	1	2	3	2	4	5	3	12	12	No target	
Number of pseudomona cases	6	0	0	0	0	0	0	2	0	1	1	1	2	0	3	3	No target	
Number of klebsiella cases	12	0	1	1	1	0	1	0	3	0	2	2	1	3	6	6	No target	
Number of bed days lost due to infection control outbreaks	9	0	4	0	0	5					0	0	6	161	167	167	<10	>30

Trust Scorecard - Safe (2)

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	21/22	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1	Zero	
Number of falls per 1,000 bed days	7.4	7.2	7	7.3	7.5	6.9	7.7	8.5	8.6	7.5	6.6	6.1	6.2	6.2	6.2	6.2	<=6	
Number of falls resulting in harm (moderate/severe)	53	4	3	4	3	6	6	5	4	6	6	4	2	3	9	6	<=3	
Number of patient safety incidents – severe harm (major/death)	58	5	2	7	4	5	6	7	4	3	10	7	2	1	10	9	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	6	1	2	1	1	1	6	6	4	2	2	1	5	4	No target	
Medication error resulting in low harm	134	7	8	14	14	9	15	8	14	10	11	11	4	13	28	15	No target	
Number of category 2 pressure ulcers acquired as in-patient	246	16	9	24	13	23	28	30	27	19	29	16	22	17	55	38	<=30	
Number of category 3 pressure ulcers acquired as in-patient	20	0	1	3	4	5	3	1	0	1	1	1	0	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	7	4	5	9	7	6	4	2	3	1	4	3	4	11	7	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	64	1	2	6	4	12	5	11	6	3	4	1	4	8	13	13	<=5	
RIDDOR																		
Number of RIDDOR	55	5	3	0	2	1	3	3	3	2	4	4	1	3	10	10	SPC	
Safeguarding																		
Number of DoLs applied for		41	59	38				45	32	46	29	54	73	57	184	184	No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	50	6	5	7	3	9	6	7	0	3	4	3	8	2	13	13	No target	
Total attendances for infants aged < 6 months, other serious injury			30			3	1	0	0	0	1	1	0	0	1	1	No target	
Total admissions aged 0-18 with DSH	97	11	15	10	10	7	11	3	6	9	15	13	26	15	54	54	No target	
Total ED attendances aged 0-18 with DSH	559	42	56	50	43	67	65	47	46	55	88	62	99	81	242	242	No target	
Total number of maternity social concerns forms completed		48								50	62	68	58	77	203	203	No target	

Trust Scorecard - Safe (3)

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	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%					>=90%	<50%
Serious Incidents																		
Number of never events reported	8	2	0	0	1	0	3	0	0	2	0	0	2	0	2	2	Zero	
Number of serious incidents reported	31	2	2	5	4	3	4	2	2	5	4	4	3	2	9	7	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%	94.0%	93.8%	90.7%	87.0%	89.8%	94.6%	91.0%	90.4%	89.2%	92.2%	89.9%	89.8%	89.3%	89.7%	89.7%	>95%	

Trust Scorecard - Effective (1)

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	21/22	Standard	Threshold
Dementia Screening - CURRENTLY SUSPENDED UNTIL AUGUST 2021 DUE TO COVID-19																		
% of patients who have been screened for dementia (within 72 hours)	68.0%	68.0%	71.0%	71.0%	79.0%	64.0%	68.0%	68.0%	65.0%	69.0%	70.0%						>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway	0.60%	0.80%	0.00%	0.00%	0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		10.40%	9.70%	8.70%	8.70%	No target	
% C-section rate (planned and emergency)	29.44%	25.94%	26.51%	27.80%	31.13%	32.91%	28.09%	34.76%	28.12%	26.79%	31.67%	30.43%	28.73%	33.96%	31.08%	31.08%	<=27%	>=30%
% emergency C-section rate	15.56%	12.08%	12.73%	16.20%	15.14%	19.50%	15.73%	20.09%	15.65%	12.24%	17.71%	16.30%	17.76%	16.77%	16.94%	16.94%	No target	
% of women booked by 12 weeks gestation	92.8%	93.3%	93.0%	92.4%	95.0%	92.3%	95.4%	92.7%	94.2%	93.1%	93.6%	93.8%	93.2%	91.5%	92.9%	92.9%	>90%	
% of women that have an induced labour	31.42%	29.70%	35.49%	31.20%	32.41%	28.72%	32.58%	32.51%	33.91%	30.72%	30.63%	28.05%	27.92%	26.40%	27.45%	27.45%	<=30%	>33%
% stillbirths as percentage of all pregnancies > 24 weeks	0.39%	0.20%	0.42%	0.00%	0.21%	0.83%	0.68%	0.22%	0.25%	0.23%	0.62%	0.00%	0.64%	0.41%	0.21%	0.21%	<0.52%	
% of women smoking at delivery	10.90%	11.29%	9.39%	13.80%	11.30%	12.58%	11.24%	11.06%	8.80%	9.24%	10.21%	9.42%	8.23%	9.56%	9.08%	9.08%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	56.4%	57.8%	57.1%	57.8%	51.7%	59.4%	56.2%	58.5%	60.2%	56.7%	54.0%	48.7%	49.0%	50.7%	50.7%		
% breastfeeding (initiation)	79.9%	76.1%	80.5%	79.7%	77.5%	76.6%	80.8%	80.4%	81.1%	83.1%	82.4%	81.0%	75.9%	78.4%	78.5%	78.5%	>=81%	
% Massive PPH >1.5 litres	4.4%	5.9%	4.8%	3.7%	5.8%	3.8%	4.3%	4.5%	3.9%	2.5%	5.2%	5.9%	5.0%	4.2%	5.0%	5.4%	<=4%	
Number of births less than 27 weeks	19	2	0	0	2	1	3	2	2	1	3	2	0	2	4	4		
Number of births less than 34 weeks	104	5	6	10	9	8	8	16	6	7	10	7	15	13	34	34		
Number of births less than 37 weeks	379	33	30	43	29	38	21	34	23	27	29	28	44	34	105	105		
Number of maternal deaths	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0		
Total births	5,570	511	481	497	472	482	443	445	408	437	483	463	468	486	1,415	1,415		
Percentage of babies <3rd centile born > 37+6 weeks	1.7%									1.8%	1.0%	2.3%	1.5%	1.7%	1.2%	1.2%		

Trust Scorecard - Effective (2)

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	21/22	Standard	Threshold
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1	1.1	1.1	1.1	1.1	1.1	1	1	1	1							NHS Digital	
Hospital standardised mortality ratio (HSMR)	107.9	107.1	104.6	105.1	104.7	103.9	105.2	108.2	107.9	104.9							Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	111.7	114.4	110.8	108.8	107.4	105.5	108.9	109.8	111.7	111.9							Dr Foster	
Number of inpatient deaths	1,657	112	120	143	147	142	182	246	277	159	129	145	153	145	443	443	No target	
Number of deaths of patients with a learning disability	19	0	1	3	4	1	1	1	2	1	0	2	4	0	6	6	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.90%	7.18%	7.86%	8.49%	7.37%	7.78%	7.91%	7.65%	8.96%	8.13%	7.90%	7.97%	7.87%		7.92%	7.92%	<8.25%	>8.75%
Research																		
Research accruals	4,152	54	126	350	629	461	578	382	177	110	220	315	206	312	833	833	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	53.2%	45.0%	63.5%	60.9%	52.9%	46.6%	54.7%	51.7%	56.1%	62.5%	54.4%	53.5%	48.9%			51.2%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	83.5%	84.0%	95.1%	89.7%	96.9%	81.3%	87.5%	90.1%	84.6%	88.4%	90.2%	83.1%	89.3%			83.1%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	45.00%	65.00%	74.50%	50.70%	51.60%	34.50%	36.50%	16.10%	24.40%	38.80%	49.20%	37.00%	44.10%			40.60%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	68.00%	65.00%	78.60%	59.30%	62.70%	63.50%	64.70%	70.60%	71.80%	74.60%	60.70%	63.20%	67.90%			65.60%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	67.6%	72.7%	50.6%	71.9%	63.6%	66.1%	85.1%	74.6%	75.8%	61.5%	64.1%	84.4%	52.5%	66.3%	66.3%	66.3%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	66.61%	70.91%	49.41%	70.18%	62.12%	66.10%	82.98%	73.02%	75.76%	61.54%	64.06%	84.44%	52.54%	66.27%	66.31%	66.31%	>=65%	<55%

Trust Scorecard - Caring (1)

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	91.9%	87.0%	86.0%	88.7%	86.4%	85.7%	84.8%	89.7%	89.4%	89.6%	88.3%	90.2%	89.7%	89.4%	89.4%	>=90%	<86%
ED % positive	81.4%	86.8%	81.8%	77.2%	73.0%	75.4%	83.7%	77.6%	87.2%	83.9%	77.5%	76.3%	73.6%	74.8%	75.1%	75.1%	>=84%	<81%
Maternity % positive	92.9%	90.2%	100.0%	85.2%	93.9%	88.9%	88.4%	96.7%	98.6%	92.9%	92.6%	96.2%	93.0%	89.2%	92.5%	92.5%	>=97%	<94%
Outpatients % positive	94.0%	93.9%	93.7%	93.5%	92.8%	94.0%	94.1%	94.2%	94.7%	94.7%	94.5%	94.4%	93.6%	94.3%	94.1%	94.1%	>=94.5%	<93%
Total % positive	91.8%	92.4%	91.3%	90.0%	90.1%	91.7%	92.2%	91.9%	93.2%	92.9%	92.1%	91.5%	91.1%	91.2%	91.2%	91.2%	>=93%	<91%
Number of PALS concerns logged	2,394				273	312	227	163	137	204	262	256	275	191	722	722	No Target	
% of PALS concerns closed in 5 days	79%				73%	75%	81%	82%	86%	86%	83%	82%	85%	90%	85%	85%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	21	23	1	0	0	0	0	2	0	1	0	0	0	0	0	<=10	>=20

Trust Scorecard - Responsive (1)

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	21/22	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait	76.1%	75.1%	76.4%	78.0%	74.3%	74.3%	76.6%	78.4%	72.1%	76.6%	78.9%	79.5%	77.8%	76.6%	78.0%	78.0%	No target	
Cancer – 28 day FDS breast symptom two week wait	97.3%	98.6%	99.1%	98.0%	98.3%	97.0%	95.4%	93.8%	97.9%	96.8%	100.0%	98.6%	95.5%	96.0%	96.6%	96.6%	No target	
Cancer – 28 day FDS screening referral	72.4%	76.9%	92.3%	78.6%	66.7%	69.0%	62.9%	65.8%	52.6%	83.0%	86.5%	82.4%	85.7%	80.0%	82.4%	82.4%	No target	
Cancer – urgent referrals seen in under 2 weeks from GP	94.6%	98.0%	96.5%	90.8%	95.2%	96.0%	91.8%	93.6%	90.2%	97.1%	97.0%	94.8%	95.3%	92.7%	94.2%	94.2%	>=93%	<90%
2 week wait breast symptomatic referrals	92.4%	95.7%	96.3%	95.9%	93.3%	97.1%	85.2%	91.8%	71.8%	98.0%	99.0%	93.6%	96.5%	90.6%	93.3%	93.3%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	98.2%	97.0%	98.1%	97.1%	97.9%	100.0%	98.3%	97.5%	97.0%	99.2%	99.0%	96.5%	98.3%	98.8%	97.8%	97.8%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.7%	98.9%	100.0%	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%	99.4%	100.0%	100.0%	100.0%	99.1%	99.8%	99.8%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	95.8%	91.3%	90.5%	86.0%	98.2%	100.0%	98.6%	100.0%	96.2%	97.2%	97.6%	90.0%	95.5%	95.5%	93.3%	93.3%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	98.2%	90.7%	96.7%	98.7%	99.0%	100.0%	97.5%	99.1%	100.0%	100.0%	98.5%	98.1%	97.7%	100.0%	98.6%	98.6%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	84.7%	80.6%	85.9%	88.6%	82.2%	86.0%	81.9%	87.1%	86.4%	82.2%	84.8%	82.5%	76.5%	78.6%	79.3%	79.3%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	91.8%	66.7%	66.7%	77.8%	100.0%	100.0%	96.9%	100.0%	93.1%	88.0%	89.7%	84.1%	90.6%	97.0%	90.5%	90.5%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	83.0%	73.7%	92.3%	92.3%	92.0%	86.4%	65.4%	80.6%	78.4%	93.3%	76.7%	90.8%	65.4%	68.8%	79.7%	79.7%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	8	21	2	3	3	1	0	3	0	0	2	1	2	5	5	Zero	
Number of patients waiting over 104 days without a TCI date	269	66	38	15	8	8	9	13	14	14	12	14	10	11	35	35	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	29.54%	26.07%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	11.39%	11.39%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	1,969	1,367	1,465	1,569	1,648	1,665	1,772	1,949	1,969	1,946	1,919	1,773	1,680	1,527	1,527	1,527	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	58.3%	60.0%	60.0%	57.5%	61.2%	60.6%	58.3%	52.3%	53.4%	59.3%	58.8%	61.2%	61.4%		61.3%	61.3%	>=88%	<75%

Trust Scorecard - Responsive (2)

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	72.92%	85.07%	84.46%	73.53%	71.74%	68.96%	69.41%	65.41%	68.81%	69.50%	69.77%	64.55%	61.53%	69.55%	65.53%	65.53%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	82.19%	89.94%	90.05%	83.26%	82.34%	80.20%	79.66%	77.04%	77.82%	78.62%	80.02%	78.28%	76.34%	78.36%	77.65%	77.65%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	99.76%	98.93%	99.85%	99.91%	99.95%	99.84%	99.94%	99.88%	99.92%	100.00%	99.62%	99.73%	99.68%	94.72%	97.68%	97.68%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	72.72%	84.01%	84.46%	73.53%	71.74%	68.96%	69.41%	65.41%	68.81%	69.50%	69.77%	64.55%	61.53%	63.37%	63.10%	63.10%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	168	0	0	1	0	0	14	36	95	21	1	0	0	1	1	1	Zero	
ED: % of time to initial assessment – under 15 minutes	64.0%	72.7%	72.5%	63.7%	61.3%	66.9%	66.5%	61.3%	64.5%	62.4%	48.8%	54.6%	62.0%	55.6%	57.5%	57.5%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	39.5%	52.0%	44.5%	31.4%	30.9%	38.1%	41.8%	40.8%	48.9%	44.2%	27.8%	26.5%	23.8%	21.6%	23.9%	23.9%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	5.00%	2.57%	2.04%	4.17%	3.67%	3.95%	4.59%	8.70%	8.14%	8.06%	9.82%	8.61%	6.66%	6.73%	7.31%	7.31%	<=2.96%	
% of ambulance handovers that are over 60 minutes	3.67%	0.15%	0.03%	0.90%	0.55%	1.09%	2.63%	11.50%	9.57%	6.74%	10.36%	6.45%	2.16%	3.11%	3.86%	3.86%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	100.00%	94.00%	86.67%	94.74%	95.83%	90.50%	78.30%	14.30%	76.50%	92.30%	92.00%	87.80%	87.50%	89.30%	89.31%	>=95%	
Urgent cancelled operations	66	0	11	2	10	7	4	14	4	3	3	0	1	13	14	14	No target	
Number of patients stable for discharge	106	71	92	73	109	108	105	134	118	136	110	113	114	124	117	117	<=70	
Number of stranded patients with a length of stay of greater than 7 days	348	250	265	319	361	371	362	403	370	387	388	366	342	425	378	378	<=380	
Average length of stay (spell)	5.06	4.54	4.69	4.66	4.78	4.86	4.77	5.55	6.22	5.53	5.23	4.68	4.77	5.23	4.9	4.9	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.52	4.81	5.13	5.15	5.34	5.44	5.43	6.06	6.41	5.92	5.56	5.18	5.25	5.77	5.4	5.4	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.57	2.64	2.47	2.32	2.47	2.59	2.09	2.71	4.15	2.4	2.88	2.31	2.52	2.81	2.56	2.56	<=3.4	>4.5
% day cases of all electives	84.13%	83.82%	81.83%	78.62%	82.19%	81.26%	83.23%	86.03%	90.55%	87.92%	87.83%	83.13%	83.95%	83.29%	83.46%	83.46%	>80%	<70%
Intra-session theatre utilisation rate	83.80%	83.11%	83.42%	88.04%	86.39%	76.51%	88.04%	77.76%	79.28%	85.29%	88.31%	90.44%	90.19%	86.59%	88.96%	88.96%	>85%	<70%

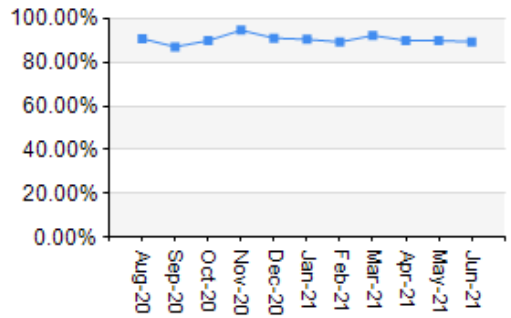
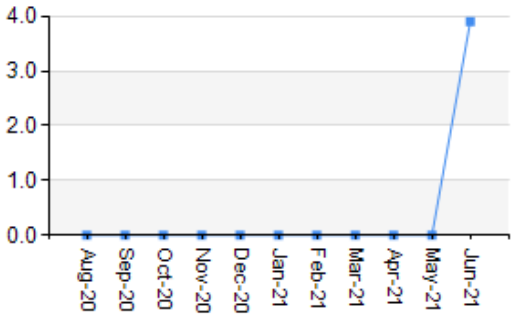
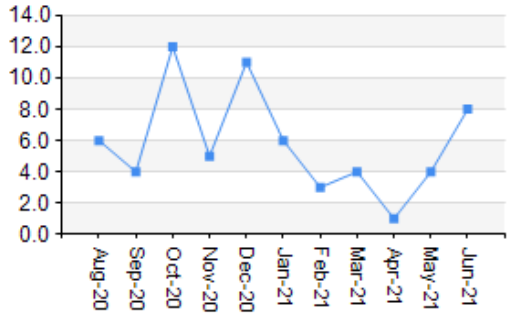
Trust Scorecard - Responsive (3)

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.05	2.28	2.03	1.99	1.94	1.88	1.95	2.14	2.13	2.23	2.09	2.05	2.01	2.04	2.03	2.03	<=1.9	
Did not attend (DNA) rates	6.00%	4.67%	5.47%	6.15%	6.48%	6.26%	6.24%	6.45%	6.47%	5.82%	5.70%	5.90%	6.01%	6.75%	6.24%	6.24%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.59%	59.06%	55.83%	60.07%	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.35%	72.34%	72.34%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,337	4,967	6,226	7,155	7,748	8,404	8,352	7,158	6,628	6,415	6,474	6,541	6,426	6,208	6,392	6,392	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,881	1,768	2,172	2,724	3,084	3,253	3,035	3,790	4,787	4,306	3,747	3,572	3,657	3,354	3,528	3,528	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,416	694	1,037	1,233	1,279	1,285	1,411	1,599	2,234	2,640	3,061	2,657	2,263	2,047	2,322	2,322	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)	127	5	17	57	77	85	111	158	243	304	459	608	667	757	677	677	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%						>=99%	
Percentage of records submitted nationally with valid NHS number	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%						>=99%	

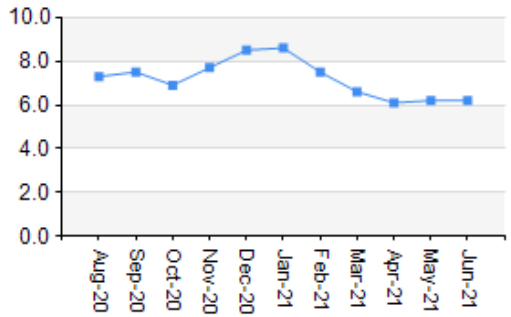
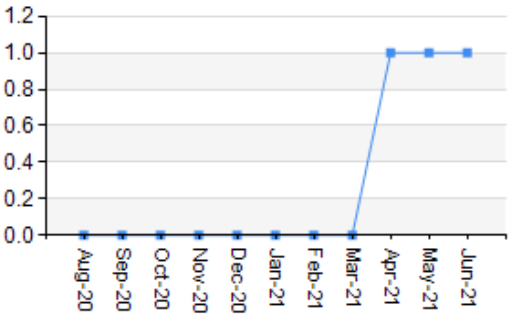
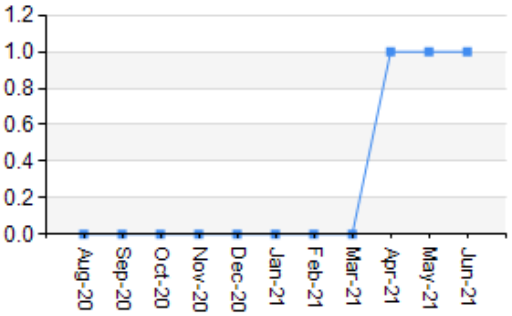
Trust Scorecard - Well Led (1)

	20/21	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	21/22 Q1	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	78.0%	80.0%	82.0%	84.0%	83.0%	83.0%	82.0%	80.0%	80.0%	83.0%	85.0%	85.0%	84.0%	84.0%		>=90%	<70%
Trust total % mandatory training compliance	90%	90%	91%	91%	94%	93%	93%	93%	93%	92%	90%	91%	90%	91%	91%		>=90%	<70%
Finance																		
Total PayBill Spend		34.3	33.2	33.9	34.7													
YTD Performance against Financial Recovery Plan		0	0	0	0													
Cost Improvement Year to Date Variance		0																
NHSI Financial Risk Rating		3																
Capital service		3																
Liquidity		4																
Agency – Performance Against NHSI Set Agency Ceiling		3																
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	94.82%	90.52%	100.77%	102.19%	93.82%	96.30%	94.93%	90.64%	90.88%	95.00%	93.10%	98.29%	96.75%		97.43%	97.43%	>=75%	<70%
% registered nurse day	93.97%	89.23%	100.82%	101.91%	93.04%	95.49%	94.37%	91.04%	89.81%	93.14%	90.71%	96.38%	96.05%		96.20%	96.20%	>=90%	<80%
% unregistered care staff day	104.90%	110.83%	122.96%	117.68%	106.50%	101.36%	102.93%	93.42%	94.97%	95.53%	101.28%	106.08%	104.33%		105.14%	105.14%	>=90%	<80%
% registered nurse night	96.36%	92.99%	100.69%	102.70%	95.27%	97.77%	95.92%	89.93%	92.76%	98.22%	97.31%	101.83%	97.99%		99.66%	99.66%	>=90%	<80%
% unregistered care staff night	113.19%	112.80%	130.21%	131.81%	114.61%	113.36%	112.05%	97.48%	99.23%	113.17%	108.91%	111.13%	113.00%		112.12%	112.12%	>=90%	<80%
Care hours per patient day RN	5.6	6.2	5.7	5.7	5.2	5.1	5.6	5.2	6.1	6.2	5.8	5.3	5.5		5.4	5.4	>=5	
Care hours per patient day HCA	3.7	4.5	4.1	4.2	3.5	3.3	3.6	3.4	3.6	3.9	3.7	3.8	3.6		3.7	3.7	>=3	
Care hours per patient day total	9.4	10.6	9.7	9.9	8.6	8.5	9.2	8.6	9.7	10.1	9.5	9.1	9.1		9.1	9.1	>=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%	7.12%				<=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%	4.15%				<=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%	6.60%				<=5%	>5.5%
Staff in post FTE		6573.86	6485.99	6463.25	6548.39	6557.43	6551.18	6546.28	6560.89	6666.58	6653.99	6678.31	6672.09	6649.85			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	510				No target	
Starters FTE		57.65	49.45	62.46	151.56	73.19	46.87	52.85	50.64	48.84	67.2	86.69	50.85	56.53			No target	
Leavers FTE		38.57	96.43	106.66	66.41	76.11	68.76	40.52	50.03	34.82	45.79	36	57.02	57.03			No target	
Workforce Expenditure and Efficiency																		
% turnover		10.4%	10.2%	10.3%	10.3%	9.6%	10.1%	9.5%	9.5%	9.5%	9.2%	9.2%	9.5%	9.9%			<=12.6%	>15%
% turnover rate for nursing		10.14%	9.98%	10.34%	10.10%	9.41%	10.23%	9.61%	9.83%	9.83%	9.86%	8.88%	8.96%	9.18%			<=12.6%	>15%
% sickness rate		3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.7%	3.7%	3.6%			<=4.05%	>4.5%

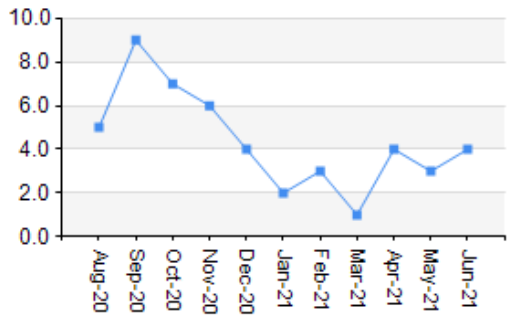
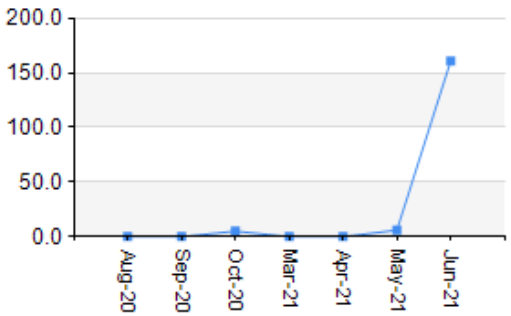
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		The VTE committee met for the first time and discussed the data available and two investigation reports. As previously reported the plan to increase percentage of risk assessments for VTE sits with the development of the EPR. The committee did review the serious incidents and have identified areas for improvement with missed drugs administration and recording of mechanical prophylaxis.	**Quality Improvement & Safety Director**
MRSA bacteraemia – infection rate per 100,000 bed days **Standard: Zero**		There has been one hospital onset health care associated MRSA bacteraemia within the renal speciality in June 2021. Initial findings suggest this is related to an invasive device specifically an peripheral venous cannula. Further investigation via the post infection review process is due to be completed. Furthermore, in line with the IPC annual strategy 2021-2022 a point prevalence audit will be performed across the trust of invasive devices to assess indication, care of the device and documentation. A report will be created and remedial actions identified and implemented to address issues that arise	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		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. Factors have been, lack of repeat assessment of risk and length of stay. There is an increase of prevalence of pressure ulcers on ward that have more HCAs than registered nurses on duty.	**Associate Chief Nurse, Director of Infection Prevention & Control**

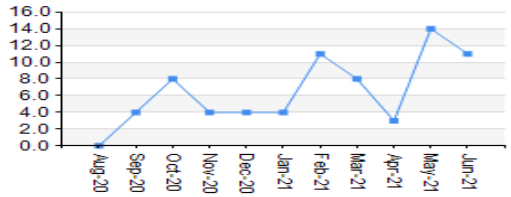
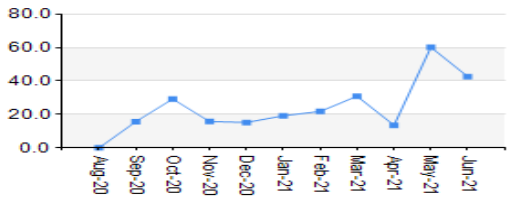
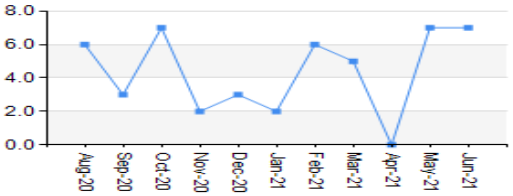
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls per 1,000 bed days **Standard: <=6**		We are recovering from a spike in the number of in-patient falls, reaching 8.6 per 1000 bed days in January 2021, performance has improved since and is now comparable and in most cases better than trusts in the South West. Wards with more falls are those with adverse nursing to healthcare assistant ratios, staffing reviews are currently underway to resolve this. Assessment of risk and implementation of falls prevention strategies using EPR has been demonstrated to reduce the risk of falling as is when the risk assessment is completed by an RN. These are areas of focus for divisions improvement programmes.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of patient safety alerts outstanding **Standard: Zero**		The alert that remains open involved the risk of having a reaction to the long term prescription of steroids. This alert will be closed in the coming month with an interim plan whilst we develop the e-prescribing module.	**Quality Improvement & Safety Director**
Number of trust apportioned MRSA bacteraemia **Standard: Zero**		There has been one hospital onset health care associated MRSA bacteraemia within the renal speciality in June 2021. Initial findings suggest this is related to an invasive device specifically an peripheral venous cannula. Further investigation via the post infection review process is due to be completed. Furthermore, in line with the IPC annual strategy 2021-2022 a point prevalence audit will be performed across the trust of invasive devices to assess indication, care of the device and documentation. A report will be created and remedial actions identified and implemented to address issues that arise	**Associate Chief Nurse, Director of Infection Prevention & Control**

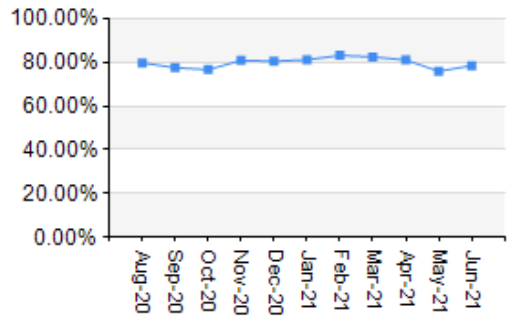
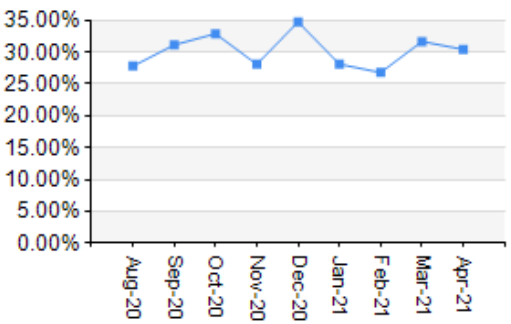
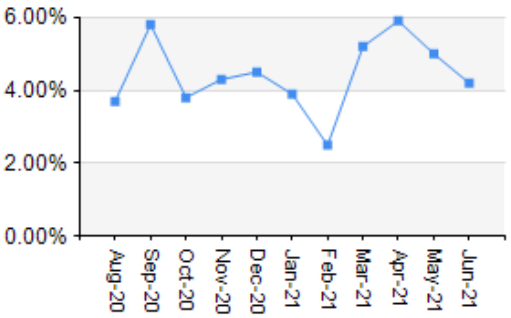
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
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. Factors have been, lack of repeat assessment of risk and length of stay. There is an increase of prevalence of pressure ulcers on ward that have more HCAs than registered nurses on duty.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of bed days lost due to infection control outbreaks **Standard: <10**		Since May 2021 there have been 6 hospital onset health care associated C.difficile cases associated with Prescott ward identified as part of C. difficile outbreak (ribotyping for 3 of the cases are the same which indicates likely patient to patient transmission). Three multidisciplinary outbreak meetings have been held and an action plan to address the suspected causes and any lapses in care has been implemented. Upon identification of the sixth positive patient the ward was completely closed to admissions and transfers on 22/6/2021; subsequently leading to closed empty beds on the ward. Before that bays had been sequentially emptied and closed to allow red cleaning (Fuse and HPV). The ward was re-opened on 29/6/2021 after all active CDI patients were moved off the ward prior to opening and completion of whole ward cleaning (which was reviewed by the IPCT prior to opening). A number of other wards have also had to have bays closed with empty beds on after identification of a COVID positive and subsequent patient exposures. Once 9A was opened for exposed/ medium risk patients bay closures had been prevented as patients could be transferred to their own single rooms on 9A. Also 9B was closed with empty beds due to an period of increased prevalence of both diarrhoea and vomiting. Whilst no causative organism was identified the ward was re-opened when affected patients were over 48 hours clear of symptoms	**Associate Chief Nurse, Director of Infection Prevention & Control**

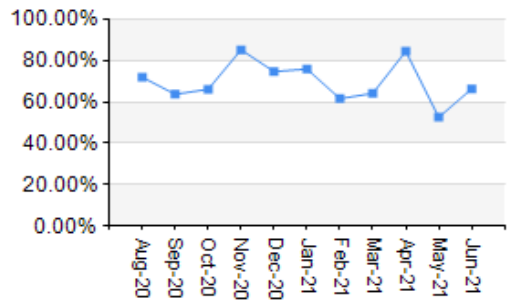
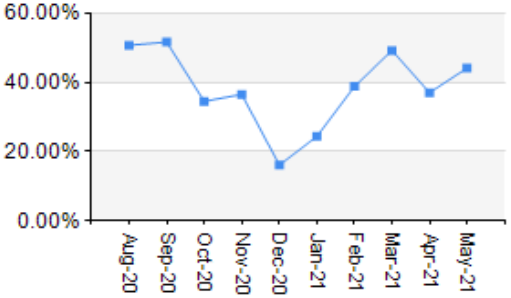
Exception Reports - Safe (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of trust apportioned Clostridium difficile cases per month **Standard: 2020/21: 75**		In June 2021 there were 7 community onset - health care associated (CO-HA) cases and 4 hospital onset - health care associated (HO-HA) cases. All HO-HA cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re-review. Three of the HO-HA cases are associated with Prescott ward and identified as part of an outbreak. Since May 2021 there have been 6 HO-HA cases associated with Prescott ward identified as part of C. difficile outbreak (ribotyping for 3 of the cases are the same which indicates likely patient to patient transmission). Three multidisciplinary outbreak meetings have been held and an action plan to address the suspected causes and any lapses in care has been implemented. Upon identification of the sixth positive patient the ward was completely closed to admissions and transfers on 22/6/2021. Before that bays had been sequentially emptied and closed to allow red cleaning (Fuse and HPV). The ward was re-opened on 29/6/2021 after all active CDI patients were moved off the ward prior to opening and completion of whole ward cleaning (which was reviewed by the IPCT prior to opening). In light of the increased number of period of increased incidences and an outbreak of C. difficile across the trust a new trust wide C. difficile reduction plan will be created to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan will therefore address cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with C. difficile infection (CDI). A meeting will be held to engage essential stakeholder in the creation of the reduction plan and assurance of action completion will be monitored through the Infection Control Committee. The ICS also met with NHSE/I on their region wide CDI improvement collaborative to agree upon 3 key improvement areas which includes antimicrobial stewardship, optimisation of CDI treatment and management and environmental cleaning/ CDI IPC bundle; this work will be progressed through the collaborative.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Clostridium difficile – infection rate per 100,000 bed days **Standard: <30.2**		As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominately identified lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Joint cleaning standard audits undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning will continue which more frequency, with any issues being addressed the point of review. The Antimicrobial Pharmacists also have undertaken a review of prescribing across Prescott. Prescott's ward pharmacists have undertaken daily review of all patients on antibiotics and escalated any issues to the Antimicrobial Pharmacists. MDT AMS ward rounds across the trust are ongoing; these are ward based round and undertaken by the Lead Nurse for AMS, Antimicrobial Pharmacists and Consultant Microbiologist. The team make remedial interventions at the time of the round, providing feedback and education to ward teams and collect data on the types of interventions being completed during the round for impact review. MDT AMS ward rounds have been focused on Prescott ward and feedback provided to the outbreak management group. A task and finish group has also been established with ICS stakeholders and the first meeting was held in May to review the post infection review process for C. difficile cases. The process will support an integrated care system approach to the review of CDI cases with a more robust process for shared learning and trend data analysis which will influence a wider ICS strategy to reduce and prevent C. difficile across the county. Furthermore, Nurse-led C. difficile ward rounds continue thrice weekly to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients.	
Number of community-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**			

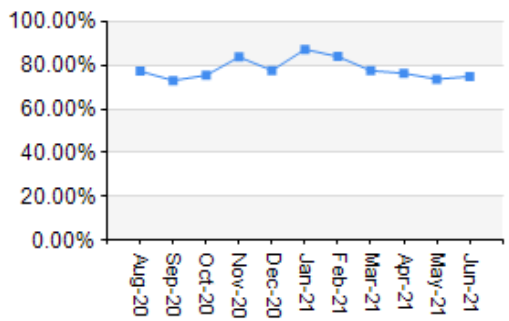
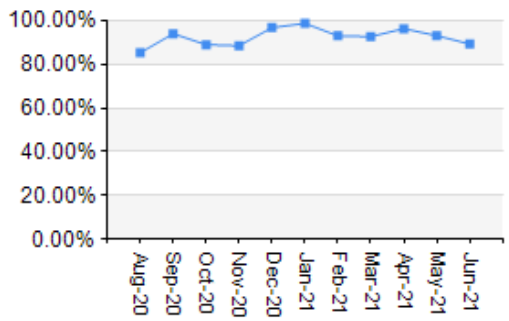
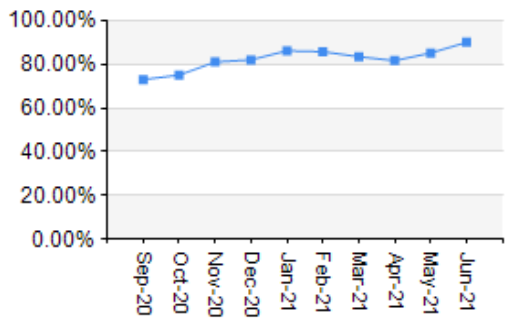
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		The service continue to use BFI standards across maternity and neonatal service with an aim to ensure sustained improvement.	**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 assess the parameters against which we report to ensure we are inline with National metrics. The BI Team have reviewed the National Maternity Dashboard and have identified several issues with the way the data is being submitted. This has been raised with NHSI who are investigating the issues identified. Once these have been addressed, we should have the opportunity to begin benchmarking against other Trusts.	**Divisional Director of Quality and Nursing and Chief Midwife**
% Massive PPH >1.5 litres **Standard: <=4%**		Christine Edwards (Specialty Director) has been liaising with a Consultant from Southmead about their QI project which reduced their PPH rates. This has given her some ideas which she will be taking forward.	**Divisional Director of Quality and Nursing and Chief Midwife**

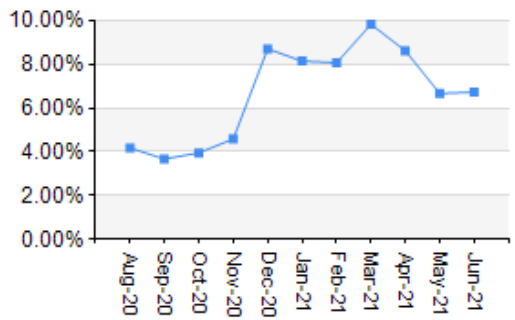
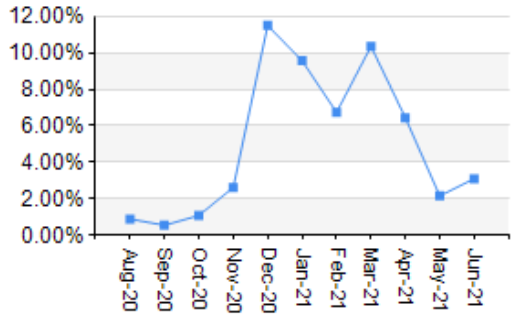
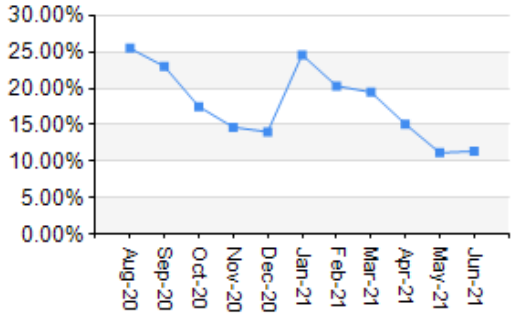
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		Although performance against this metric is below standard, it should be noted that only 85-90% of all #NOF patients are expected to be fit enough for surgery within 36 hours. The #NOF pathway works best when patients are cohorted on their 'home' ward of 3A. Overall as a specialty, we have had our Trauma bed-base reduced with the loss of 2A (21 beds) as part of the Emergency moves required for Covid. This means that there is additional demand placed on 3B for trauma beds and this has a knock-on effect for the availability of #NOF beds as we have to outlie patients. Delays to theatre have occurred when high numbers (more than 3-4) of #NOF patients are admitted within a 24-hour period. In June, there were 7 days where there were 3 admissions, 4 days with 4 admissions, 3 days with 5 admissions and 1 day with 6 admissions in a 24-hour period. This coincided with a general increase in trauma cases. The T&O pilot was discussed at the Trust's public board in February and 'Time to Theatre for Trauma' (not just #NOFs) was the only metric not achieved. The T&O Tri submitted a recovery plan to Divisional Tri in March, one key action on this plan included re-utilising sessions in Theatre 11 to create more trauma capacity; this was a big piece of work which involved job plan changes but the additional sessions 'went live' in May.	**Director of Operations - Surgery**
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=75%**		There is an increase in performance from April to May (as no June data). Improvement of 7.1% from 37% to 41.1%. Weekly clinical breach meetings now take place and are well embedded where every breach is discussed.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

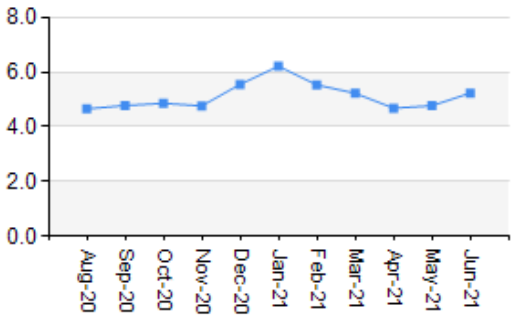
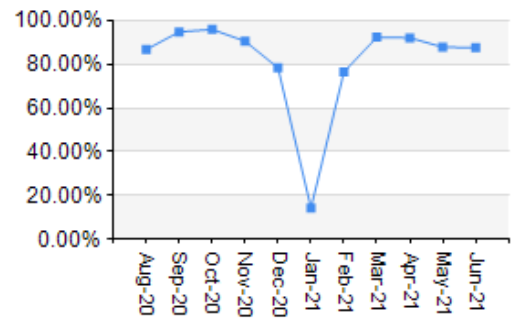
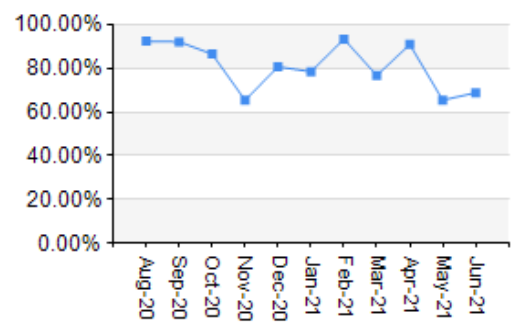
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED % positive **Standard: >=84%**		ED FFT is at 74.8% in June, and reflects some of the challenges the teams have been facing operationally. The feedback is incorporated into the patient experience improvement plan that the divisional review on a monthly basis, with updates being provided to QDG for assurance. This feedback is reviewed alongside PALS data, complaints, and also the national survey results.	**Head of Quality**
Maternity % positive **Standard: >=97%**		Maternity FFT is currently at 89.2%. The team are working on a patient experience improvement action plan, which will incorporate the FFT data alongside other experience insights, including feedback received through the maternity voices partnership. The team plan to host a workshops with staff and women in Gloucestershire to prioritise and co-design areas for improvement, which will be lead by the new Head of Midwifery.	**Head of Quality**
% of PALS concerns closed in 5 days **Standard: >=95%**		The team are at full capacity now, and new starters have embedded in the team which has enabled the team to close more cases in the target of 5 days. This month has shown a significant improvement to 90% of cases being closed in the target timeframe, but there is still further improvement needed to reach 95%. The team are delivering workshops to clinical teams across the organisation to improve understanding of PALS and wider experience data, to help support better relationships with experience and clinical teams which will support closing cases more quickly and effectively.	**Head of Quality**

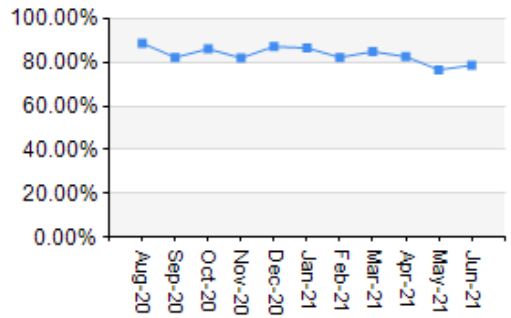
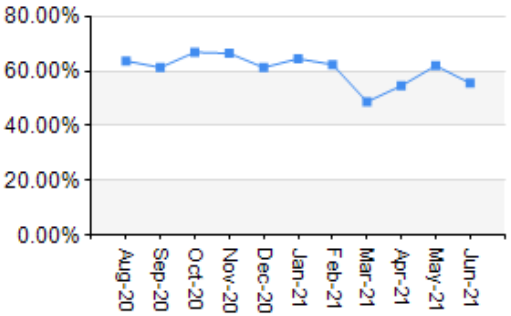
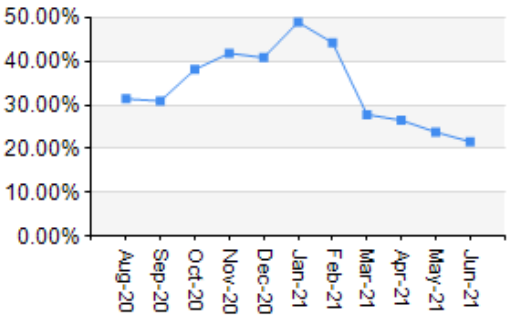
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		Increased number of patients and reduced flow has led to an increase in ambulance handover delays. Trust wide, although there has been a decrease, by 9, under 30 minutes breaches, June has seen an increase of 32 over 60 minute breaches. ACUC secured a ring fenced bed for direct admissions and a license has been applied for to accept direct referrals from the ambulance service using Mobimed.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		Increased number of patients and reduced flow has led to an increase in ambulance handover delays. Trust wide, although there has been a decrease, by 9, under 30 minutes breaches, June has seen an increase of 32 over 60 minute breaches. ACUC secured a ring fenced bed for direct admissions and a license has been applied for to accept direct referrals from the ambulance service using Mobimed.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		This has improved in line with expectations for recovery with the last two months stabilised around 11%. Cardiac continues to have the greatest proportion of breaches.	**Deputy Chief Operating Officer**

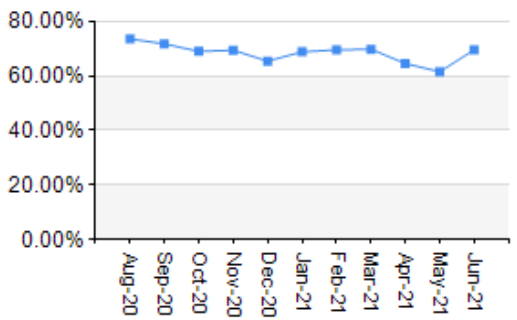
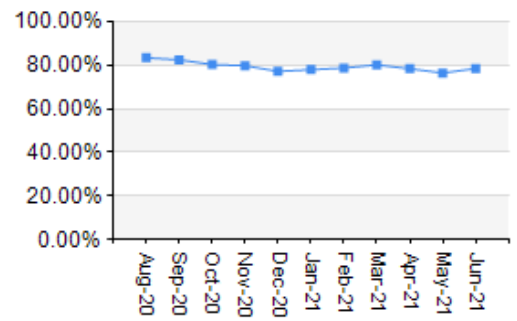
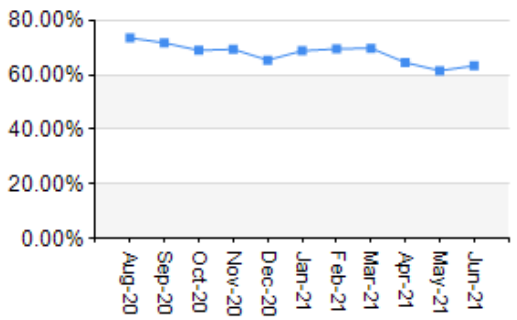
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Average length of stay (spell) **Standard: <=5.06**		- LOS under review through Divisions - HDS work transforming care through the provision of data – PSDA with clinical leads w/c 19 July	**Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In April 7 patients were cancelled on the day that could not be rescheduled within 28 days. This included 2 T&O; 2 Pain Management; Cardiology patients, 1 Ophthalmology; 1 Urology and 1 Vascular Surgery. The reasons varied from Graft material failing; unable to identify side room, or bed capacity.	**Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated)= 68.80% Target = n/a National performance = 83.6% 16 treatments & 5 breaches Lower GI 2 Lung 1.5 Urology 1 Testicular 0.5 3 tertiary related breaches (1 out to Bristol and 2 into Surgery and Oncology) 1 patient was a covid inpatient which impacted time to treat 1 complex patient requiring multiple investigations	**Director of Planned Care and Deputy Chief Operating Officer**

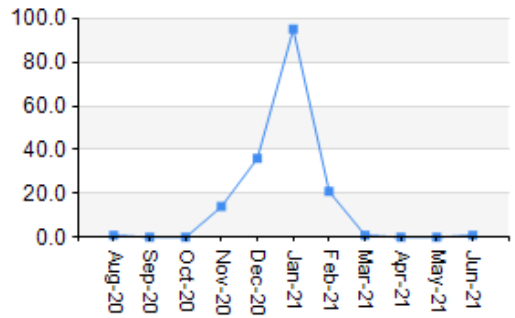
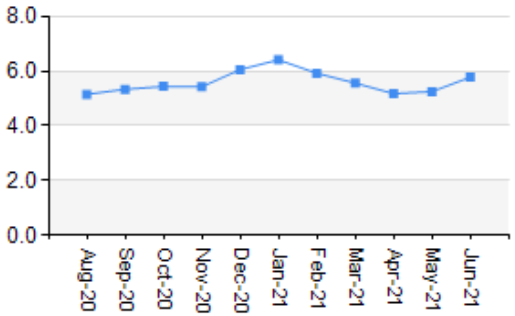
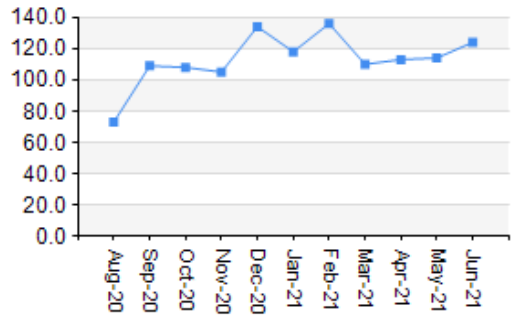
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) = 78.4% Target = 85% National performance = 73.0% 180.5 treatments & 38.5 breaches Gynae 7.5 LGI 6.5 Lung 5.5 Haem 4 Skin 4 Key actions: - Lower GI pathway review with implementation of RDS pathway Re-instigate gynae project meetings T&F Haem Cancer Improvement project Support pathology in embedding TCLE system Lung GIRFT actions around 62 day	**Director of Planned Care and Deputy Chief Operating Officer**
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Triage for ambulance patients remains within the 15 minute target (14.7 minutes) however walk in patients have an average triage time of 23.3 minutes. The new EPR system has impacted this due to the change in process at initial assessment.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		Ongoing medical staffing problems and an increase in patients coming through the door has led to a decrease in 60 minute to see a doctor performance. However there has been an improvement in overall time spent waiting to see a doctor.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

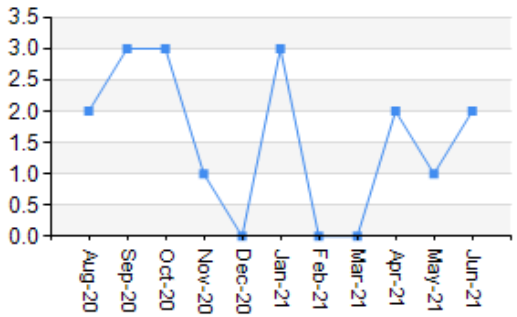
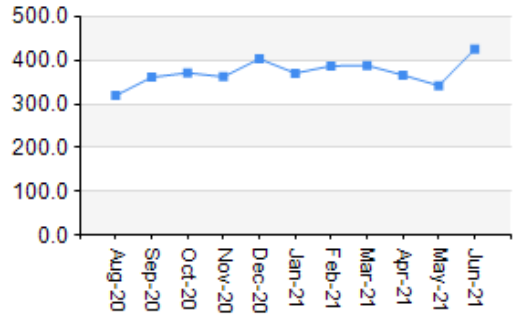
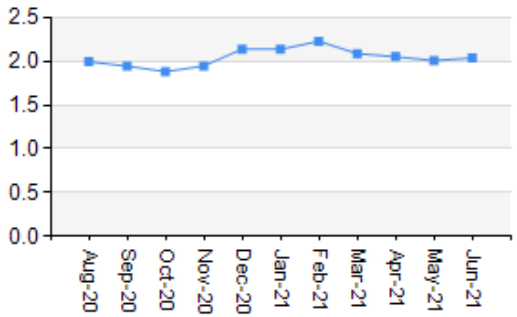
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		Since opening as an ED again CGH has seen an increase number of patients coming through the door, with similar staffing numbers, this is reflected in the 4 hour performance at CGH which has seen a decrease of 4.96%. However trust wide 4 hour performance has increased by 2.09%. Reduced discharges, reduced flow & reduced staffing numbers, combined with increased number of patients has ultimately lead to an increase in numbers of admitted patients breaching in ED. The average total time in department is up by on average 20 minutes, whilst the average time from DTA to admission has increased by over half an hour.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		Since opening as an ED again CGH has seen an increase number of patients coming through the door, with similar staffing numbers, this is reflected in the 4 hour performance at CGH which has seen a decrease of 4.96%. However system wide 4 hour performance has increased by 2.02%. Reduced discharges, reduced flow & reduced staffing numbers, combined with increased number of patients has ultimately lead to an increase in numbers of admitted patients breaching in ED. The average total time in department is up by on average 20 minutes, whilst the average time from DTA to admission has increased by over half an hour.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		Since opening as an ED again CGH has seen an increase number of patients coming through the door, with similar staffing numbers, this is reflected in the 4 hour performance at CGH which has seen a decrease of 4.96%. However trust wide 4 hour performance has increased by 2.09%. Reduced discharges, reduced flow & reduced staffing numbers, combined with increased number of patients has ultimately lead to an increase in numbers of admitted patients breaching in ED. The average total time in department is up by on average 20 minutes, whilst the average time from DTA to admission has increased by over half an hour.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

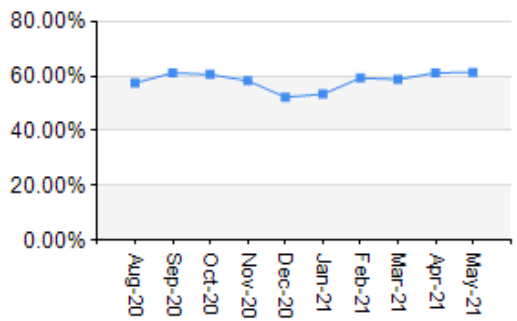
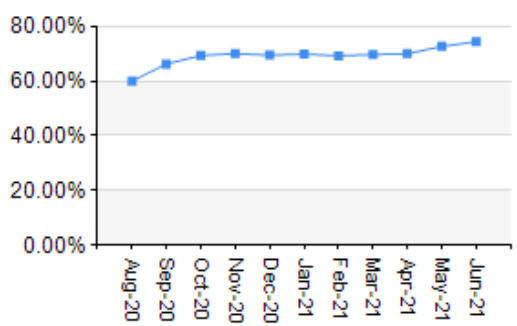
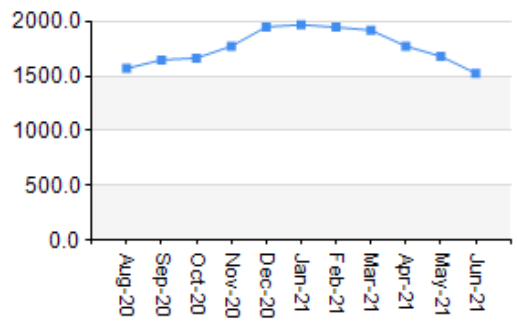
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		One 12 hour breach in June which was a clinical breach.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		- LOS under review through Divisions - HDS work transforming care through the provision of data – PSDA with clinical leads w/c 19 July	**Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		COVID impact on elderly patients in terms of isolation and clinical decline leading significant increase in the amount of referrals into onward care pathways. This in turn is leading to significant delays in discharge, with the MOFD list growing rather than reaching the desired target of <70. Ongoing internal and system work focusing on this patient cohort.	**Head of Therapy & OCT**

Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Lower GI 1 Gynaecological 2 Grand Total 3 >104 day numbers holding consistently at 11-13 currently. High numbers of tertiary related patients still impacting position.	**Director of Planned Care and Deputy Chief Operating Officer**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		- LOS under review through Divisions - HDS work transforming care through the provision of data – PSDA with clinical leads w/c 19 July - The DCOO will lead a twice weekly call with system partners to support criteria led discharge commissioned by the COO.	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		These remain relatively consistent around 2.04, and just over the target of <=1.9.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

Exception Reports - Responsive (7)

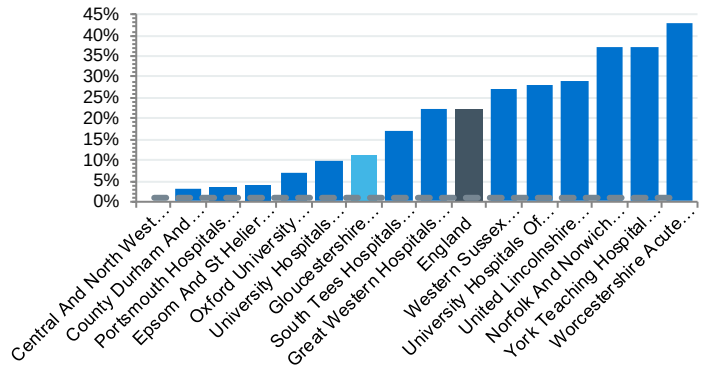
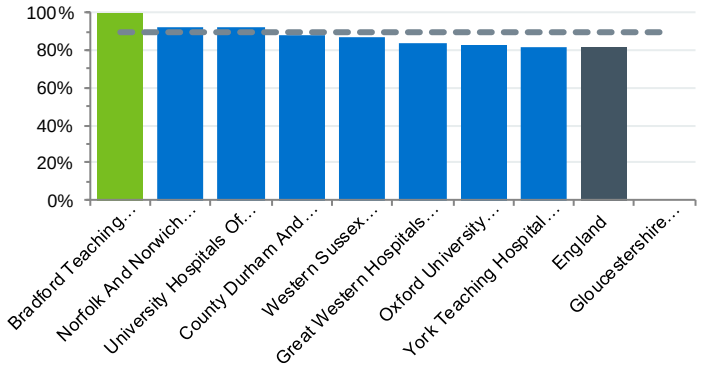
Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		There has been a slight improvement in this over the last three months but overall performance remains poor. Improvements should be seen when the discharge summaries are generated on Sunrrise but the timeframe for this remains uncertain.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. Restoration and recovery has resumed following the second wave. Outpatient clinic activity has increased together with theatre availability. Performance has seen a further stepped increase in month of around +2% . The QPR has an unvalidated position of 74.35% but this is not anticipated to change for the June month end 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. The position has improved by 153 patients from 1680 to 1527 total.	**Medical Director**

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

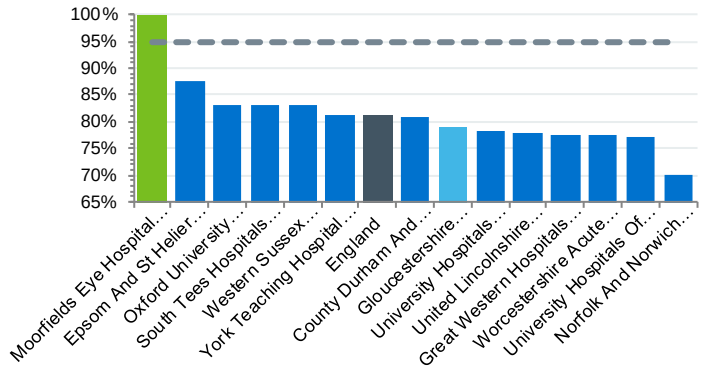
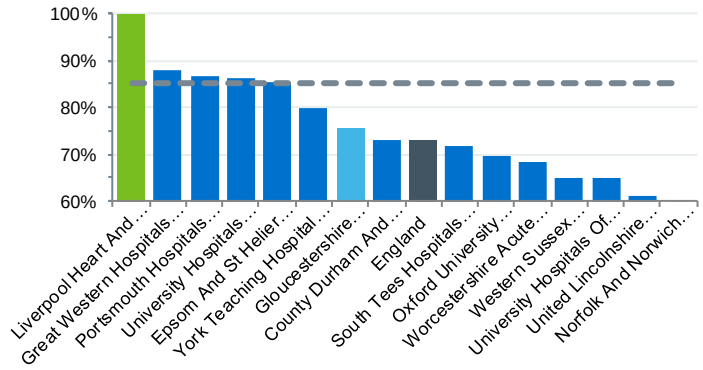
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	May-21		65 / 158	2nd
Dementia	February-20		82 / 82	4th

Benchmarking (2)

Gloucestershire Hospitals NHS Foundation Trust

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

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

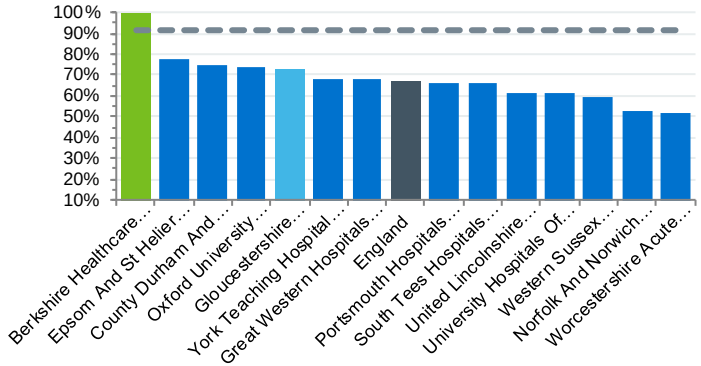
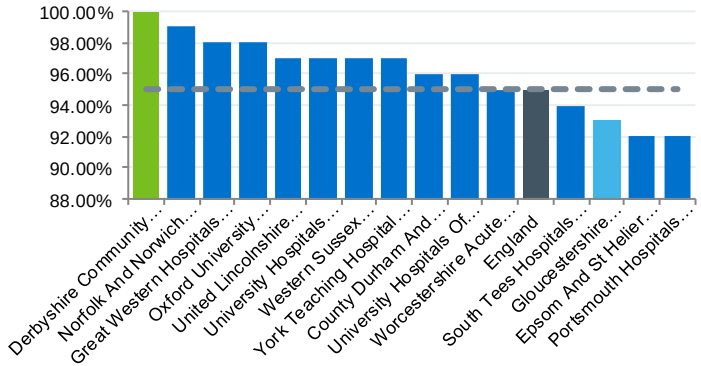
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	June-21		71 / 113	3rd
Cancer 62 Days GP Referrals	May-21		61 / 133	2nd

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

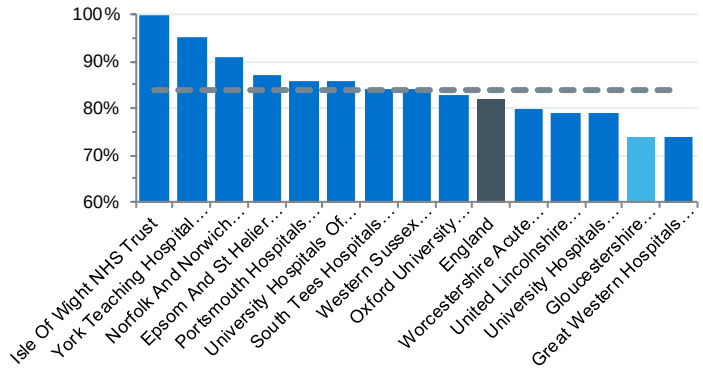
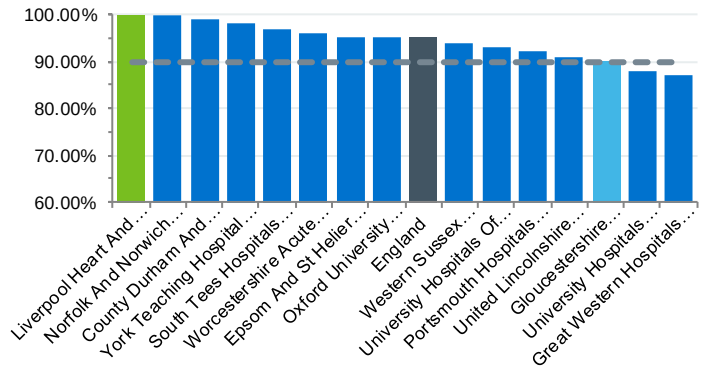
Metric	Period	Peer Group	Rank	Quartile
RTT	May-21		71 / 154	2nd
VTE (published quarterly)	December-19		116 / 149	4th

Benchmarking (4)

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

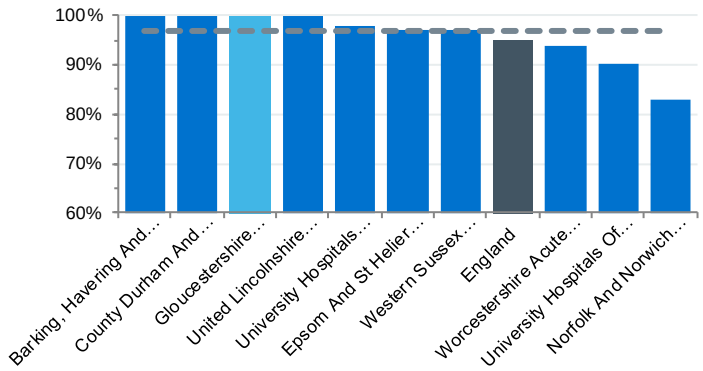
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	May-21		103 / 115	4th
FFT - Inpatient	May-21		116 / 132	4th

Benchmarking (5)

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
FFT - Maternity	May-21		8 / 96	1st

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period June 2021

Presented at July 2021 Q&P and August 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 continue 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 continues into May and June and currently meets the gateway targets for elective activity.

During June, 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 June was 69.55%. The system did not meet the delivery of 90% for the system in June, at 78.36%.

The Trust did not meet the diagnostics standard for June at 11.39% but this was an improving position. 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 not meet the standard for 2 week wait cancer at 92.7% or for the 62 day cancer waits standard at 78.6% in June, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 74.65% (un-validated) in June, work continues to ensure that the performance is stabilised & patients are treated in clinical order. 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 2,047 in June. 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	Jun-21	76.6%	
Cancer	Cancer – 28 day FDS breast symptom two week wait	No target	Jun-21	96.0%	
Cancer	Cancer – 28 day FDS screening referral	No target	Jun-21	80.0%	
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Jun-21	92.7%	
Cancer	2 week wait breast symptomatic referrals	>=93%	Jun-21	90.6%	
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Jun-21	98.8%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Jun-21	99.1%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Jun-21	95.5%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Jun-21	100.0%	
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Jun-21	78.6%	
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Jun-21	97.0%	
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Jun-21	68.8%	
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Jun-21	2	
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Jun-21	11	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Jun-21	11.39%	
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Jun-21	1,527	
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	May-21	61.40%	
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Jun-21	69.55%	
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Jun-21	78.36%	
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Jun-21	94.72%	
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Jun-21	63.37%	

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	Jun-21	1	
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Jun-21	55.6%	
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Jun-21	21.6%	
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Jun-21	6.73%	
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Jun-21	3.11%	
Maternity	% of women booked by 12 weeks gestation	>90%	Jun-21	91.5%	
Operational Efficiency	Number of patients stable for discharge	<=70	Jun-21	124	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Jun-21	425	
Operational Efficiency	Average length of stay (spell)	<=5.06	Jun-21	5.23	
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Jun-21	5.7744	
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Jun-21	2.8	
Operational Efficiency	% day cases of all electives	>80%	Jun-21	83.3%	
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Jun-21	86.6%	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Jun-21	87.5%	
Operational Efficiency	Urgent cancelled operations	No target	Jun-21	13	
Outpatient	Outpatient new to follow up ratio's	<=1.9	Jun-21	2.0367	
Outpatient	Did not attend (DNA) rates	<=7.6%	Jun-21	6.8%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	May-21	7.9%	
Research	Research accruals	No target	Jun-21	312	

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.

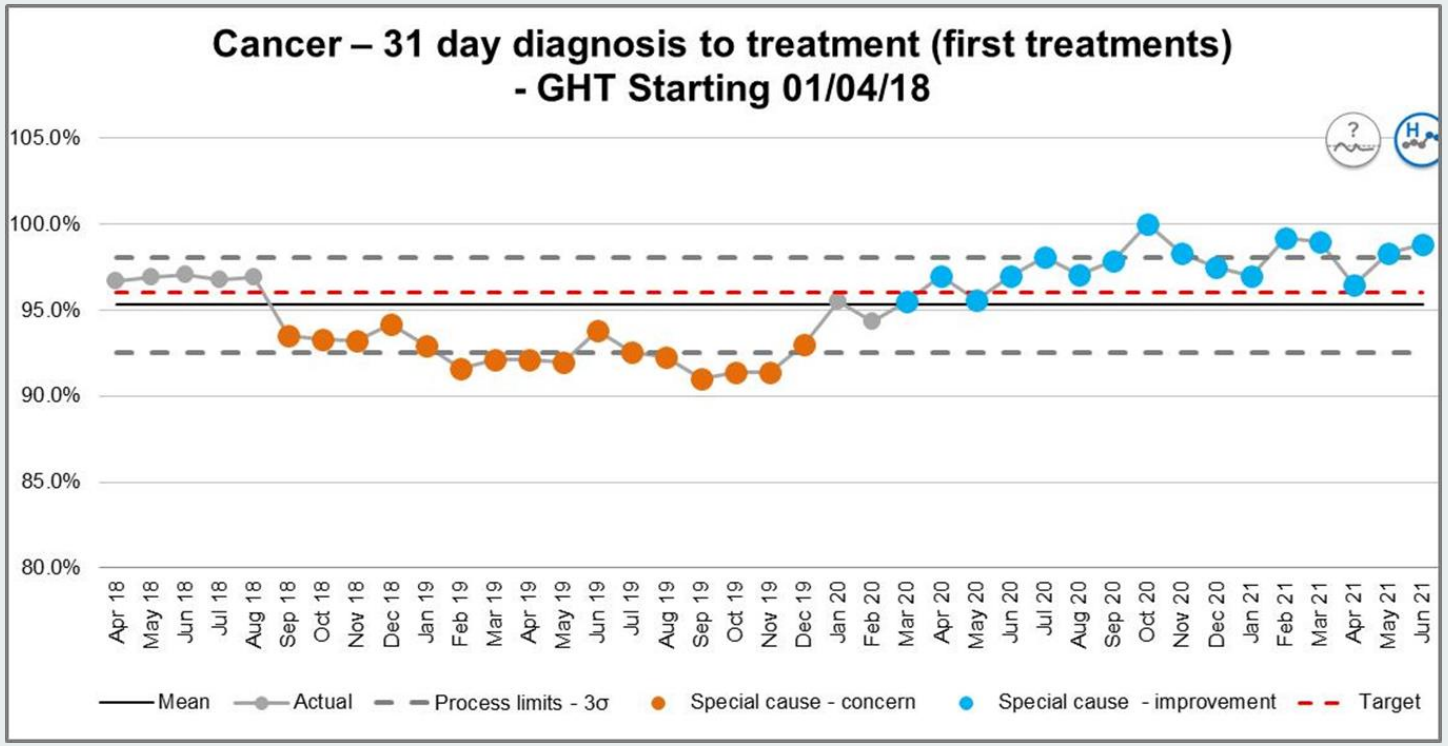
Key

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Jun-21	74.35%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Jun-21	6,208	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Jun-21	3,354	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Jun-21	2,047	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Jun-21	757	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		May-21	48.9%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		May-21	89.3%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		May-21	44.1%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		May-21	67.9%	
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%		Jun-21	66.30%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Jun-21	66.3%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day new performance (unvalidated) = 98.8%
Target = 96%
National performance = 95.1%

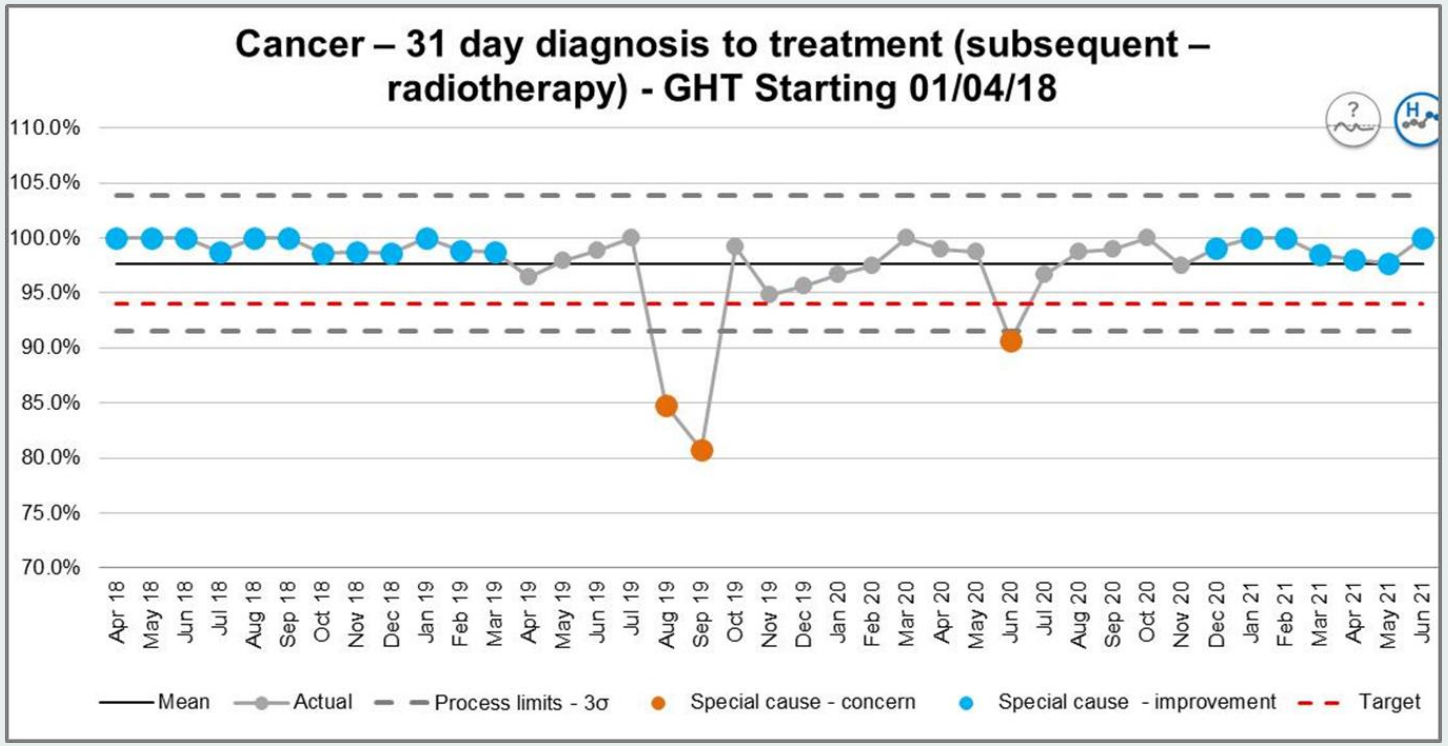
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day subs radiotherapy performance (unvalidated) = 100.0%
Target = 94%
National performance = 97.1%

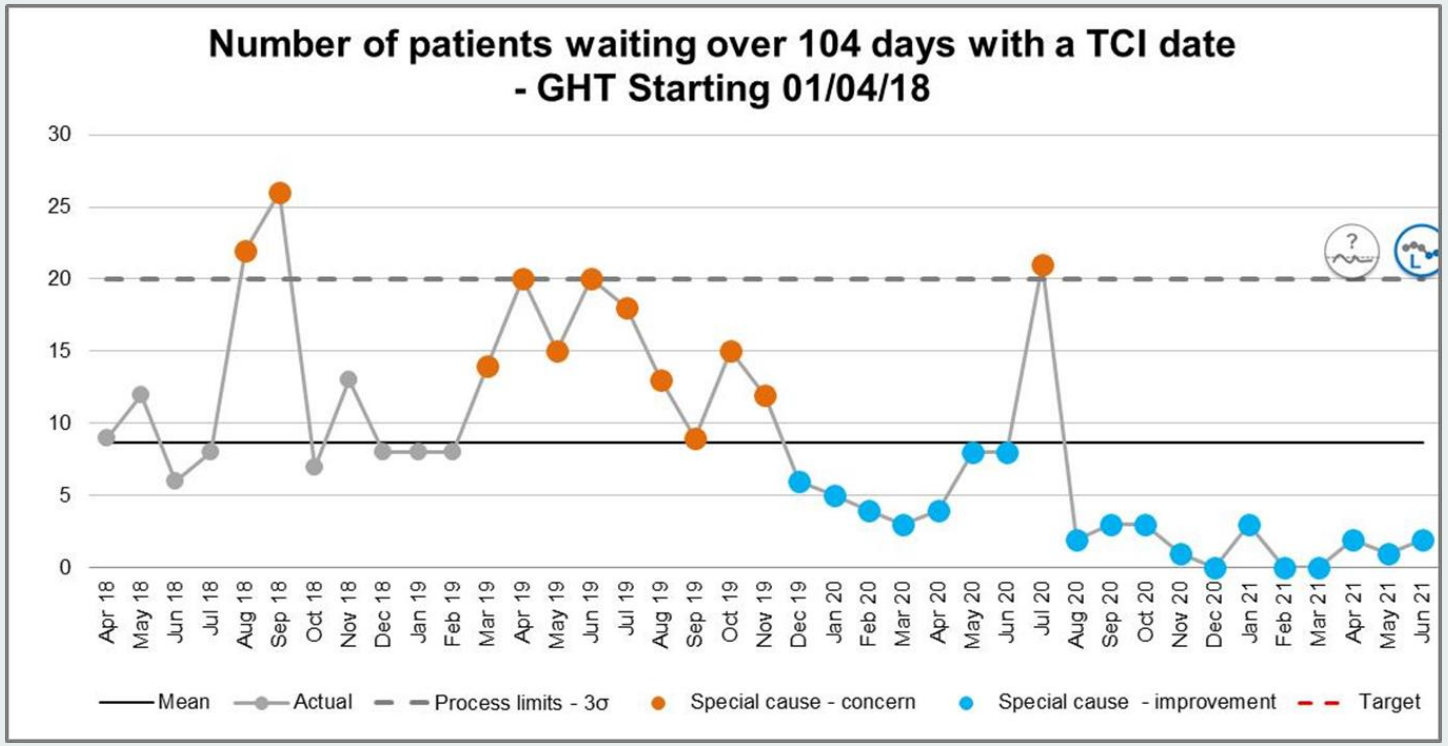
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Lower GI 1
Gynaecological 2
Grand Total 3

>104 day numbers holding consistently at 11-13 currently. High numbers of tertiary related patients still impacting position.

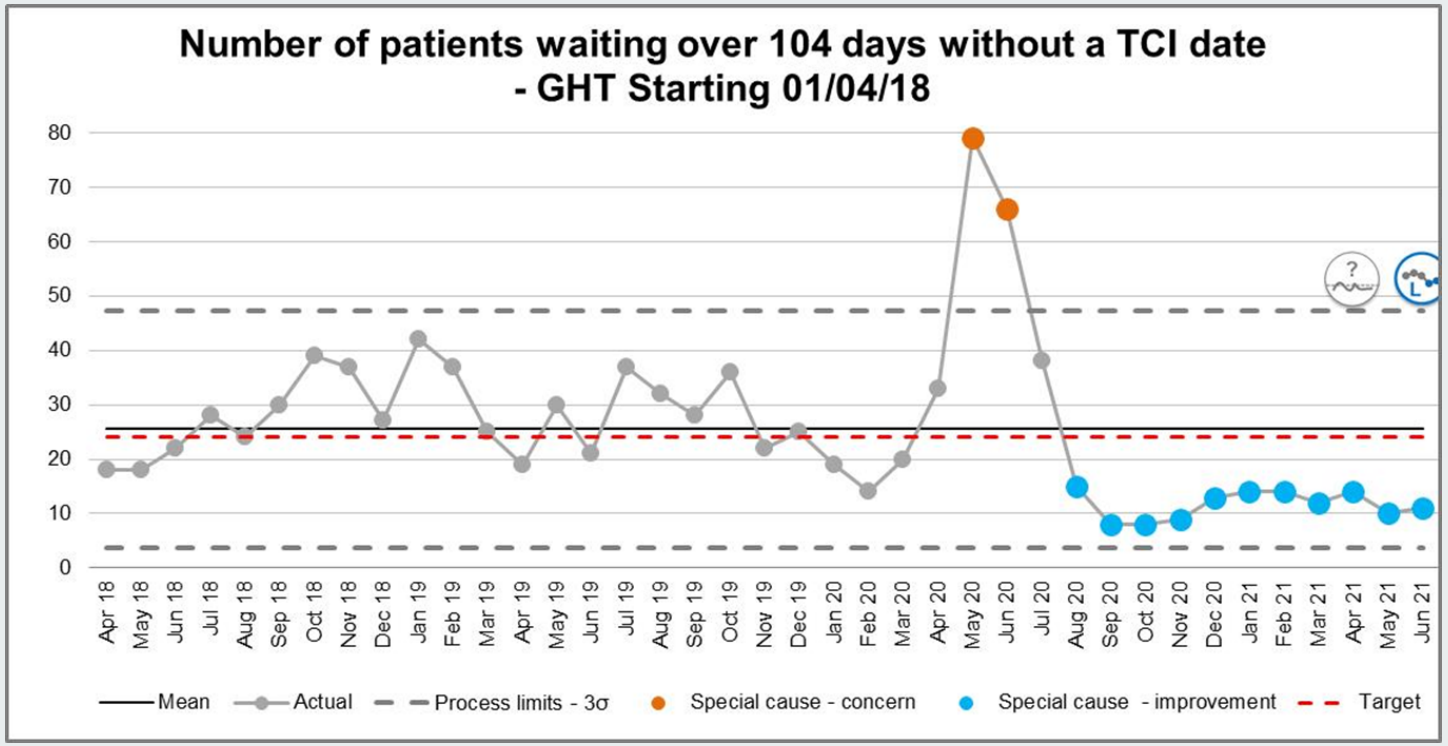
- Director of Planned Care and Deputy Chief Operating Officer

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Urological 1
Head & neck 1
Grand Total 9

Lower GI 3
Gynaecological 1

Haematological 2
Other 1

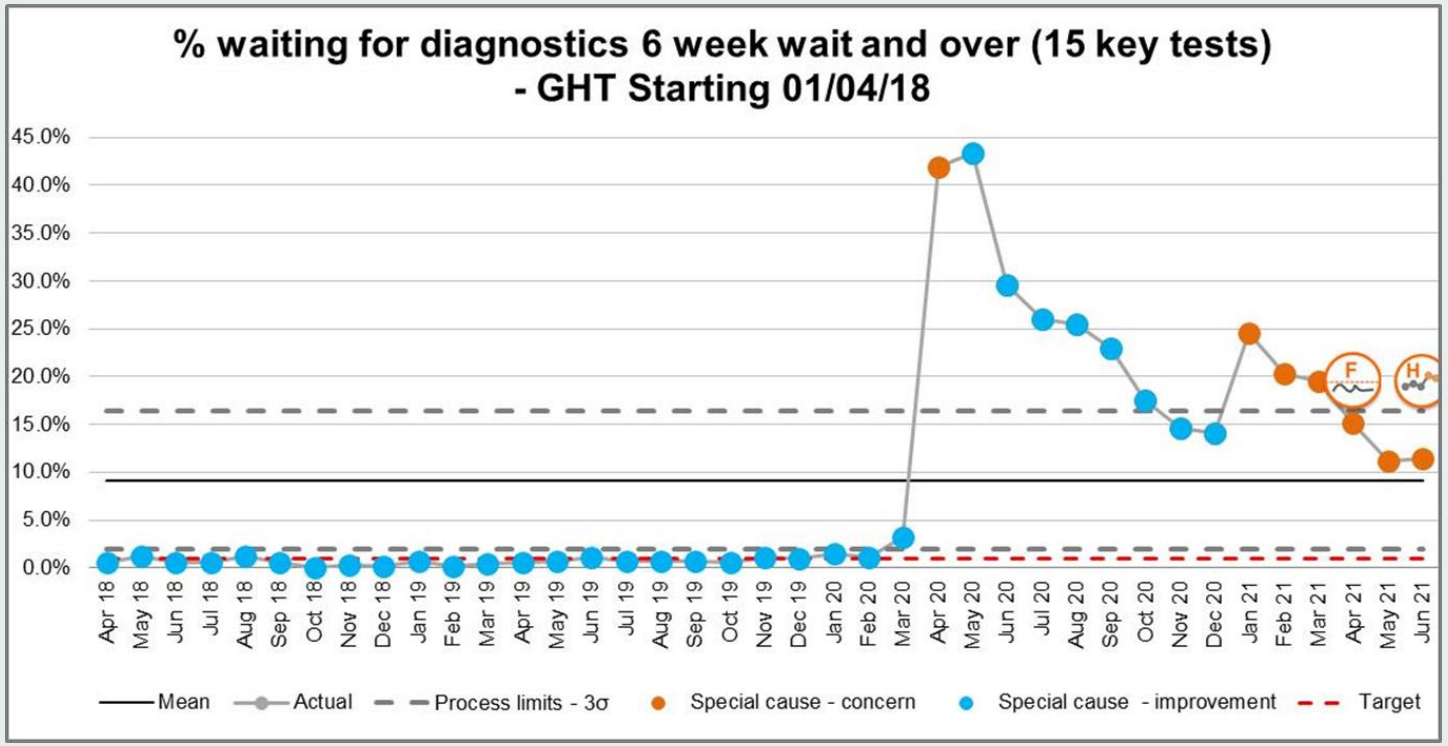
- Director of Planned Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

This has improved in line with expectations for recovery with the last two months stabilised around 11%. Cardiac continues to have the greatest proportion of breaches.

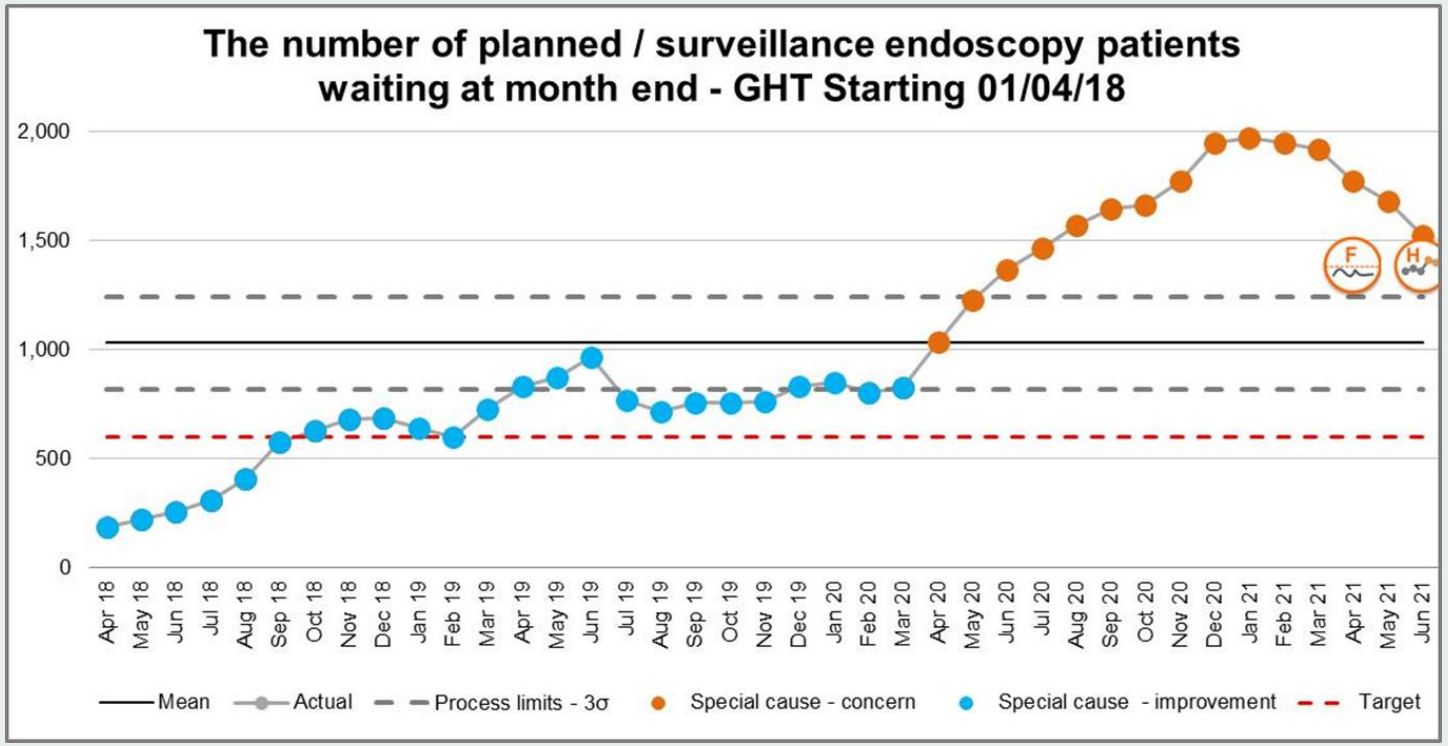
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 10 data points which are above the line. There are 23 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

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. The position has improved by 153 patients from 1680 to 1527 total.

- 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 13 data points which are above the line. There are 18 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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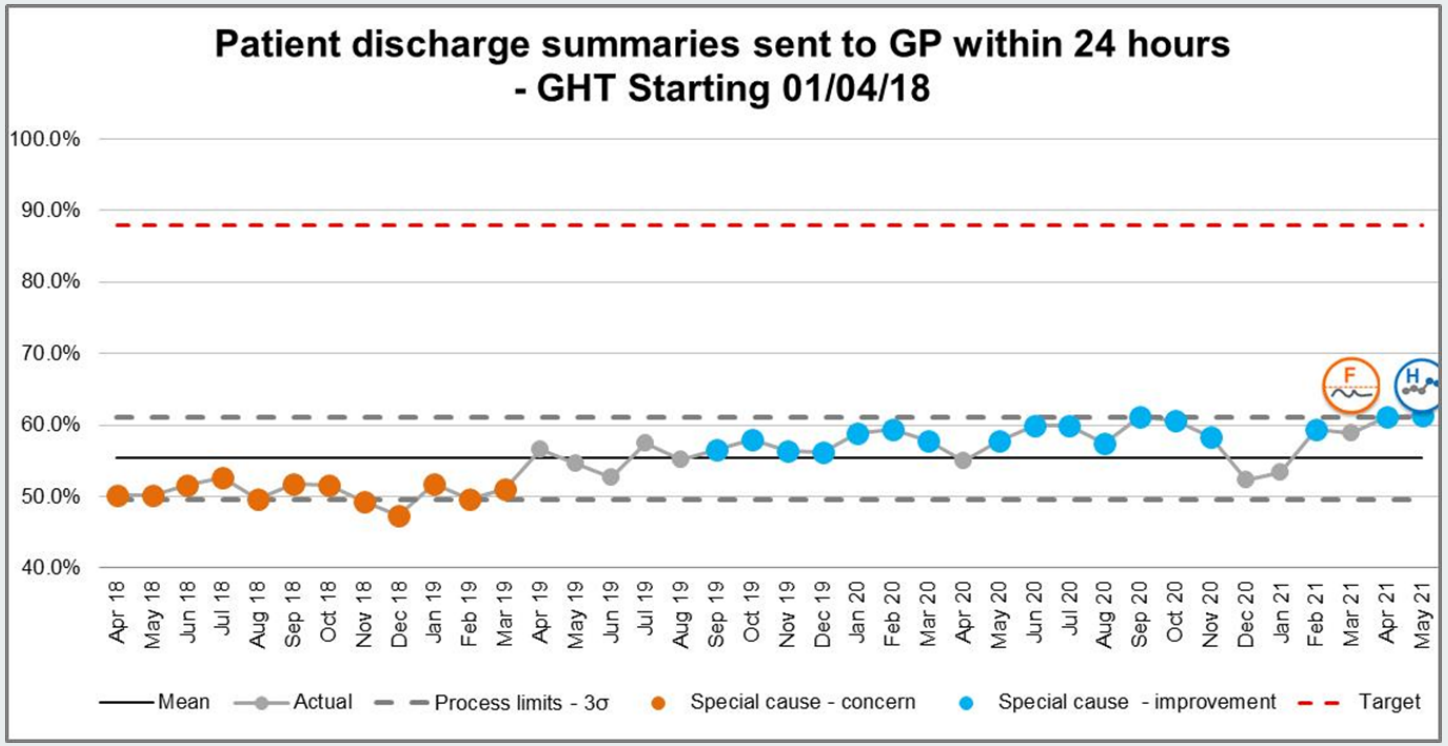
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There has been a slight improvement in this over the last three months but overall performance remains poor. Improvements should be seen when the discharge summaries are generated on Sunrrise but the timeframe for this remains uncertain.

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

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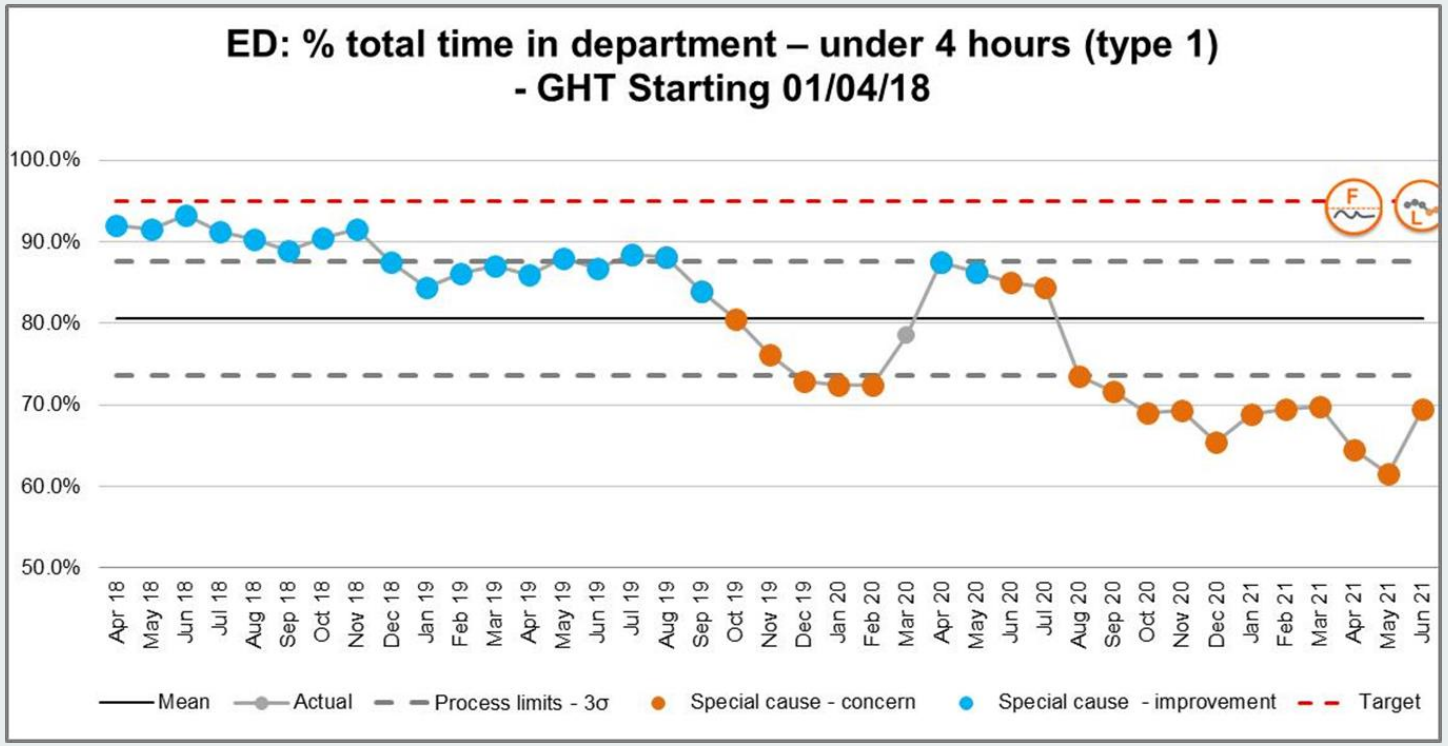
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Since opening as an ED again CGH has seen an increase number of patients coming through the door, with similar staffing numbers, this is reflected in the 4 hour performance at CGH which has seen a decrease of 4.96%. However trust wide 4 hour performance has increased by 2.09%. Reduced discharges, reduced flow & reduced staffing numbers, combined with increased number of patients has ultimately lead to an increase in numbers of admitted patients breaching in ED. The average total time in department is up by on average 20 minutes, whilst the average time from DTA to admission has increased by over half an hour.

- 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 11 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 falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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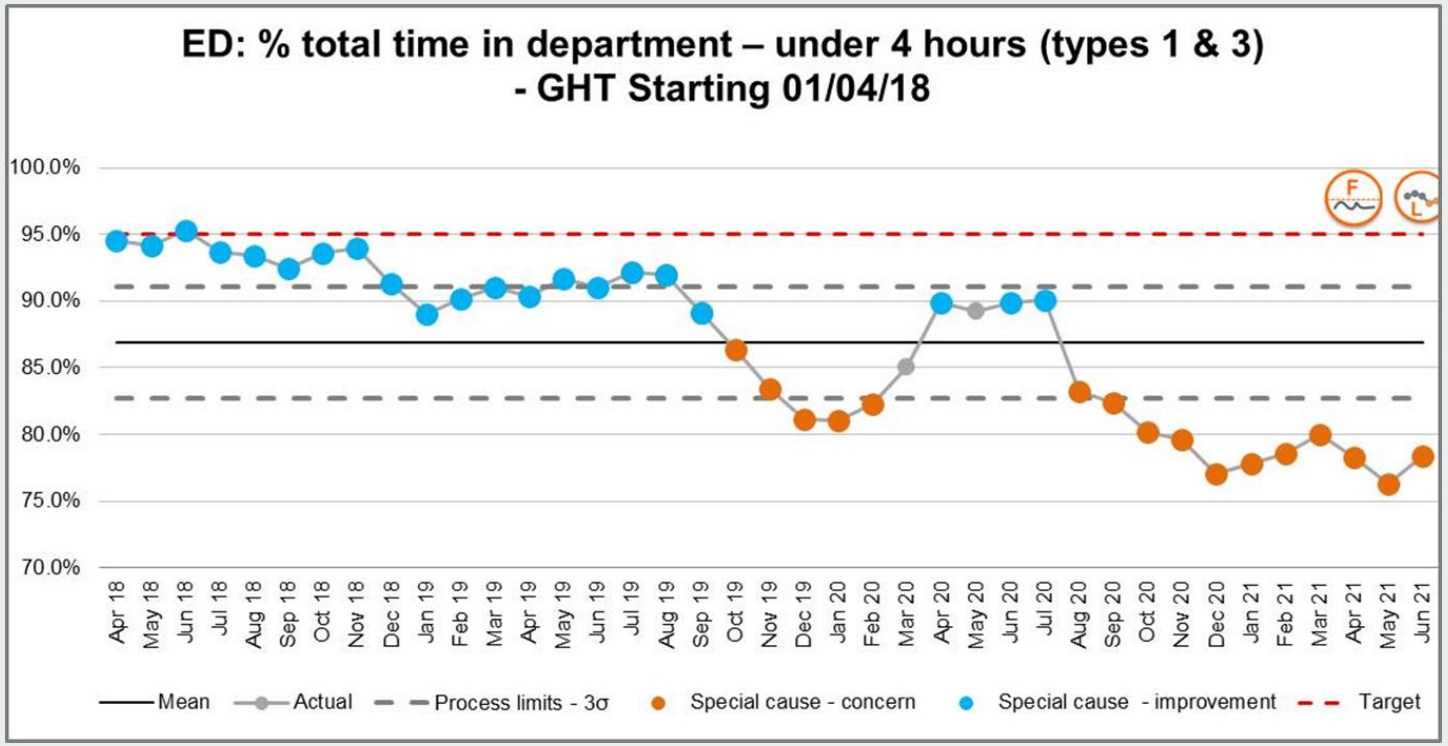
Gloucestershire Hospitals NHS Foundation Trust



Commentary

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- 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 12 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.
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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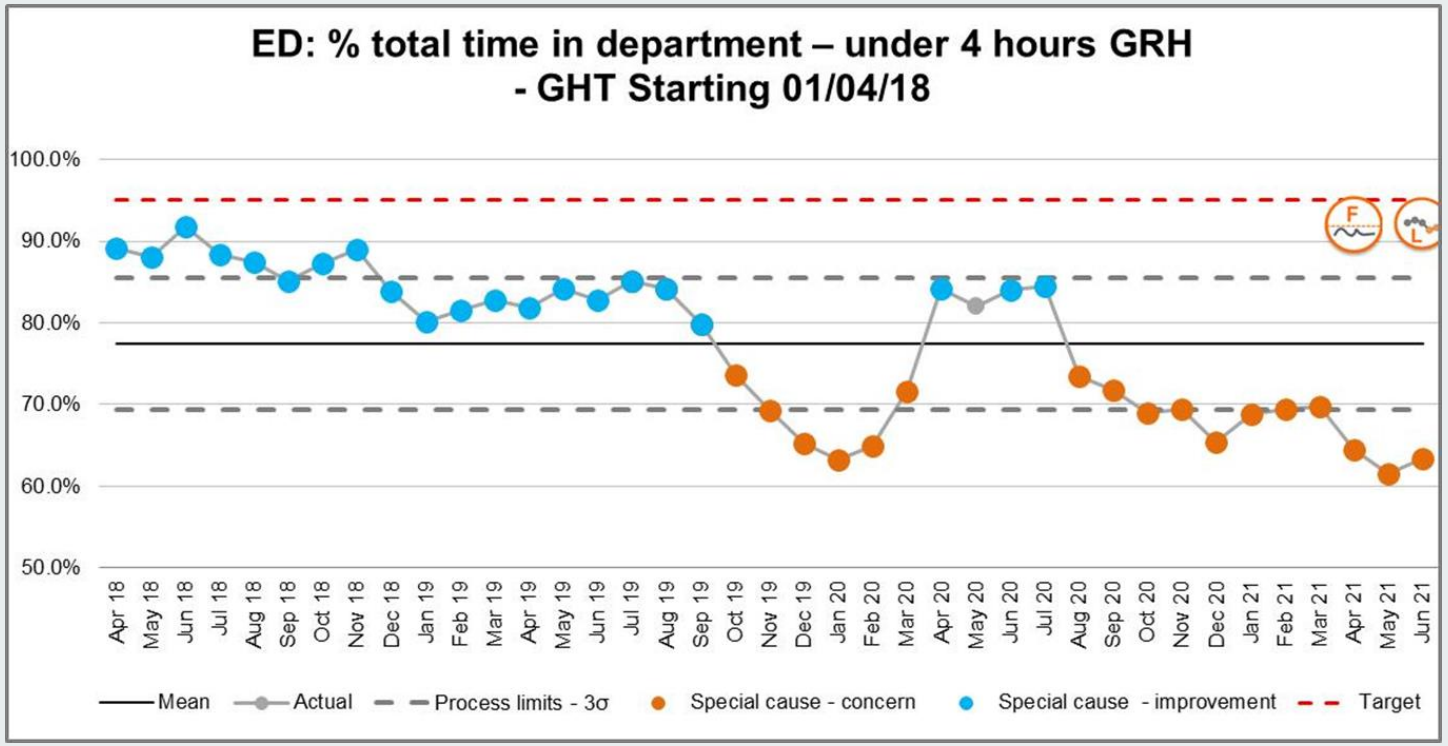

Commentary

Since opening as an ED again CGH has seen an increase number of patients coming through the door, with similar staffing numbers, this is reflected in the 4 hour performance at CGH which has seen a decrease of 4.96%. However trust wide 4 hour performance has increased by 2.09%. Reduced discharges, reduced flow & reduced staffing numbers, combined with increased number of patients has ultimately lead to an increase in numbers of admitted patients breaching in ED. The average total time in department is up by on average 20 minutes, whilst the average time from DTA to admission has increased by over half an hour.

- 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
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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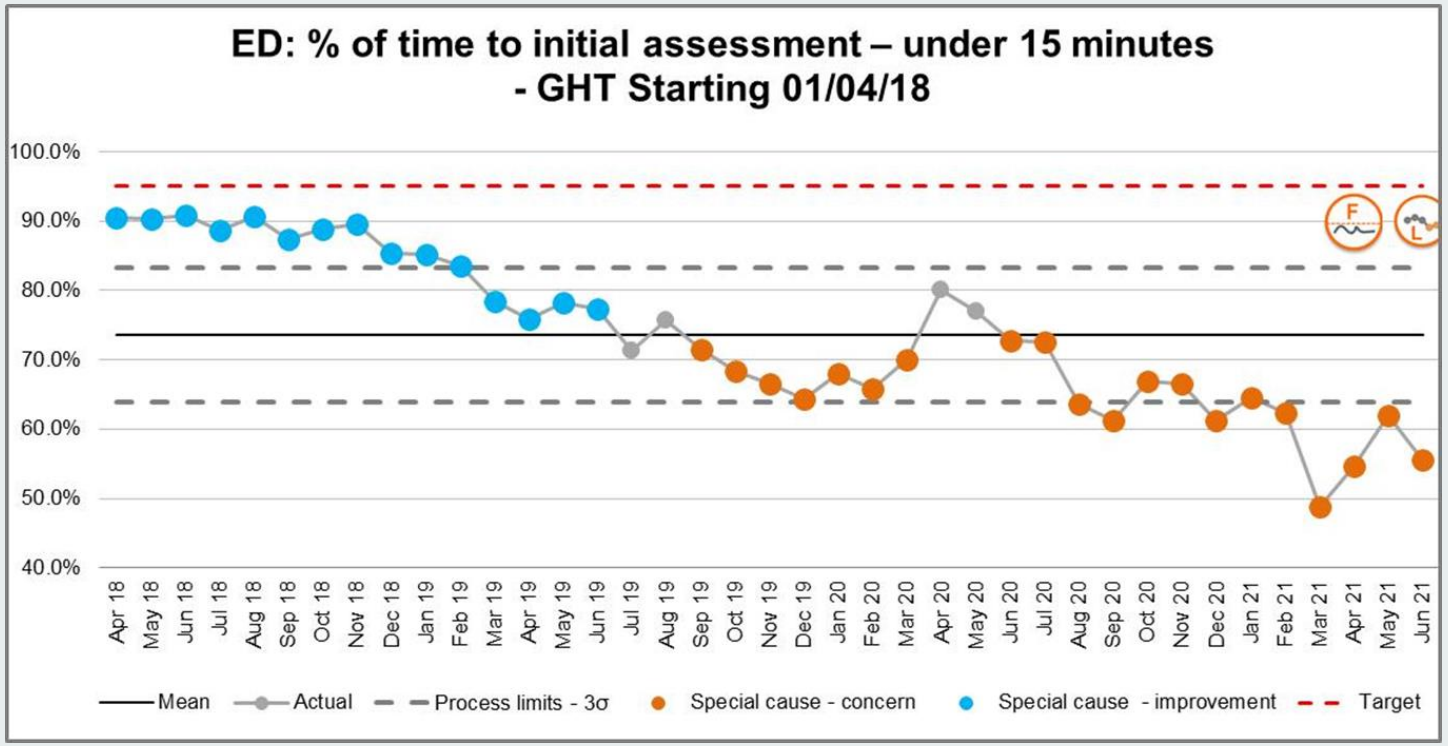
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Triage for ambulance patients remains within the 15 minute target (14.7 minutes) however walk in patients have an average triage time of 23.3 minutes. The new EPR system has impacted this due to the change in process at initial assessment.

- 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 11 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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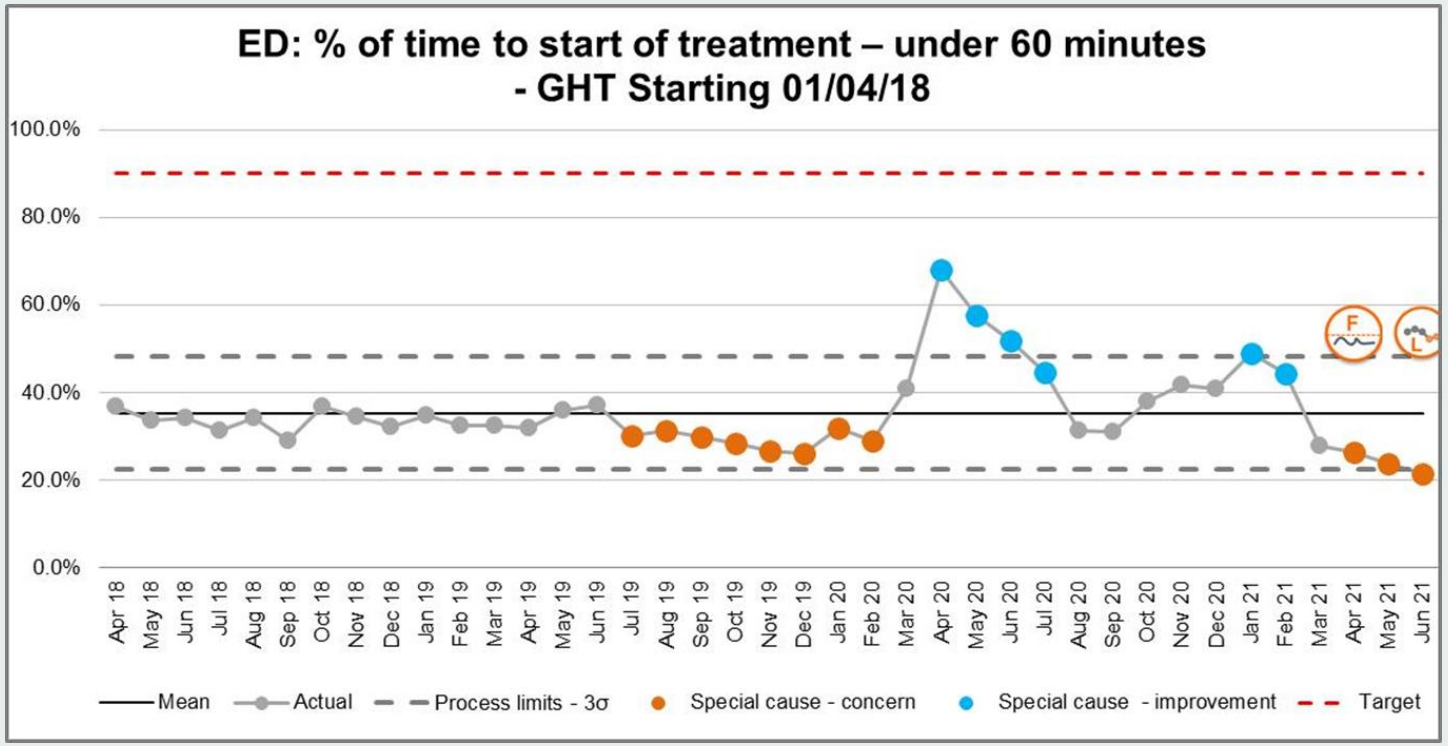
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Ongoing medical staffing problems and an increase in patients coming through the door has led to a decrease in 60 minute to see a doctor performance. However there has been an improvement in overall time spent waiting to see a doctor.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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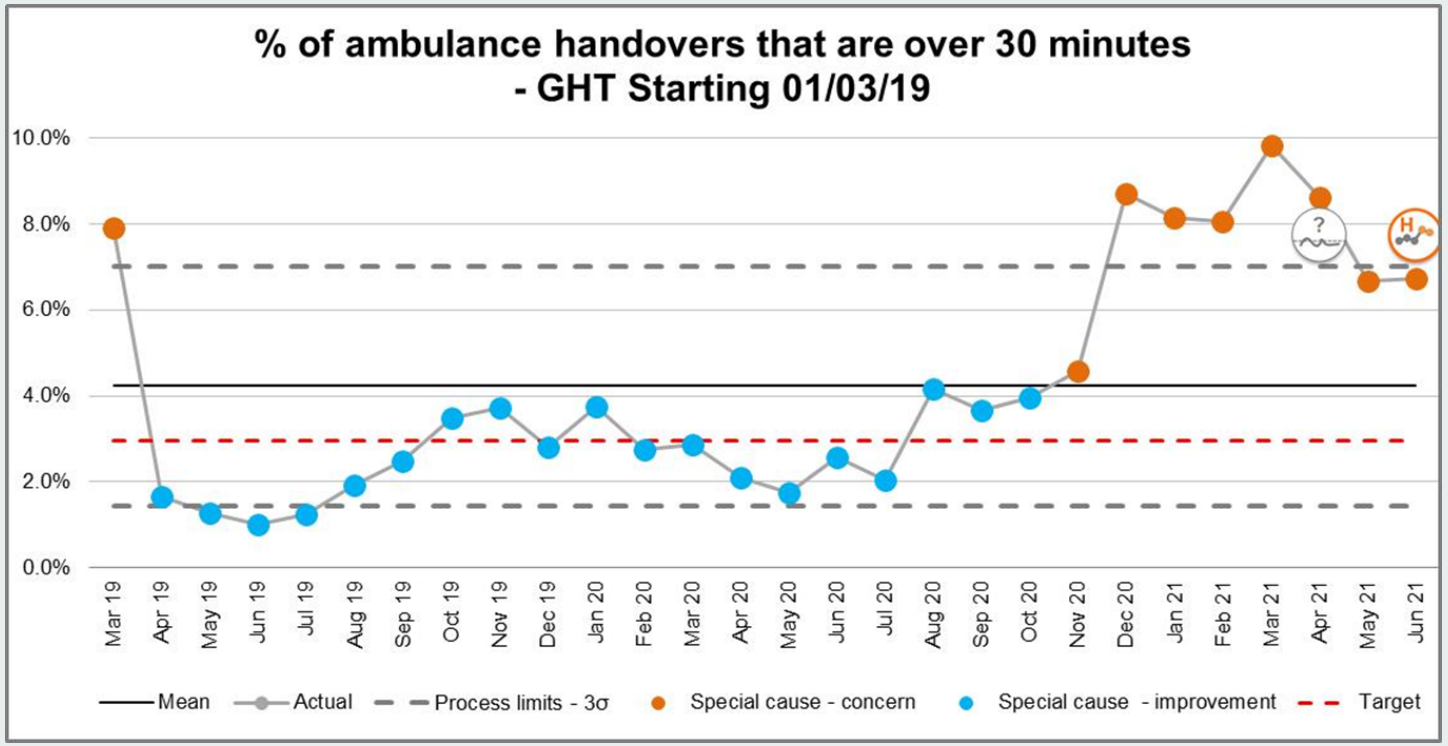

Commentary

Increased number of patients and reduced flow has led to an increase in ambulance handover delays. Trust wide, although there has been a decrease, by 9, under 30 minutes breaches, June has seen an increase of 32 over 60 minute breaches. ACUC secured a ring fenced bed for direct admissions and a license has been applied for to accept direct referrals from the ambulance service using Mobimed.

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

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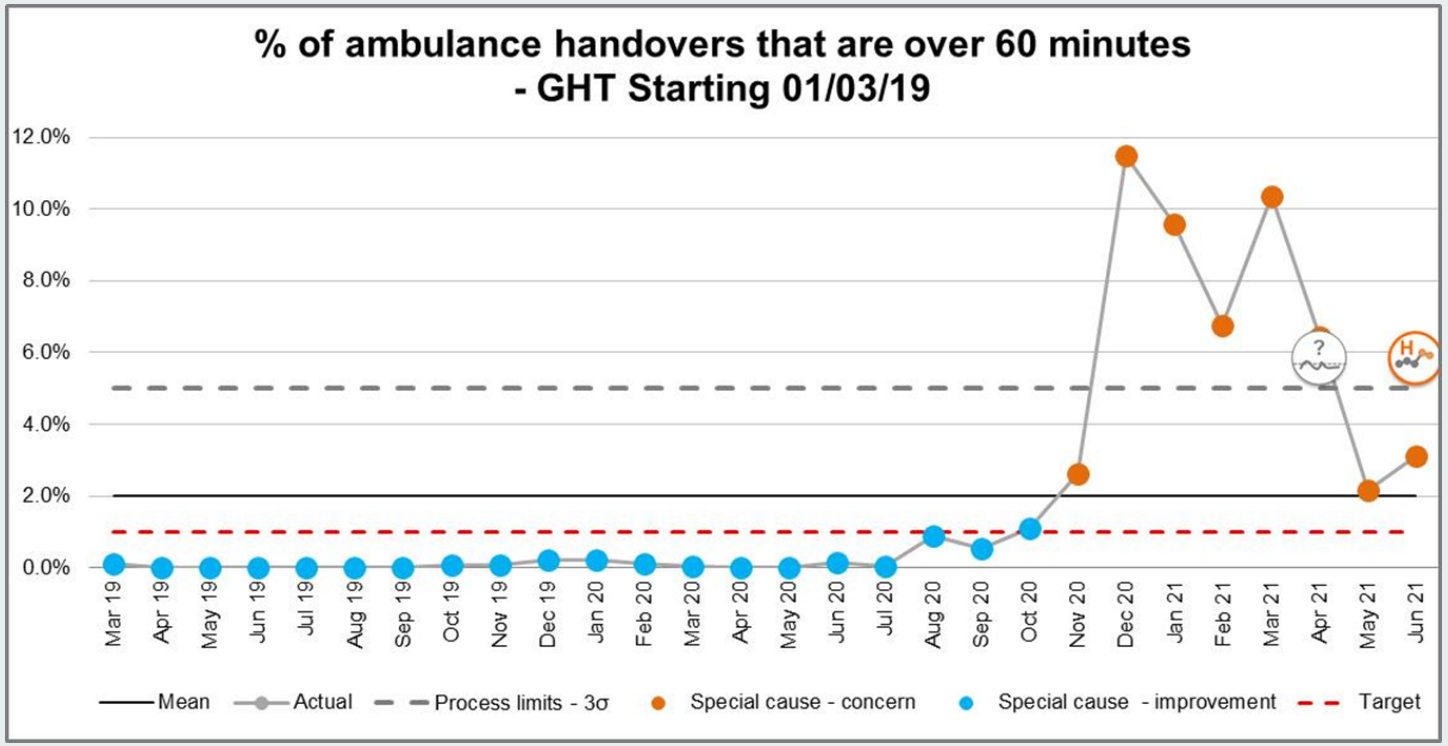

Commentary

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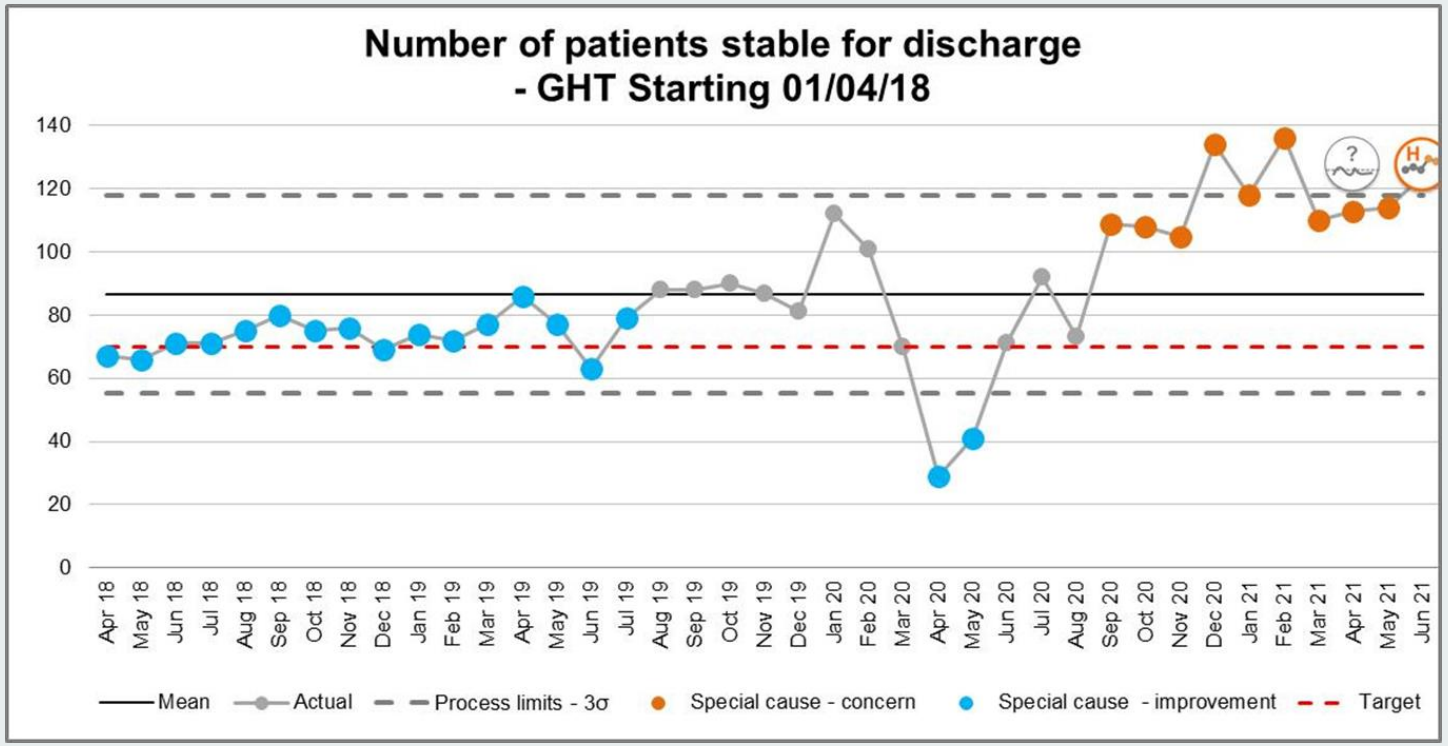
- Director of Unscheduled Care and Deputy Chief Operating Officer

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.
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

COVID impact on elderly patients in terms of isolation and clinical decline leading significant increase in the amount of referrals into onward care pathways. This in turn is leading to significant delays in discharge, with the MOFD list growing rather than reaching the desired target of <70. Ongoing internal and system work focusing on this patient cohort.

- 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.
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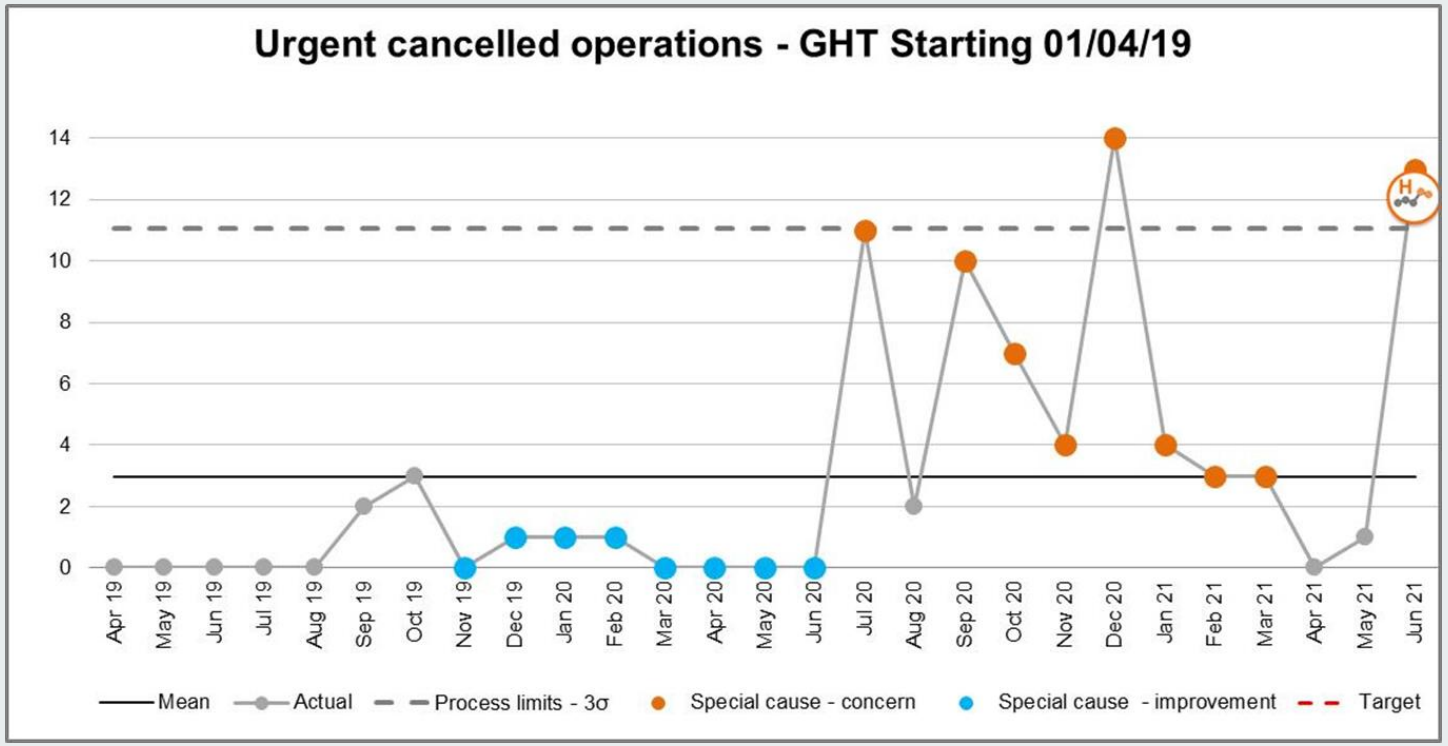

Commentary

All cancellations are reviewed weekly. For June for theatre elective procedures of the 12 listed, x6 were due to bed issues, x1 lack of blood results, x4 booking issues and x1 equipment unavailable. All OTD cancellations are reviewed at utilisation, with learning put in place to avoid repetition where possible.

- Director of Operations - Surgery

Data Observations

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

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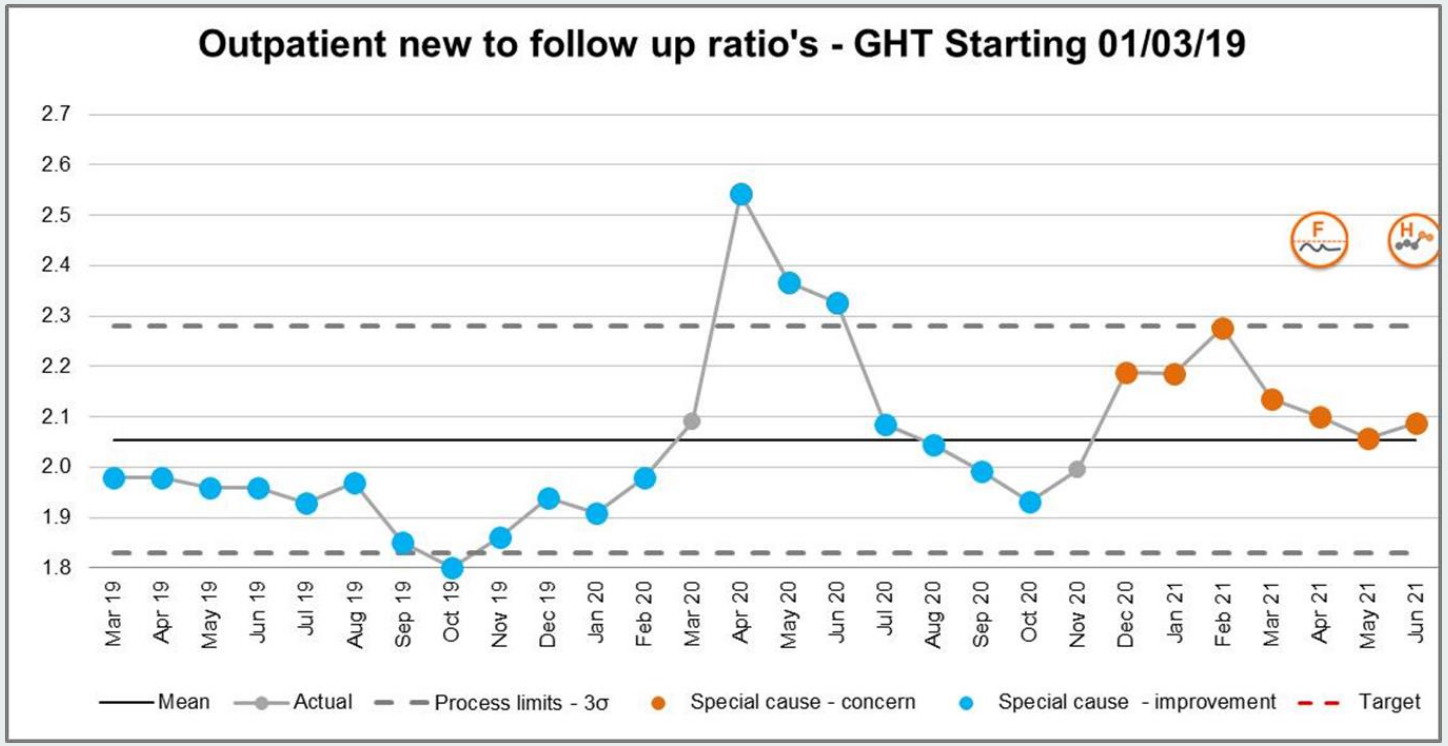

Commentary

These remain relatively consistent around 2.04, and just over the target of <=1.9.

- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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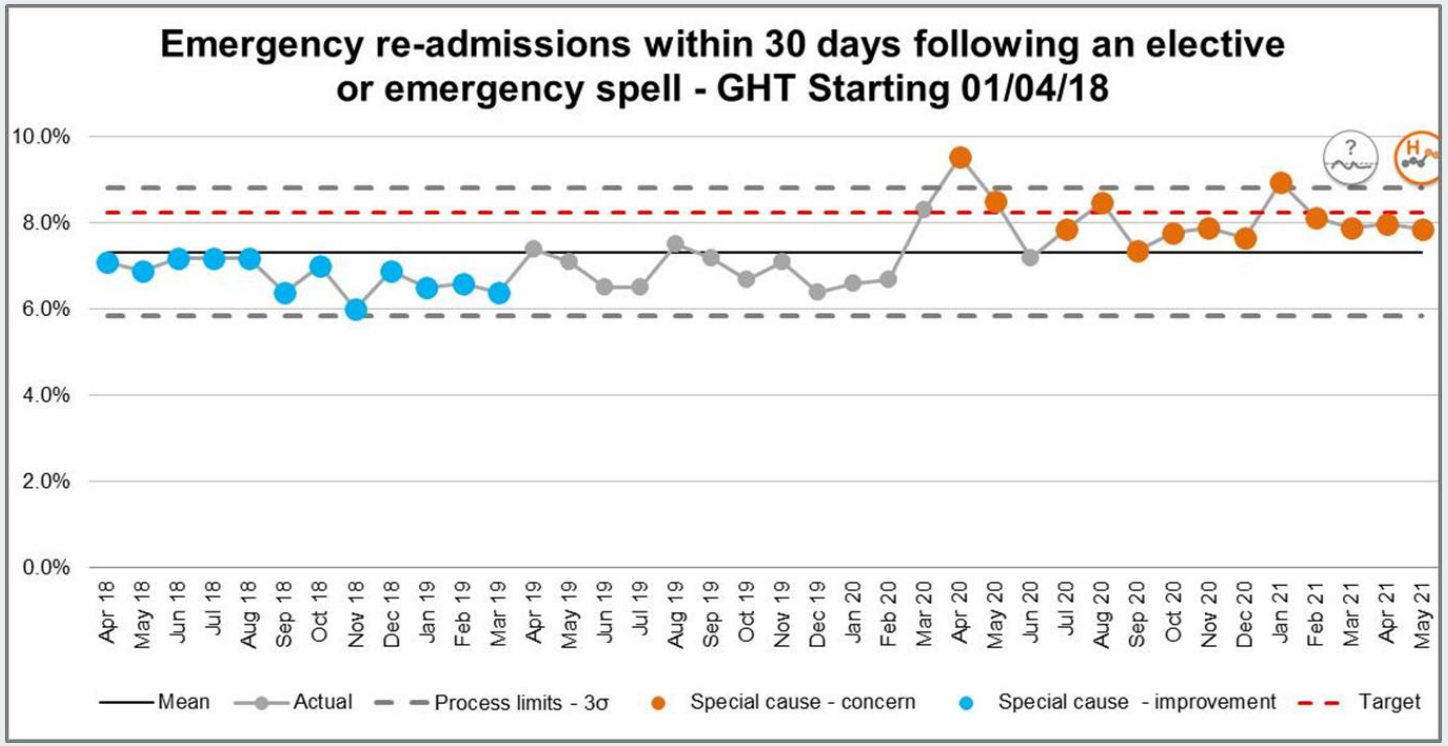

Commentary

This metric has been green for the last four months and has shown a gradual improvement in this time. This most likely reflects an increase in elective activity following the second wave of the pandemic.

- 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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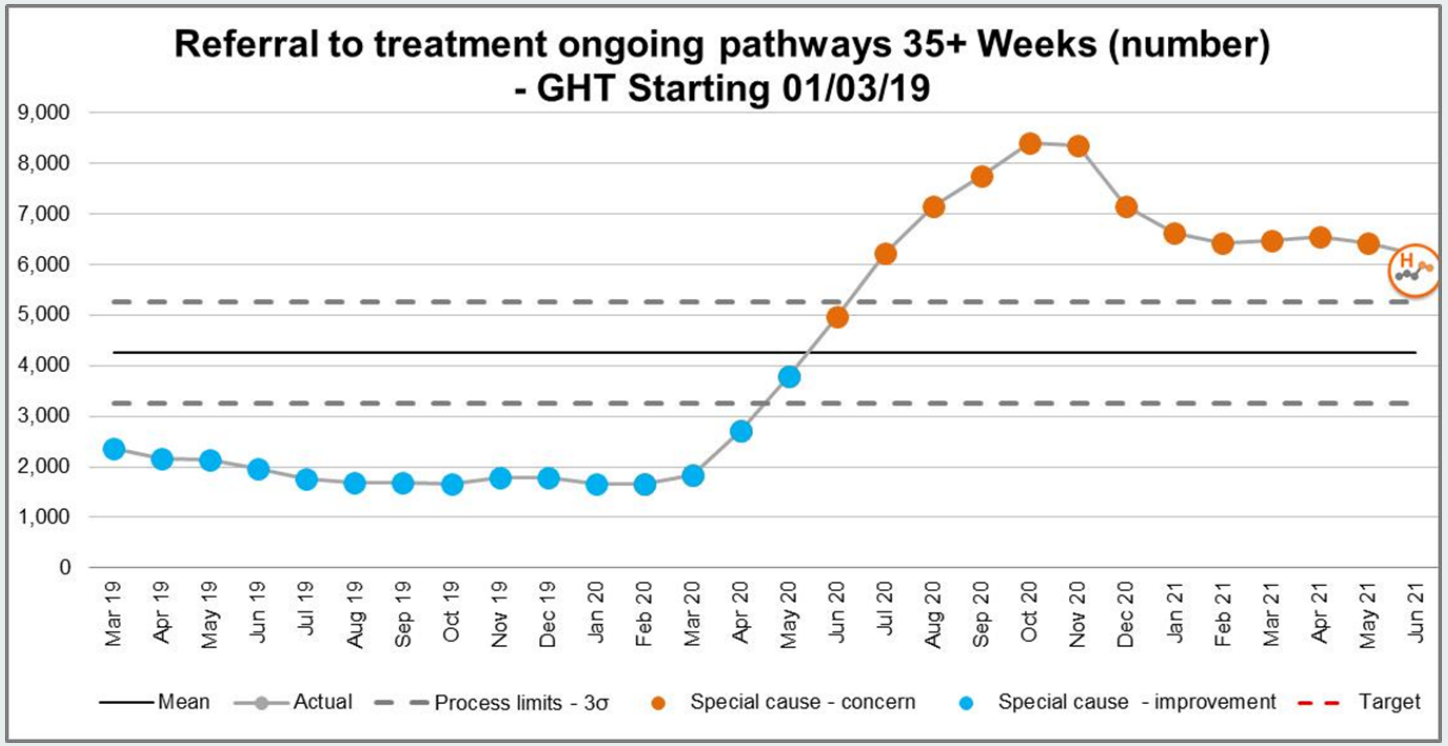

Commentary

Outpatient clinic activity has increased together with theatre availability. The cohort of patients over 35+ weeks has decreased in month by just over 200 patients, but typically this number ranges from 6,200 to 6,500.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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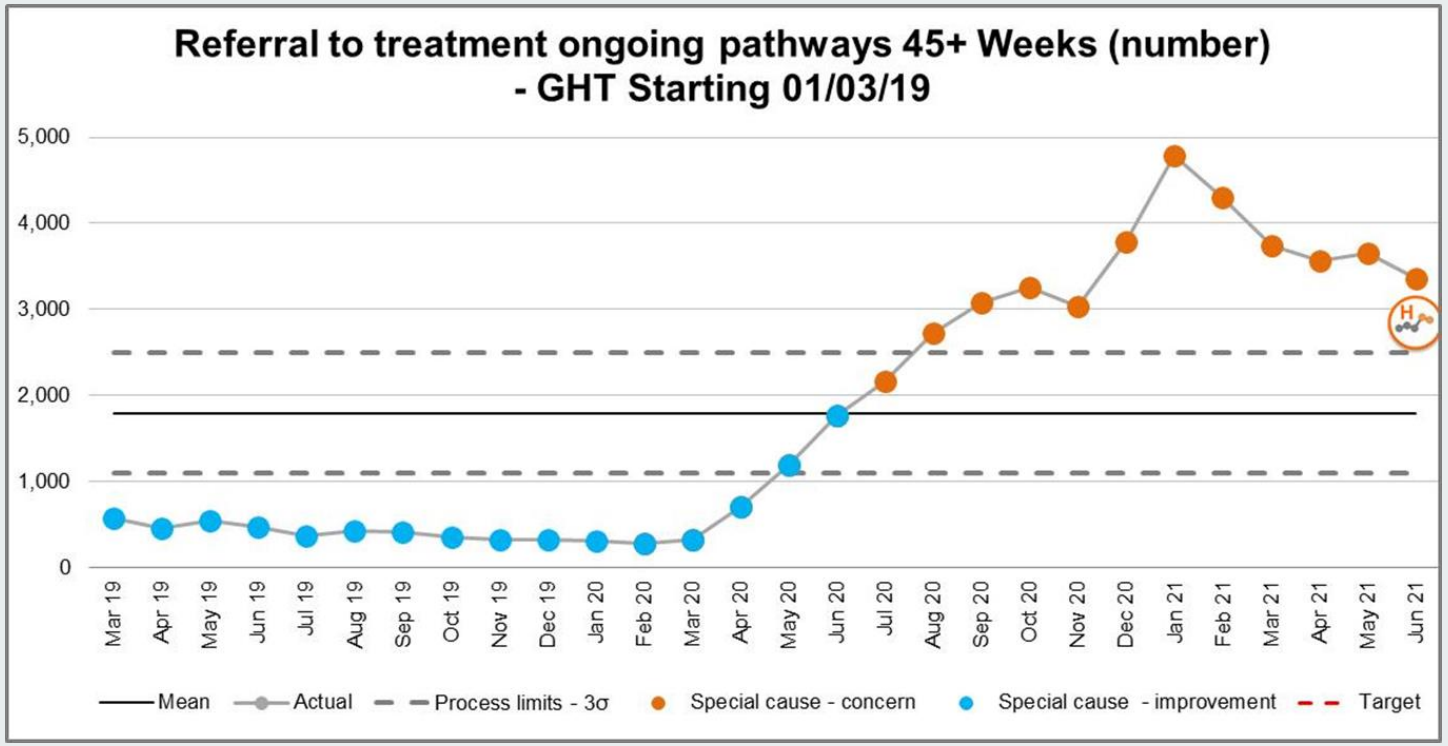
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Outpatient clinic activity has increased together with theatre availability. In month a reduction of ~300 has been made. With the exception of one month, this has been the trend for the past five.

- 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 11 data points which are above the line. There are 14 data point(s) below the line
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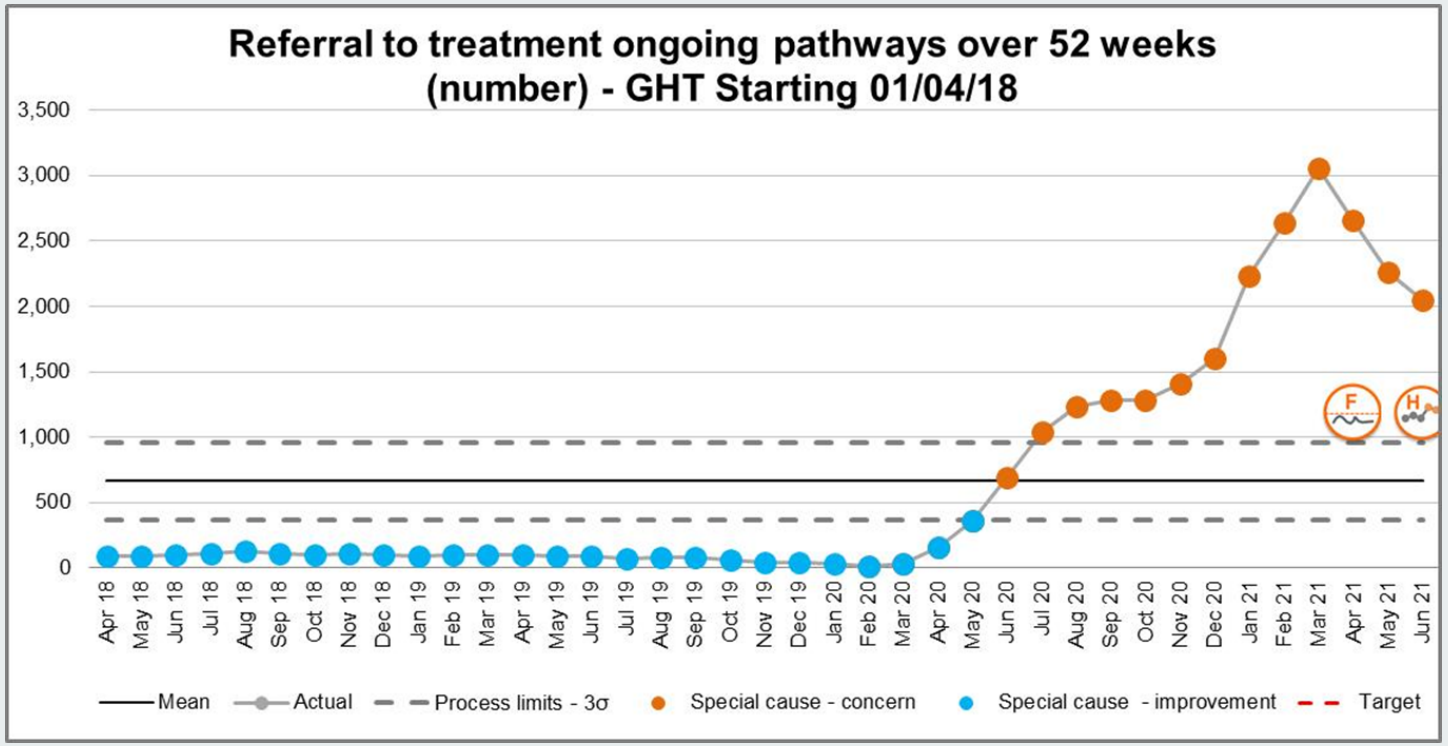

Commentary

See Planned Care Exception report for full details. Restoration and recovery has resumed with both an increase in outpatients and theatre availability. For the third consecutive month a reduction has been made with this cohort of patients (albeit lesser in June). However given TCIs are allocated on clinical priority, this does mean that some of those waiting greater than 70, 78 and 104 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 12 data points which are above the line. There are 26 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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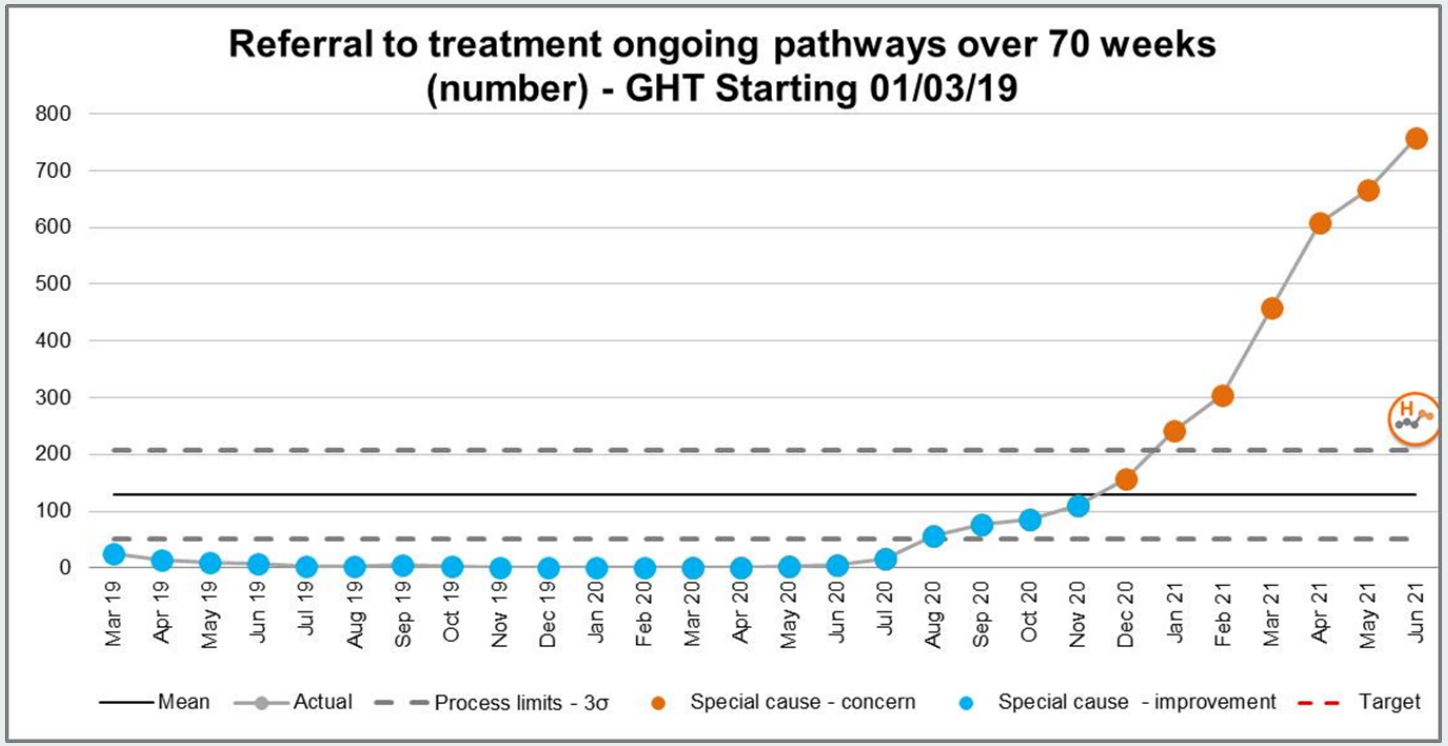

Commentary

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 90 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 6 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 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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Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Mar-21	70%
Friends & Family Test	Inpatients % positive	>=90%	Jun-21	89.7%
Friends & Family Test	ED % positive	>=84%	Jun-21	74.8%
Friends & Family Test	Maternity % positive	>=97%	Jun-21	89.2%
Friends & Family Test	Outpatients % positive	>=94.5%	Jun-21	94.3%
Friends & Family Test	Total % positive	>=93%	Jun-21	91.2%
PALS	Number of PALS concerns logged	No Target	Jun-21	191
PALS	% of PALS concerns closed in 5 days	>=95%	Jun-21	90%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Jun-21	1
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Jun-21	3.9
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Jun-21	11
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jun-21	7
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jun-21	4
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Jun-21	42.6
Infection Control	Number of MSSA bacteraemia cases	<=8	Jun-21	2
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Jun-21	7.7
Infection Control	Number of ecoli cases	No target	Jun-21	3
Infection Control	Number of pseudomona cases	No target	Jun-21	0
Infection Control	Number of klebsiella cases	No target	Jun-21	3
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Jun-21	161
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	No target	Jun-21	15

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	Jun-21	13
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	No target	Jun-21	2
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	No target	Jun-21	1
Maternity	% C-section rate (planned and emergency)	<=27%	Jun-21	0
Maternity	% emergency C-section rate	No target	Jun-21	16.8%
Maternity	% of women smoking at delivery	<=14.5%	Jun-21	0
Maternity	% of women that have an induced labour	<=30%	Jun-21	26.4%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Jun-21	0.41%
Maternity	% of women on a Continuity of Carer pathway	No target	Jun-21	9.70%
Maternity	% breastfeeding (initiation)	>=81%	Jun-21	78.4%
Maternity	% Massive PPH >1.5 litres	<=4%	Jun-21	4.2%
Maternity	Number of births less than 27 weeks	NULL	Jun-21	2
Maternity	Number of births less than 34 weeks	NULL	Jun-21	13
Maternity	Number of births less than 37 weeks	NULL	Jun-21	34
Maternity	Number of maternal deaths	NULL	Jun-21	0
Maternity	Total births	NULL	Jun-21	486
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Jun-21	1.65%
Maternity	% breastfeeding (discharge to CMW)	NULL	Jun-21	49.0%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Feb-21	1.0
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Feb-21	104.9
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Feb-21	111.9

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

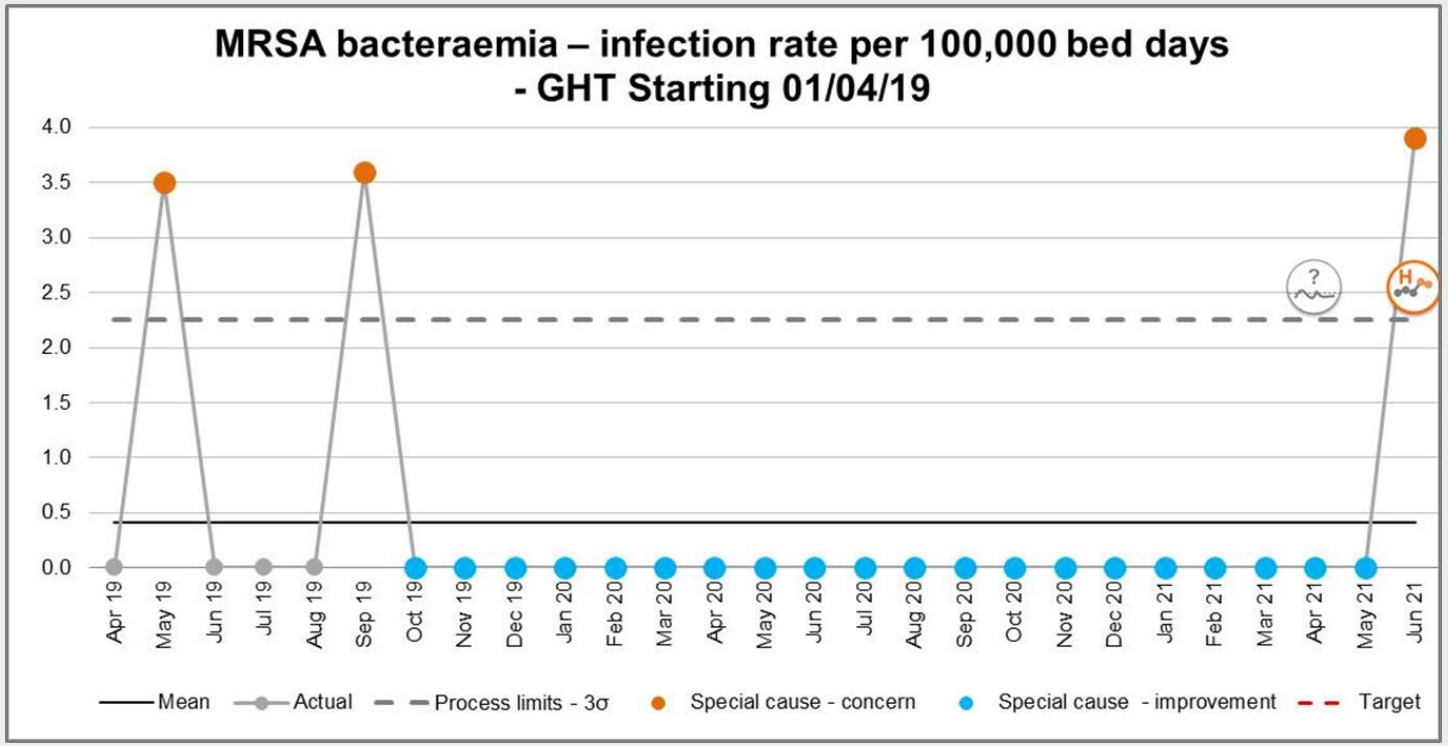
Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	Jun-21	145	
Mortality	Number of deaths of patients with a learning disability	No target	Jun-21	0	
MSA	Number of breaches of mixed sex accommodation	<=10	Jun-21	0	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Jun-21	1	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Jun-21	6.2	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Jun-21	3	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Jun-21	1	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Jun-21	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Jun-21	1	
Patient Safety Incidents	Medication error resulting in low harm	No target	Jun-21	13	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Jun-21	17	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Jun-21	1	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Jun-21	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Jun-21	4	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Jun-21	8	
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	Jun-21	3	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Jun-21	0	
Serious Incidents	Number of serious incidents reported	No target	Jun-21	2	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Jun-21	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Jun-21	100%	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Jun-21	89.3%	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target	Nov-19	95%	
Safeguarding	Number of DoLs applied for	No target	Jun-21	57	
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target	Jun-21	2	
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	Jun-21	0	
Safeguarding	Total admissions aged 0-18 with DSH	No target	Jun-21	15	
Safeguarding	Total ED attendances aged 0-18 with DSH	No target	Jun-21	81	
Safeguarding	Total number of maternity social concerns forms completed	No target	Jun-21	77	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There has been one hospital onset health care associated MRSA bacteraemia within the renal speciality in June 2021. Initial findings suggest this is related to an invasive device specifically an peripheral venous cannula. Further investigation via the post infection review process is due to be completed. Furthermore, in line with the IPC annual strategy 2021-2022 a point prevalence audit will be performed across the trust of invasive devices to assess indication, care of the device and documentation. A report will be created and remedial actions identified and implemented to address issues that arise

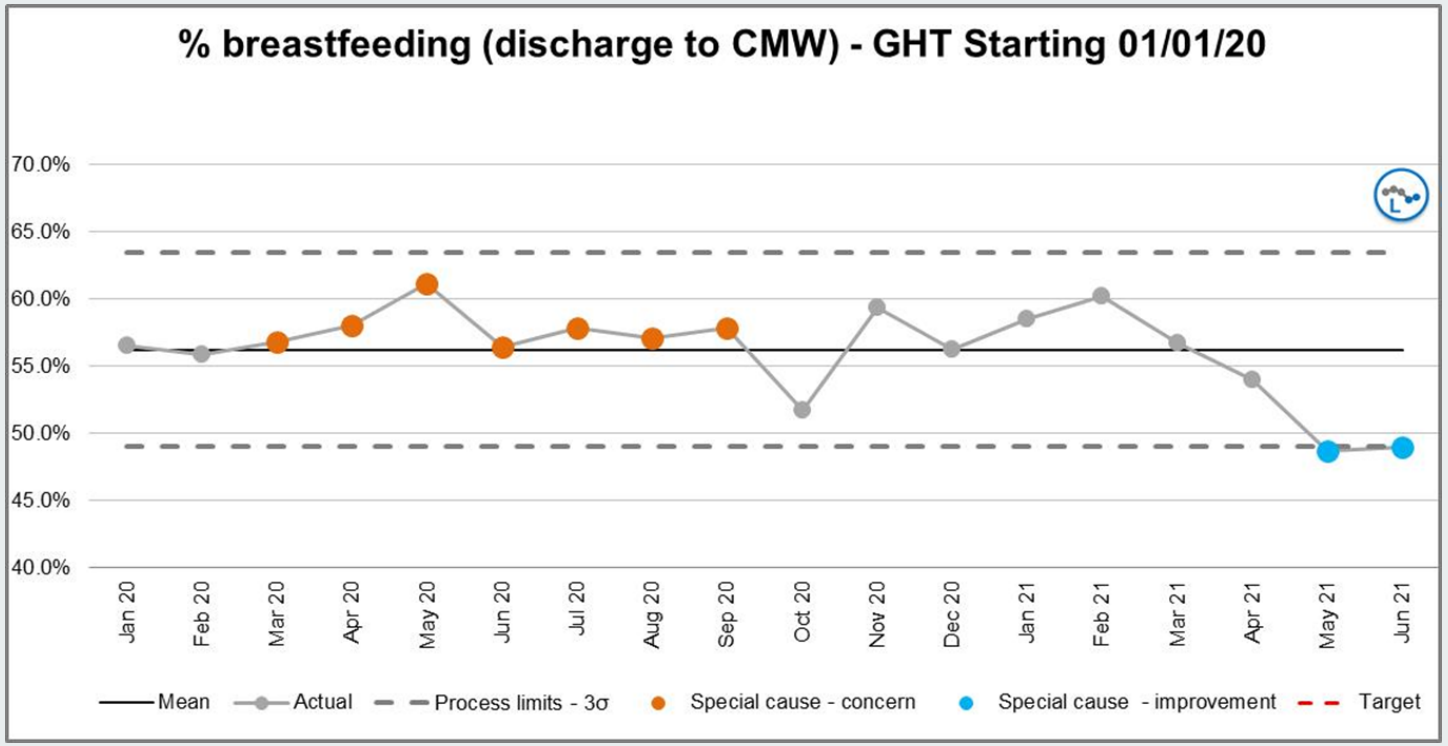
- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The service continue to use BFI standards across maternity and neonatal service with an aim to ensure sustained improvement.

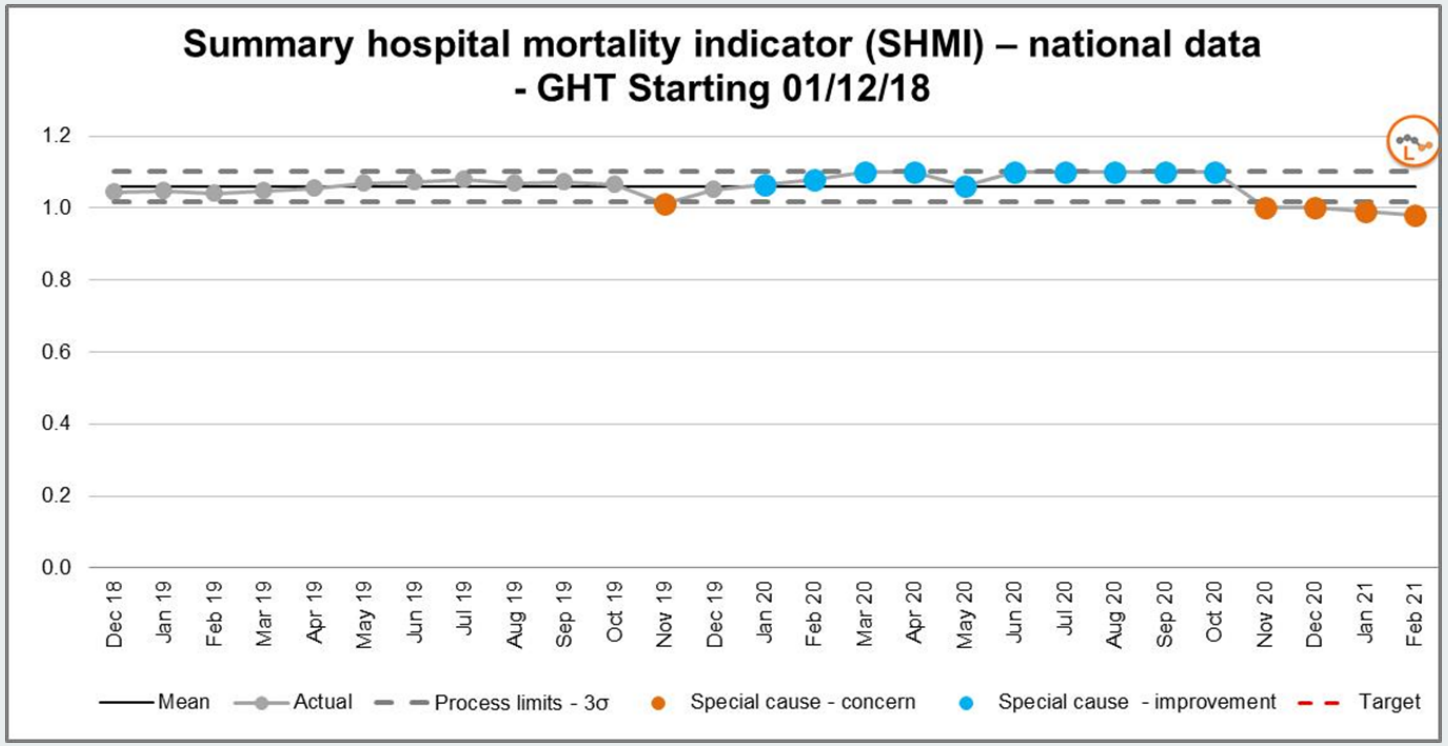
- Divisional Director of Quality and Nursing and Chief Midwife

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Trust remains within the "as expected" range of SHMI which excludes mortality from COVID when coded as a primary or secondary diagnosis.

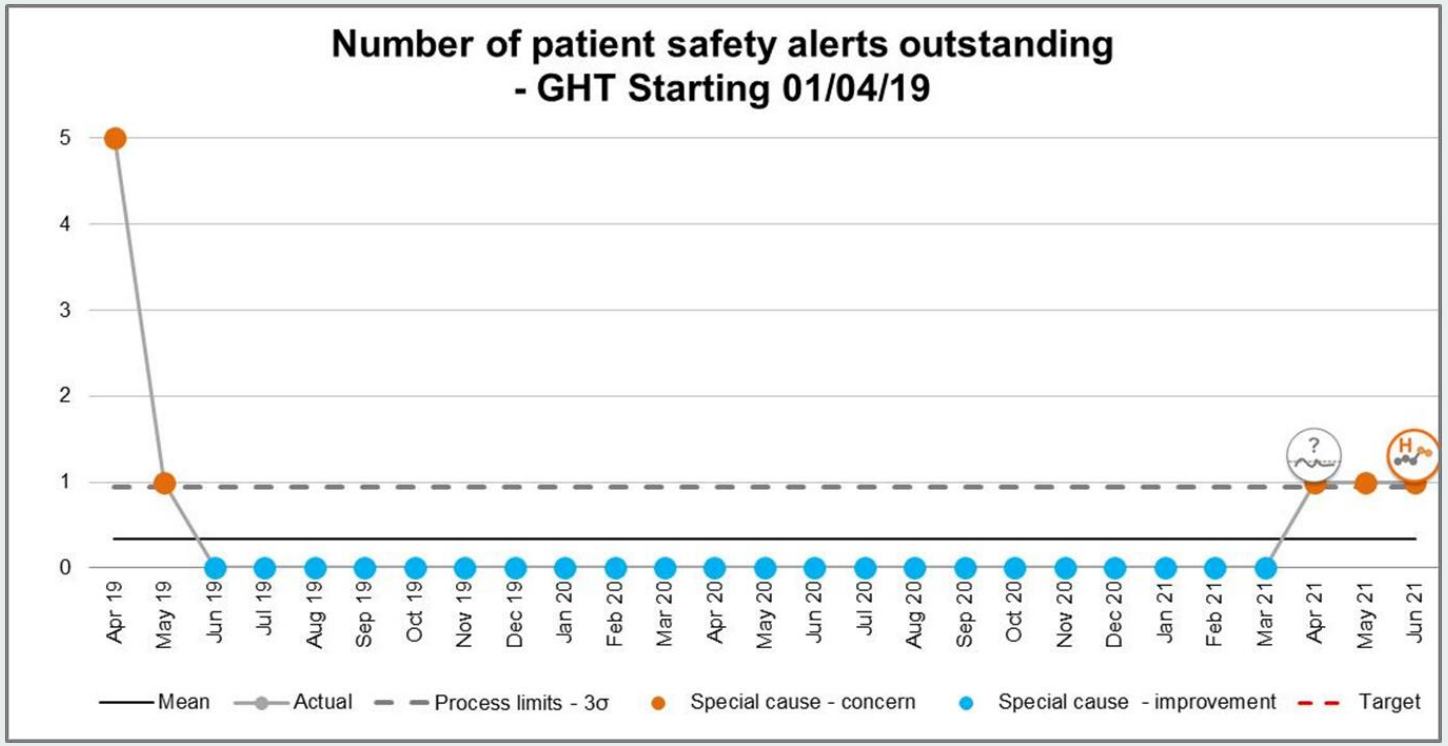
- Medical Division Audit and M&M Lead

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The alert that remains open involved the risk of having a reaction to the long term prescription of steroids. This alert will be closed in the coming month with an interim plan whilst we develop the e-prescribing module.

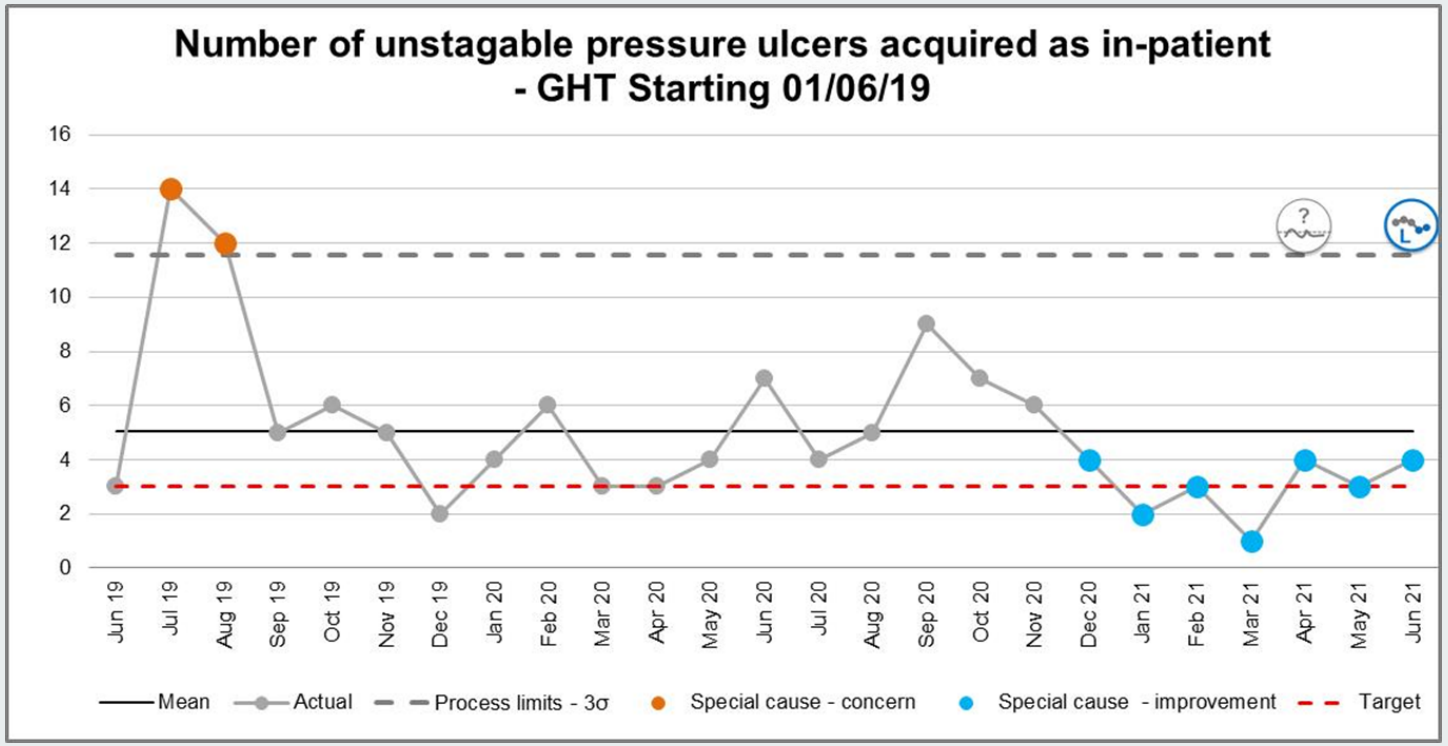
- Quality Improvement & Safety Director

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

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. Factors have been, lack of repeat assessment of risk and length of stay. There is an increase of prevalence of pressure ulcers on ward that have more HCAs than registered nurses on duty.

- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

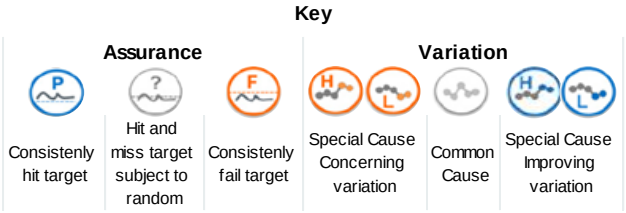
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	N/A
Finance	NHSI Financial Risk Rating		Sep-20	N/A
Finance	Capital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

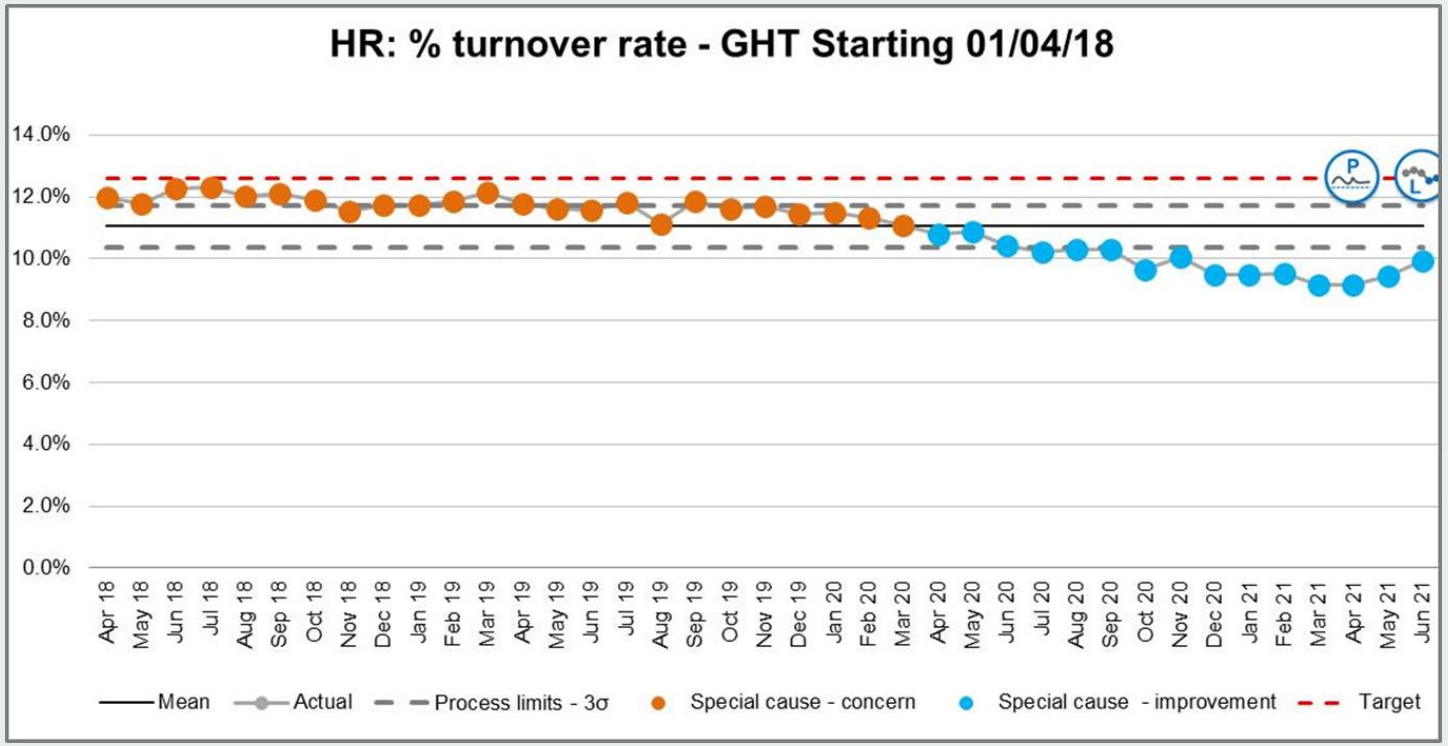
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%		Jun-21	84.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Jun-21	91%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		May-21	96.8%	
Safe Nurse Staffing	% registered nurse day	>=90%		May-21	96.1%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		May-21	104.3%	
Safe Nurse Staffing	% registered nurse night	>=90%		May-21	98.0%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		May-21	113.0%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		May-21	5.5	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		May-21	3.6	
Safe nurse staffing	Care hours per patient day total	>=8		May-21	9.1	
Vacancy and WTE	Staff in post FTE	No target		Jun-21	6649.9	
Vacancy and WTE	Vacancy FTE	No target		May-21	510	
Vacancy and WTE	Starters FTE	No target		Jun-21	56.53	
Vacancy and WTE	Leavers FTE	No target		Jun-21	57.03	
Vacancy and WTE	% total vacancy rate	<=11.5%		May-21	7.12%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		May-21	4.15%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		May-21	6.60%	
Workforce Expenditure	% turnover	<=12.6%		Jun-21	9.9%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Jun-21	9.2%	
Workforce Expenditure	% sickness rate	<=4.05%		Jun-21	3.6%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The rolling annual turnover rate, for all staff and Nursing, remains below our model hospital peer rate, placing the Trust in the top quartile for retention.

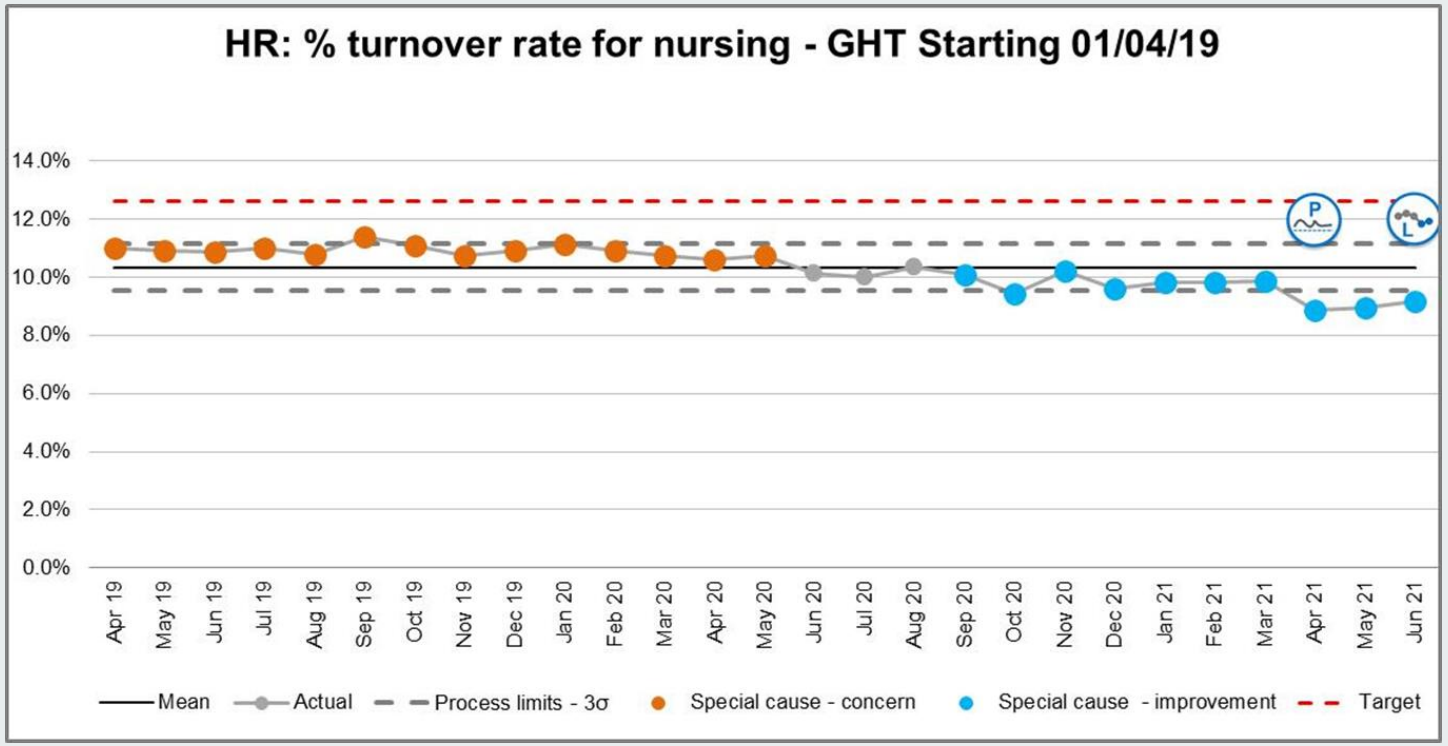
- **Director of Human Resources and Operational Development**

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 14 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.
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

The rolling annual turnover rate, for all staff and Nursing, remains below our model hospital peer rate, placing the Trust in the top quartile for retention.

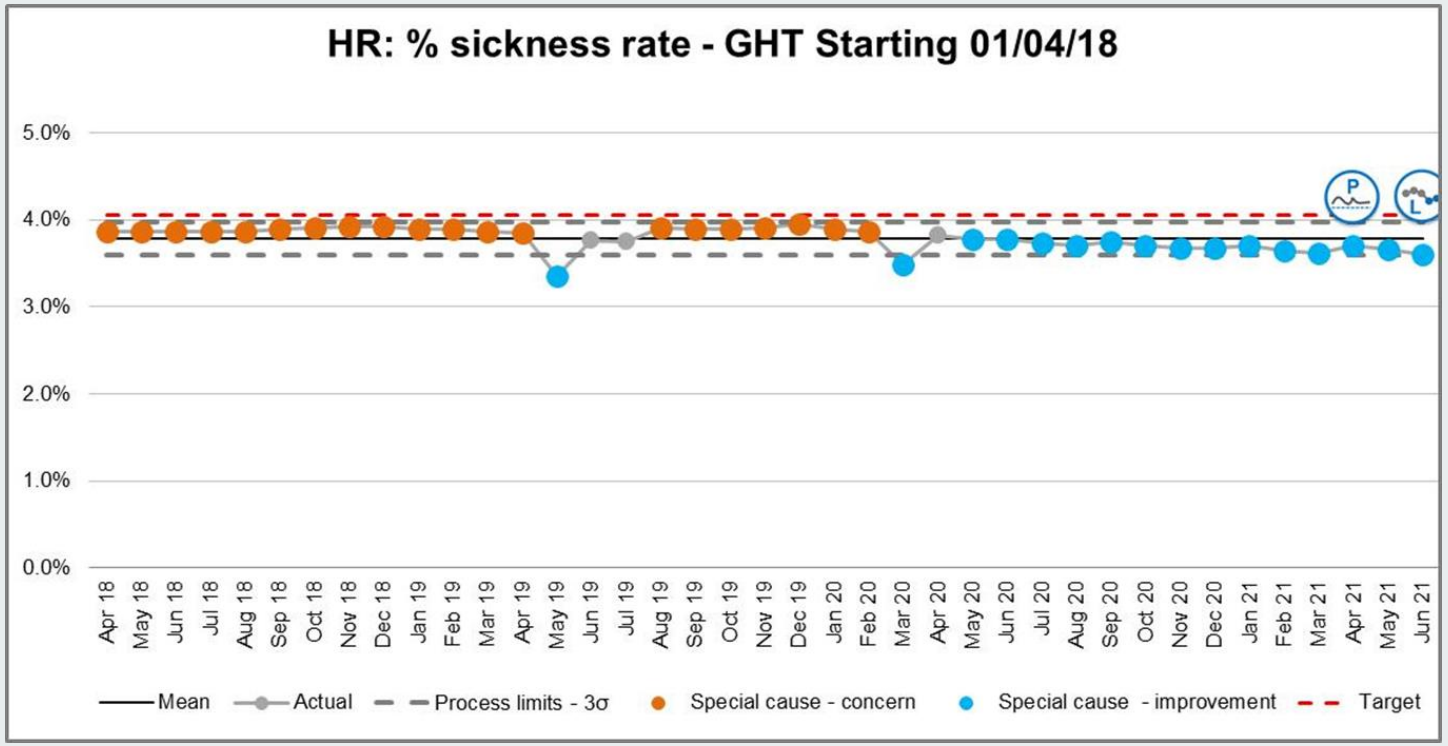
- **Director of Human Resources and Operational Development**

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

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 AUGUST 2021

Report Title
Cancer Services Annual Report 20/21
Sponsor and Author(s)
Sponsors: Qadar Zada – Chief Operating Officer Authors: James Curtis - GM, Cancer Services and Screening
Executive Summary
2020/21 was a challenging year for the Trust and Cancer Services with the arrival of the COVID-19 pandemic. However due to the commitment and hard work of hundreds of clinicians and non-clinicians across the Trust, the Trust was able to maintain delivery of diagnostics and treatments throughout the pandemic. The Trust was tested on multiple fronts but evidence suggests we coped in delivering cancer care during the pandemic and left us well placed for 2021/22. The Trust secured its best performance in respect to Cancer Wait Times with all 8 standards achieving above national average and becoming a regional leader in this sphere. The service also managed to continue delivering improvements with the Personalised Care, Prehabilitation and Patient Experience.
Recommendations
That Trust Board receive this annual report and note the progress within Cancer in the organisation within the last year.
Impact Upon Strategic Objectives
Impact Upon Corporate Risks
Regulatory and/or Legal Implications
Equality & Patient Impact

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

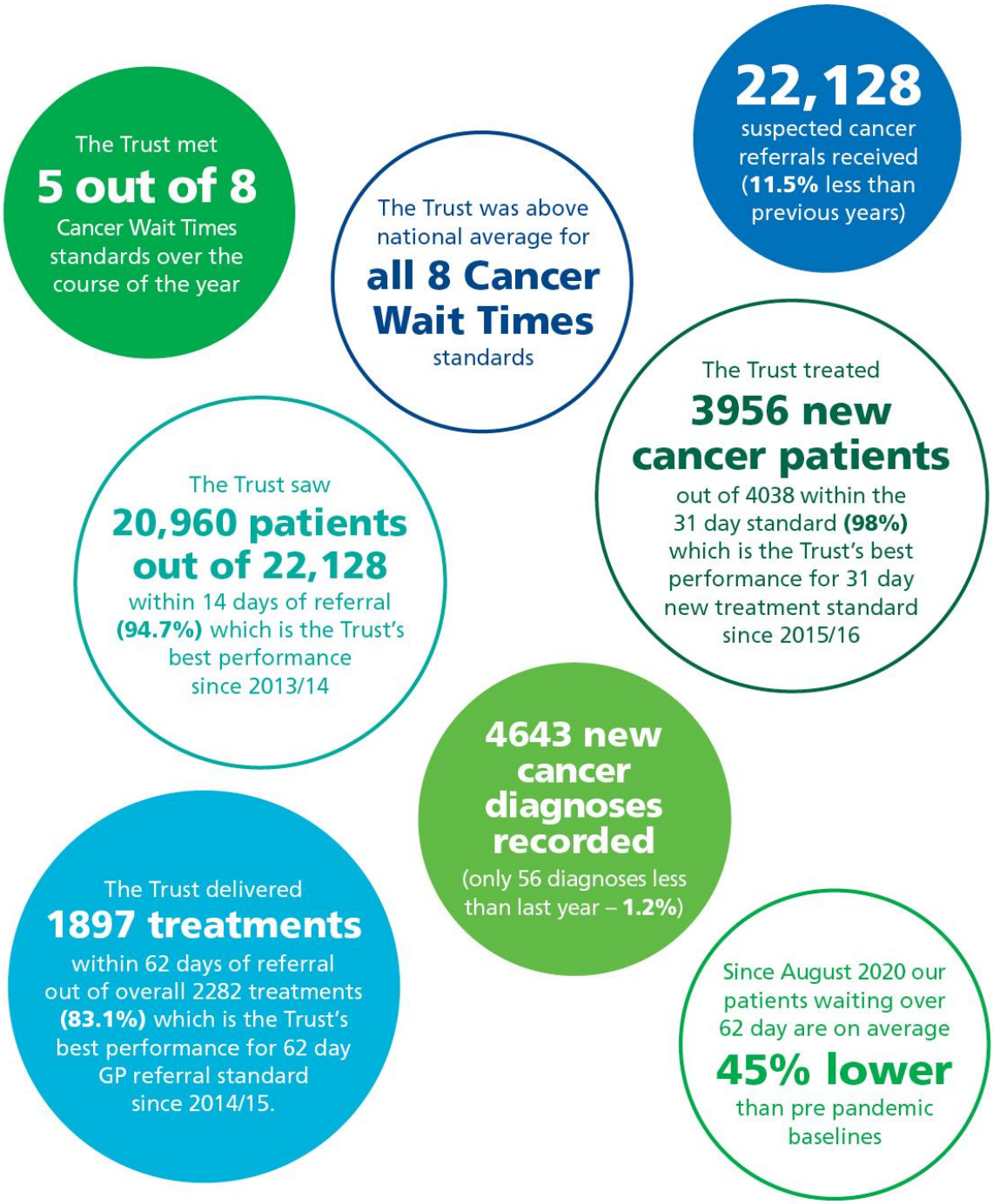
Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	X

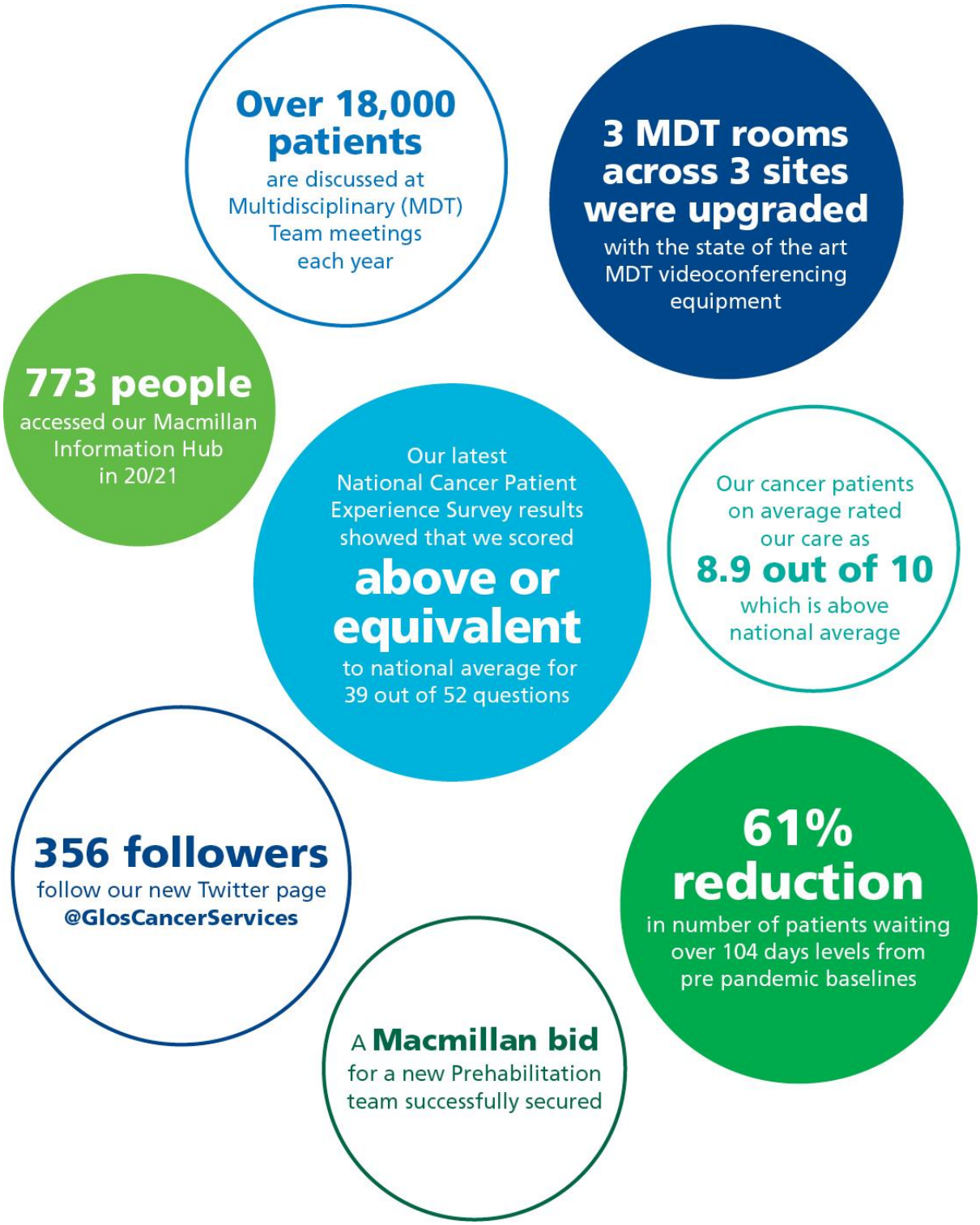
Date the paper was presented to previous Committees and/or Trust Leadership Team (TLT)							
Audit & Assurance Committee	**Finance & Digital Committee**	**Estates & Facilities Committee**	**People & OD Committee**	**Quality & Performance Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
				23/06/21			
Outcome of discussion when presented to previous Committees/TLT							

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Cancer Services Annual Report 2020–2021

Key Achievements for 20/21




Over 18,000 patients
are discussed at Multidisciplinary (MDT) Team meetings each year
3 MDT rooms across 3 sites were upgraded
with the state of the art MDT videoconferencing equipment
773 people
accessed our Macmillan Information Hub in 20/21
Our latest National Cancer Patient Experience Survey results showed that we scored
above or equivalent
to national average for 39 out of 52 questions
Our cancer patients on average rated our care as
8.9 out of 10
which is above national average
356 followers
follow our new Twitter page
@GlosCancerServices
61% reduction
in number of patients waiting over 104 days levels from pre pandemic baselines
A Macmillan bid
for a new Prehabilitation team successfully secured

Introduction

2020/21 was a challenging year for the Trust and Cancer Services with the arrival of the COVID-19 pandemic. However due to the commitment and hard work of hundreds of clinicians and non-clinicians across the Trust, the Trust was able to maintain delivery of diagnostics and treatments throughout the pandemic.

97% of all Gloucestershire patients have cancer treatments delivered at Gloucestershire Hospitals therefore it was in our gift to flex and change our pathways as appropriate to meet the need and circumstances at the time. The Trust also continued to receive and deliver specialist treatments from the region such as Transanal Endoscopic Microsurgery (TEMS) and Robotic Assisted Laparoscopic Prostatectomy (RALP)

Our Oncology centre receives patients from across Gloucestershire, Hereford, South Worcestershire and parts of Powys and continued to deliver oncological treatments with minimal disruption to service. The Team worked hard as part of the MDT's across the Trust to ensure all new and subsequent cancer treatments were delivered in a timely and safe fashion.

Cancer Services in conjunction with Countywide IT Services had been working on a project to upgrade the MDT videoconferencing equipment on 3 sites to state of the art equipment. This equipment was immediately utilised so that our MDT teams could operate remotely within Covid guidelines.

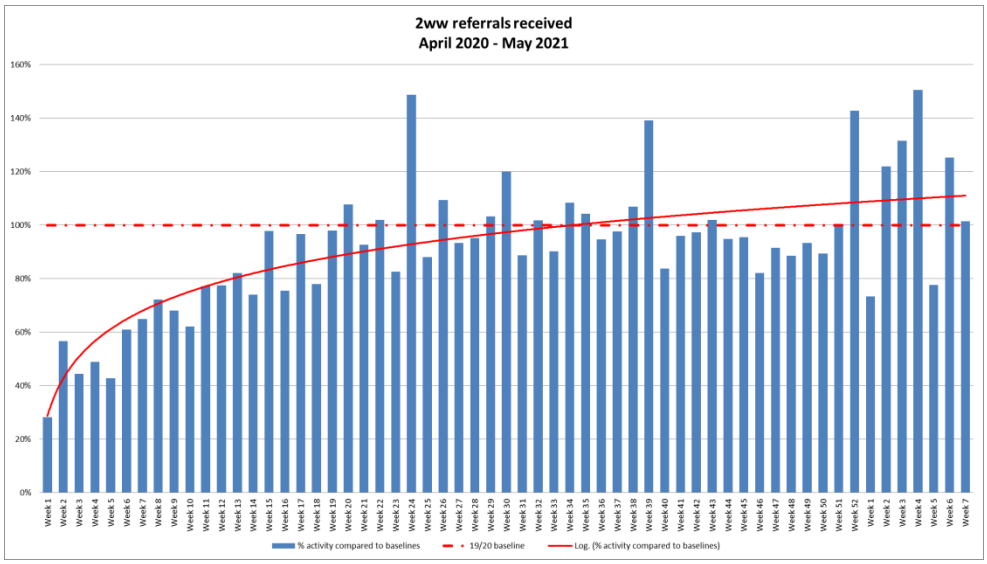
The Trust was tested on multiple fronts but evidence suggests we coped in delivering cancer care during the pandemic and left us well placed for 2021/22. A big thank you goes to our MDT's, CNS teams and all other clinical teams supporting cancer pathways. The Trust admin functions such as Central Booking Office, MDT coordinator team and all other admin teams supporting respective specialties provided a vital role in ensuring continuity of services and supporting patient pathways.

The core Cancer Services team responded to the pandemic in different ways. Some staff were redeployed to help with the Covid response in areas such as Critical Care to Incident Management Team, the wards or to create a new 'Supportive Care' team that used Cancer CNSs in supporting very unwell patients, and providing pastoral support to ward staff in conjunction with Palliative care colleagues. The rest of the team remained to continue monitoring and ensure patients were prioritised whilst also providing valuable assurance around safety netting. Despite the challenges, the Team did fantastically well and this report shows why. Please read on to understand what Cancer Services delivered in collaboration with specialties in 20/21.

Impact analysis from Covid-19

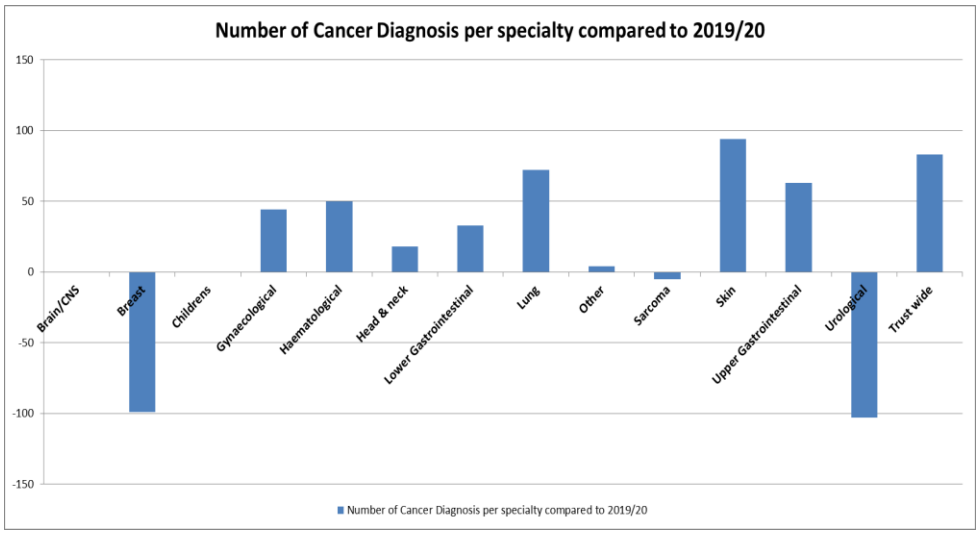
Referrals

Referral rates were severely impacted in the first wave with reduced impact in subsequent waves. The Trust continued to receive 2ww referrals through out the pandemic. Referral rates are now well past 19/20 baselines.



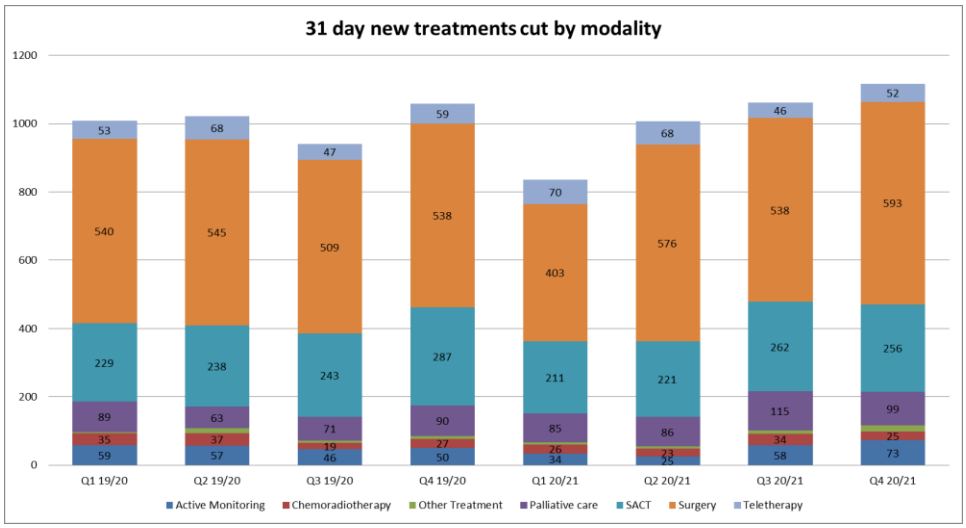
Diagnoses

Despite national attention around ‘missed diagnoses’ the Trust has to date recorded 1.8% more diagnoses than 19/20. This equates to 83 diagnoses more (please see appendix for more information). There is specialty variation showing more diagnoses for Lower GI, Skin, Haematology, Lung, Gynae and Upper GI. Fewer diagnoses were found in Breast and Urology. The first clearly impacted by the national directive to stop screening for a period of time. Urology referral numbers took longer to recover from the first wave than other specialties, initial analysis showing fewer diagnoses in prostate cancer.



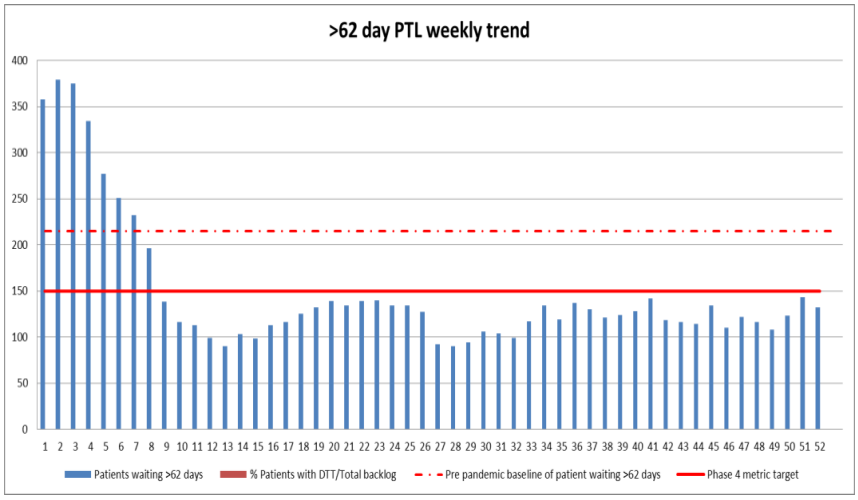
Treatments

The Trust delivered 4019 new cancer treatments which is only 11 treatments fewer than 19/20. This is in direct comparison to the national picture where treatment levels are yet to recover to normal treatment levels. Analysis on types of first treatment for cancer has shown proportionally no real change in treatment option with only a slight increase in palliative care. A clinical audit of our staging data will be conducted to identify any learning from the pandemic.

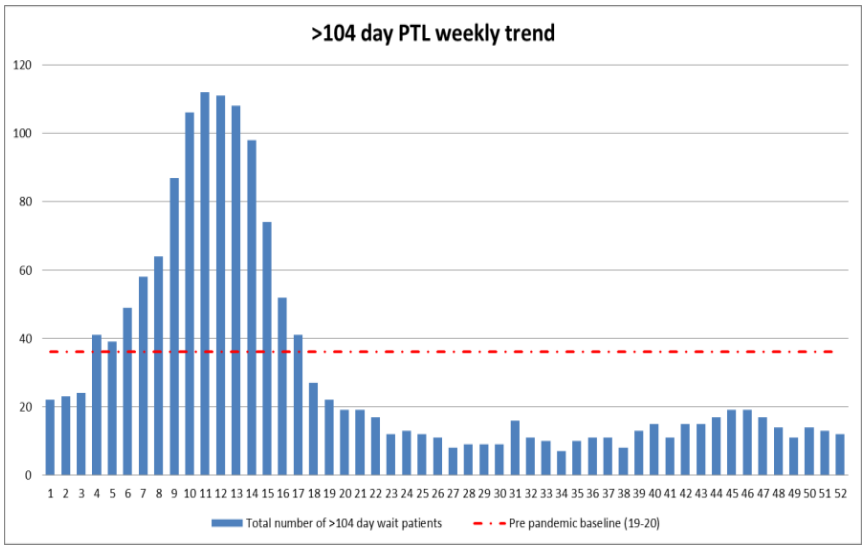


Backlogs

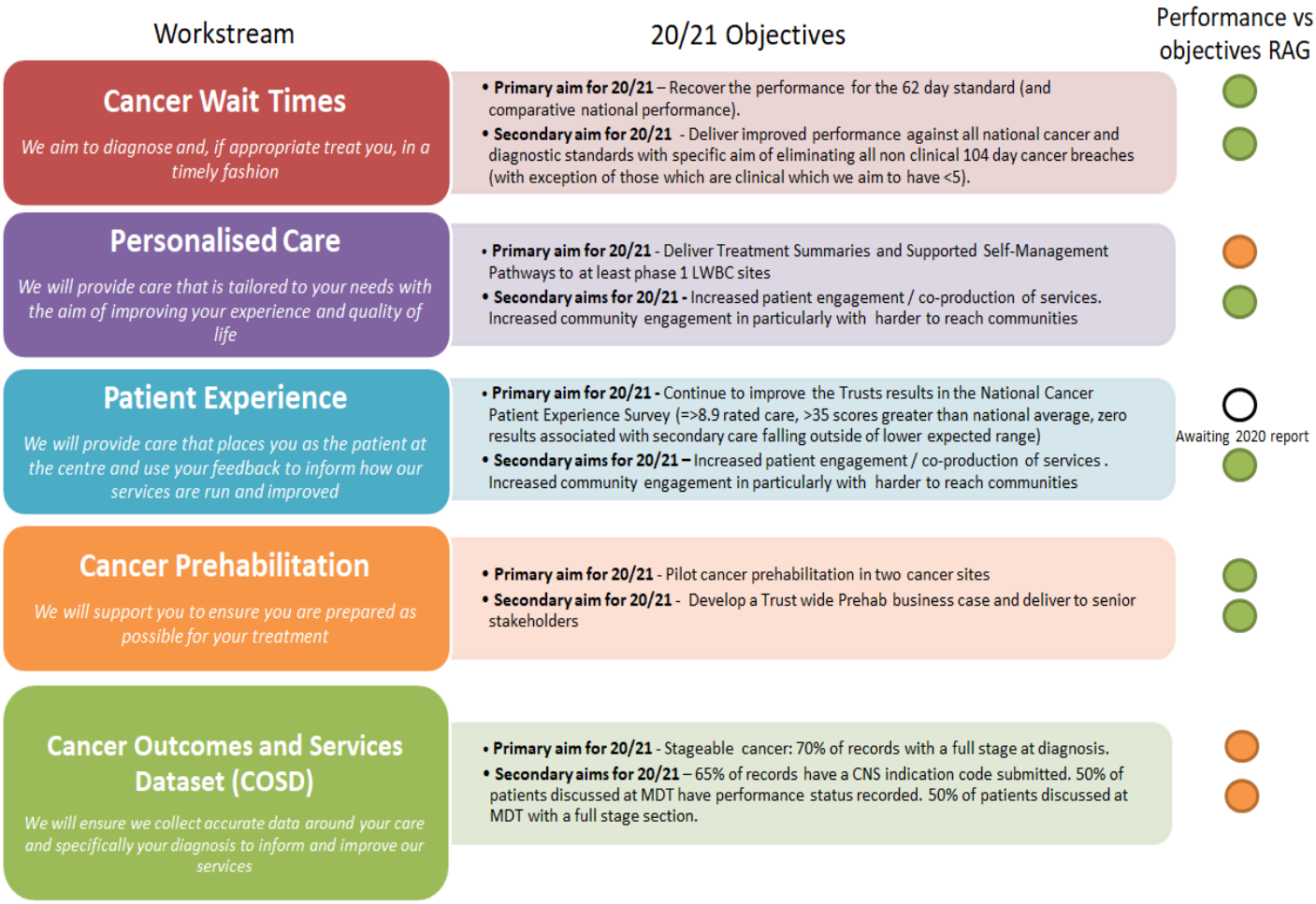
The Trust has seen a reduction in the number of patients waiting over 62 days. After the initial impact from the suspension of endoscopy services, the number of patients waiting over 62 days decreased significantly and has held between 70-100 patients less than pre-pandemic levels.



The number of patients waiting over 104 days increased during the spring and early summer to above 100 patients, with the majority patients waiting for endoscopy services. The number of patients waiting over 104 days decreased and held at an average of 14 from a pandemic level of 36 patients (a 61% reduction).



Key Workstreams, Objectives and Review of 20/21 Performance



The Personalised care work stream was placed on hold during the pandemic. This was due to redeployment of staff to support the Trust's Covid response.

Patient Experience workstream is waiting predominantly for the 2020 report to be published. The National Cancer Patient Experience Survey was on voluntary basis given the pandemic but Cancer Services decided to volunteer as an indicator of the importance it places on gaining patient experience feedback.

Multiple factors affected the COSD data collection work stream; the Trust invested in upgrading the Cancer Waiting Times data collection system and the focus of the MDT coordinators, who complete the data entry, was directed towards the Covid response and the progress of patients on current suspected cancer pathways.

Cancer Wait Times (CWT) Performance

We aim to diagnose and, if appropriate treat you in a timely fashion

- **Primary aim for 20/21**

  Recover the performance for the 62 day standard (and comparative national performance).

- **Secondary aim for 20/21**

  Deliver improved performance against all national cancer and diagnostic standards with specific aim of eliminating all non-clinical 104 day cancer breaches (with exception of those which are clinical which we aim to have <5).

Over the course of 20/21 the Trust has become a regional and national leader in Cancer Wait Times performance with performance for all 8 standards landing in the upper quintiles nationally. Over the course of the last year there has been major improvements seen in the three main standards (2ww, 31 day new treatments and 62 day GP referral). The following table shows our final 19/20 and 20/21 performance measured against 20/21 national performance showing the Trust's performed above national average in all 8 CWT standards.

CWT standard	Target	19/20 GHFT	20/21 GHFT	20/21 National
2ww standard	*93%*	92.60%	94.72%	88.70%
2ww standard (breast symptomatic)	*93%*	97.60%	92.49%	76.00%
31 day new treatment	*96%*	93.60%	97.97%	95.00%
62 day GP referral treatments	*85%*	73.80%	83.13%	74.30%
62 day screening	*90%*	94.90%	89.78%	75.10%
31 day subs - Surgery	*94%*	93.70%	95.38%	88.00%
31 day subs - Chemotherapy	*98%*	99.50%	99.74%	99.10%
31 day subs - Radiotherapy	*94%*	95.50%	98.13%	96.40%

The Trust has comfortably met the 2ww standard which hasn't been achieved since 2013/14. 2ww Breast symptomatic was just 0.5%% off the standard due to operational pressures which has been a national issue. This is reflected in the fact the Trusts performance was still over well above 19/20 national performance. The Trust has met the 31 day new cancer treatment standard for 20/21 (97.9%) which is the best performance since 2015/16. There have also been considerable improvements made in 62 day GP standard. The Trust achieved 83.1% which is the best performance since 2014/15. Please see appendix for annual performance figures.

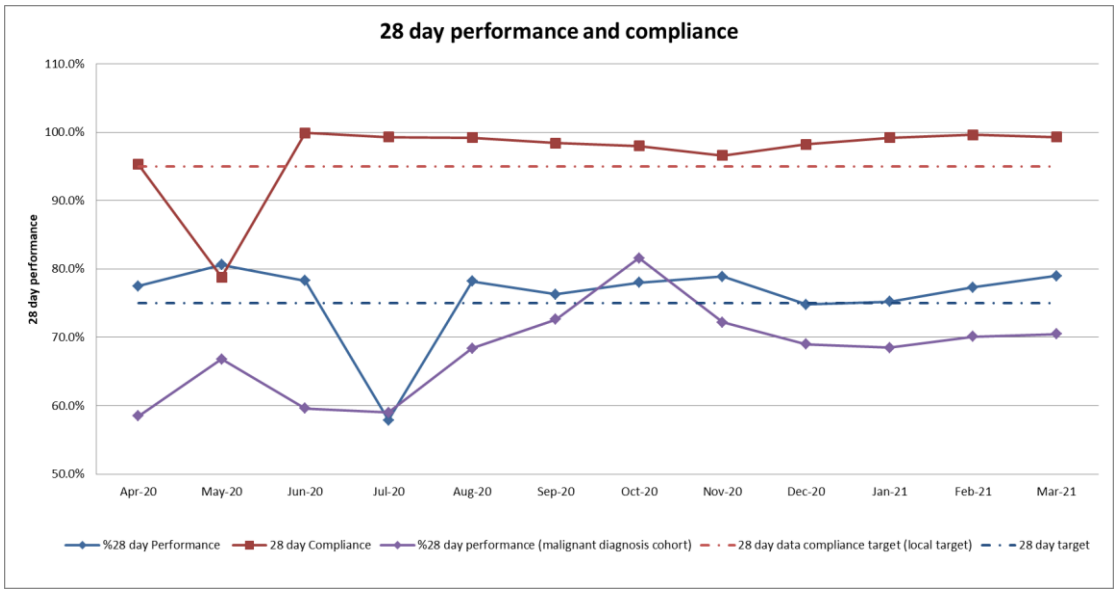
The Trust met the 62 day standard in five months between April 2020 and March 2021. This is in direct contrast to the national 62 day performance which has deteriorated.

This has been achieved through a number of improvements related to the Trust's delivery plan:-

- The cancer operating system, InfoFlex, was upgraded in December 2019, with continuous operational developments throughout 2020. This improved Cancer Services ability to track and expedite patients on suspected cancer pathways
- Considerable improvements in our Prostate pathway, the Trust introduced a straight to MRI pathway and new biopsy technique, deliverable within a clinic setting, with reduced side effects
- For Lower GI patients a new diagnostic test, qFIT, is now in place as a filter test prior to a 2ww Lower GI referral. Patients are now able to receive a benign diagnosis quicker without the need to have an invasive diagnostic in the form of colonoscopy. It also safeguards precious Endoscopy resource for the patients who need it, therefore delivering a faster diagnosis and treatment
- Introduction of consultant triage and 'see and treat' clinics in the Gynaecological cancer pathway in conjunction with speeding up the initial pathway, ensures the service delivers diagnostic tests in a timely fashion
- Launch of 'diagnostic bundles' that encourage the practice of arranging diagnostic tests in parallel to reduce the time to diagnosis and to treatment for lung cancer

Faster Diagnosis Standard

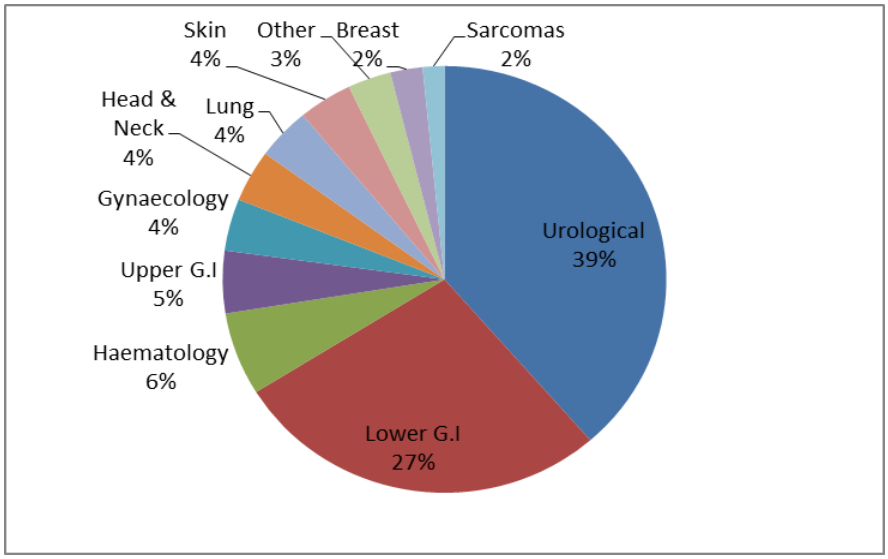
NHS England launched a new cancer standard in 2019 in the form of 28 day Faster Diagnosis Standard. Cancer Services prepared through 2019 to be ready for shadow reporting and eventual go live as a new standard in 2020. Cancer Services ensured Infoflex was adapted to collect the new data fields and worked with specialties to speed up respective diagnostic pathways. 28 day validated annual performance is 76% (target 75%) with only 3 months in 20/21 not meeting the standard (April, September and February – first and last being impacted by the pandemic). The work conducted in 2020 should ensure sustainable delivery of this new standard into the future.



Cancer Services Clinical Review

The NHSE *Managing long waiting cancer patients – policy on 'backstop' measures*) requires Trusts to have effective processes in place to review patient specific pathways and escalate approaches for delays. Cancer Services launched a new initiative to increase our focus and improve our process regarding patients treated for cancer who waited greater than 104 days. The cumulative total of patients across 20/21 can be found below and the breakdown between specialties.

Urological	**49**
Lower G.I	**35**
Haematology	**8**
Upper G.I	**6**
Gynaecology	**5**
Head & Neck	**5**
Lung	**5**
Skin	**5**
Other	**4**
Breast	**3**
Sarcomas	**2**
Total	**124**



Cancer patients who are "long waiters" or have been on the Patient Tracking List (PTL) for longer than 104 days, have been historically tracked and monitored within GHFT cancer services. A gap was identified where patient's clinical information could add to an overall understanding of the delays in patient pathways. The overall aim is to ascertain any lessons learned to improve future patient experience and management of cancer patients.

An experienced nurse with project management training within Cancer Services is responsible for undertaking a clinical thematic root cause analysis. A comprehensive record and detailed clinical timeline is created for each >104 cancer patient.

Each month, the GHFT Cancer General Manager sends a patient specific cancer clinical harm review request to the treating Consultant. A record of any appropriate Datix submission is included on the proforma which is subsequently addressed by the Trust's Datix team. Any level D/severe harm identified is addressed through the serious incident process. The patient's clinical harm status is recorded on the patient's InfoFlex record. Any patients that are perceived to have experienced potential clinical harm are discussed at an internal Cancer Services Clinical Review meeting to ascertain lessons learned. Please see Appendix for information on the new Clinical Review Group.

Number of 104 clinical harm requests sent (July 20 - April 2021	**78**
Awaiting return	**13**
Harm level A (no harm)	**67**
Harm level B (low harm)	**8**
Harm level C (moderate harm)	**2**
Harm level D (severe harm)	**1**

62 day Upgrades project

Background:

Having benchmarked against neighbouring Trusts of similar size, it was clear GHFT did not register enough treatments via the Consultant upgrade route (62 day Upgrades).

Issue:

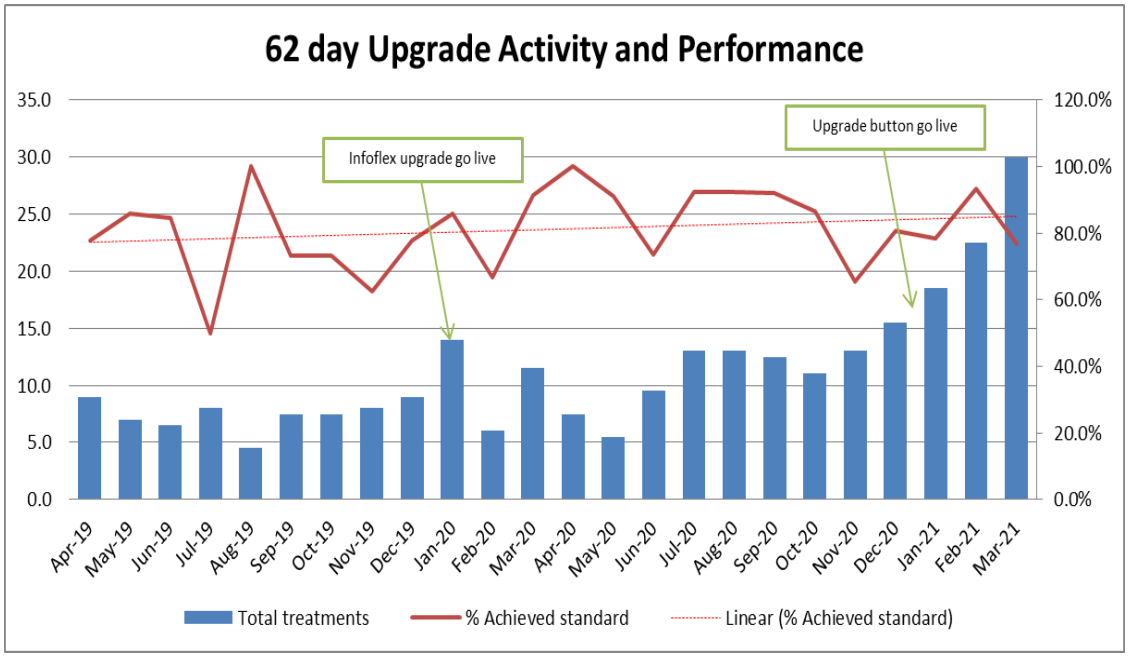
Patients do not benefit from the expedited pathways that can be achieved with the focused tracking of cancer services and the subsequent cancer diagnoses are not recorded (if not upgraded then Cancer Services has no knowledge of the treatment). Patients who are upgraded are often upgraded later within their pathway usually at the point of MDT discussion.

Solution:

Offer a simple technological solution with help from Digital colleagues that provides a 'button' on Trakcare Outpatient module for clinicians to press if they suspect cancer. This ensures the patient details are entered on Infoflex as part of our DATALINK between Trak and Infoflex.

Benefit:

Pre go live, the Trust averaged 20 upgrade treatments per Quarter. Post go live the number of treatments recorded rose by 250% to 71 in Q4 20/21 (see appendix for table). 62 day Upgrade performance over 20/21 also improved.



MDT Videoconferencing project

Cancer Services in conjunction with Countywide IT Services (CITS) delivered a project to time and scope with the aim to update our MDT videoconferencing equipment for state of the art equipment in three rooms (Oncology Seminar Room, Sandford Education Centre and Redwood Education Centre). The aim was to improve our connectivity between sites but also to utilise technology so clinicians could remotely dial remotely therefore saving time and transport costs. The second aim was to ensure clinicians could dial into MDTs at our satellite site in Hereford and other tertiary MDT's e.g. UHBirmingham and UHBristol.

Personalised Care

We will provide care that is tailored to your needs with the aim of improving your experience whilst in our care and quality of life

- **Primary aim for 20/21**

  Deliver Treatment Summaries and Supported Self-Management Pathways to at least phase 1 LWBC sites

- **Secondary aims for 20/21**

  Increased patient engagement / co-production of services. Increased community engagement in particularly with harder to reach communities

Despite the past 12 months, Cancer Services has continued to work towards delivering many aspects of Personalised Care. A significant achievement included the roll out of End of Treatment Summaries in the Breast Cancer Service which went live in November 2020; consisting of a telephone appointment with their Cancer Nurse Specialist to discuss their personal symptoms followed by a document summary of this conversation sent out in the post to the patient. The aim of an End of Treatment Summary is to empower patients to make informed decisions about their own health and well-being, in addition to improving communication between the Acute Trust and primary care, especially as we work towards an ICS. Patient evaluation forms were sent out to patients during the initial three months and we received 27 responses. All 27 patients felt that the information contained in the End of Treatment Summary was useful and 21 patients felt that the document felt personalised to them. As part of our continued delivery of personalised care, we aim to introduce End of Treatment Summaries to all cancer sites.

With the upgrade of Infoflex, there has been a focus on developing digital solutions to support specialities; an IT solution to support management of follow-up and surveillance tests has been implemented; ensuring that patients are adequately safety netted and allowing for more time to focus on patient care, meeting the needs of Cancer Nurse Specialists and Cancer Support Workers.

Remote Monitoring, using My Medical Record, has also been at the forefront of our agenda as part of delivering personalised care. My Medical Record was introduced to the trust in 2018, with Prostate patients on PSA follow-up being the first cohort of patients to enrol on the remote monitoring programme, PSA tracker. To date, there are 429 prostate patients registered.

Development has started for Colorectal and Breast cancer patients to have access to My Medical Record, with plans for further cancer sites to be added as part of a phased approach.

Lead Cancer Support Workers

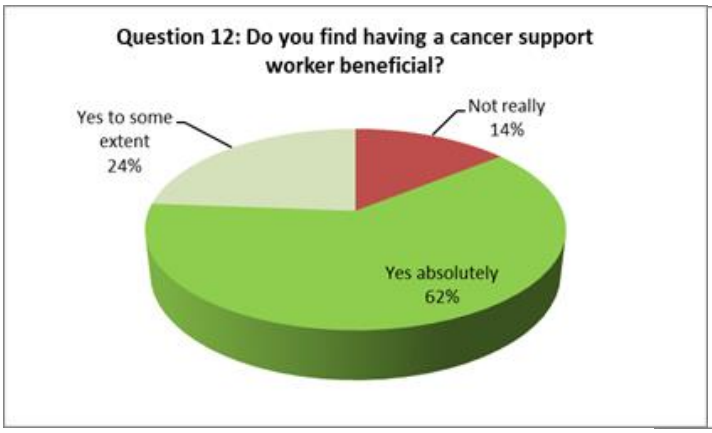
Feedback from the 2019 National Cancer Patient Experience Survey was the best the Trust had received to date and Deborah Lee acknowledged that this was a direct reflection of the work of the Cancer Support Workers. In July 2020 two Support Workers Supervisor roles were created to provide coordination and continue to develop the Cancer Support Worker (CSW) role whilst providing vital patient support through the pandemic.

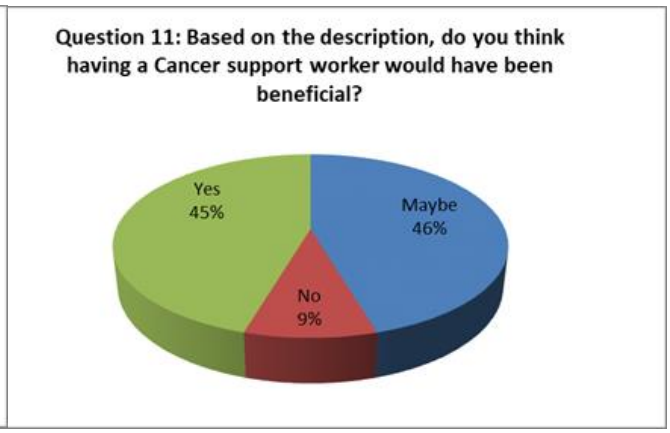
Initial focus was directed to Holistic Needs Analysis (HNA) and the disparity between actual activity and what was recorded on the eHNA platform (where HNA's are recorded). The upgraded Infoflex was adapted to offer a place to record patient contact, with the added benefit of providing visibility to CNS teams and clinicians.

- 2,521 HNA's were offered in 20/21. To date 66% of these patients have also been offered a Care Plan.
- Top concerns include worry and anxiety, thinking about the future and sleep/fatigue.

In April the first eHNA, Cancer Support Worker survey was sent to 249 patients diagnosed in October 2020. We had a 21% response rate.

Out of 45 patients surveyed so far, just under half (22 patients) indicated that they have a Cancer support worker. Of these 62% said they found having a cancer support work beneficial and 24% said they found having a cancer support worker beneficial to some extent. Of those that indicated that they do not have a Cancer Support worker, 45% said they think having one would have been beneficial.





Other work focused on:

- Introduction of a Cancer Support Worker lanyard
- Development of an induction programme for new CSW's
- Updating the CSW job description and person specification
- Establishing a CSW Council
- Working with the Macmillan Hub to set up a virtual patient platform
- Identifying gaps in CSW training and organising relevant training
- Networking with CSW's from other areas to share knowledge and experience with a view to setting up a CSW Forum with Herefordshire and Worcestershire.
- Organising and chairing regular CSW Team meetings and offering ongoing 1 to 1 support.
- Ongoing audit of care plans
- Identifying training needs for the CSW Team.

Social Media

Cancer Services increased its social media presence through 20/21 with a new Twitter Page in January 2020. It has provided an invaluable medium to communicate specific messaging such as:-

- Pandemic related messaging (see below)
- Self-help videos to support self-management
- Cancer awareness days such as Sun Awareness for example
- Raising cancer workforce profiles and what Cancer Services does

The Trust was aware of the reduction in referral levels during the first wave. The service was also aware of patients already referred reporting reticence for attending the hospital. In order to encourage patients to attend the hospital if they had a 2ww appointment post first wave, the Service in conjunction with Communications team developed a video that was sent out via Facebook and Twitter. On Twitter alone, this video was played 4,500 times.

Patient experience

We will provide care that places you as the patient at the centre and use your feedback to inform how our services are run and improved

- **Primary aim for 20/21**

  Continue to improve the Trusts results in the National Cancer Patient Experience Survey (=>8.9 rated care, >35 scores greater than national average, zero results associated with secondary care falling outside of lower expected range)

- **Secondary aims for 20/21**

  Increased patient engagement / co-production of services Increased community engagement in particularly with harder to reach communities

In 20/21 the Trust received the results of the 2019 National Cancer Patient Experience Survey which showed the best results the Trust has received to date, particularly pleasing given the emphasis the Trust has placed on improving results in this area. Due to the pandemic there is no mandatory requirement for the 2020 survey, however the Trust has volunteered to deliver the survey further highlighting the importance placed on getting it right for our patients.

	2015	2016	2017	2018	2019
Number of scores better than national average	21	32	14	12	34
Number of scores the same as national average	2	2	8	12	5
Number of scores worse than national average	26	18	30	28	13

Many of the planned improvements associated with patient experience were placed on pause due to the pandemic, the Lead Cancer Nurse the lead for the work stream was redeployed twice to support the Covid response. However, the Trust has recruited additional Clinical Nurse Specialists and Cancer Support Workers to bolster support to cancer patients whilst also collaborating with NHS England with a patient experience focused national Quality Improvement project

The Service participated in a National Collaborative QI Project with specific focus on creating videos in 4 different languages within the local South Asian community in Gloucestershire, to increase attendance in 2ww Gynae cancer clinics by 30% within 12 months

Macmillan Information Hub

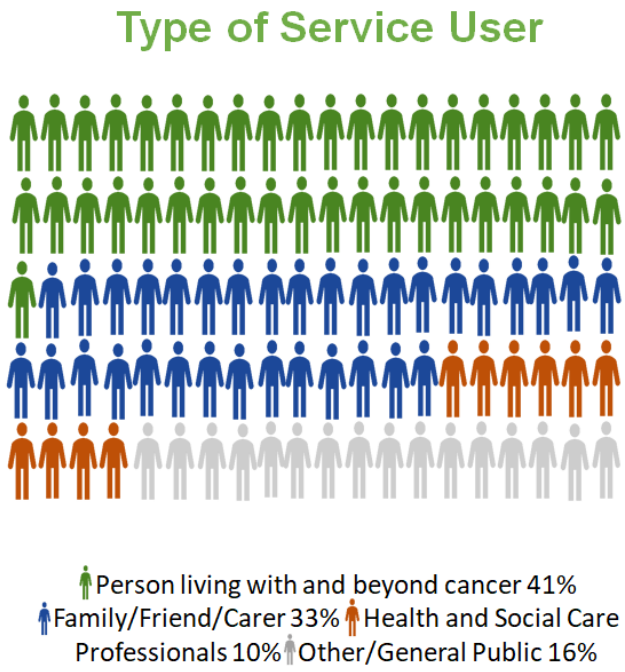
The Information Hub proved an invaluable asset during the pandemic; it became central to the Trusts Bereavement Patient Services Support, whilst our Hub Manager along with the invaluable Hub volunteers continued to support patients.
In total the service handed over in excess 600 items of belongings to the deceased patients next of kin.

The Hub had 773 visitors in 20/21. 20% of visitors were undergoing treatment; 18% of visitors were recently diagnosed. 15% of visitors were undergoing tests.

With the reduction of footfall in The Hub due to COVID-19 and the growing need for supporting patients remotely, the service introduced a specific 2WW telephone information service; to date 175 calls have been logged from patients who have been referred in on the 2 week wait pathway.

Patient Support
Service Hub

Understanding what to expect from the appointment followed by chasing of an outpatient appointment, were the primary reasons for patients initiating contact. The Clinical Nurse Specialist Team has been the most contacted service by The Hub, indicating how the Information Hub is now a critical aspect to joining up a patients care.



With COVID-19 reducing our ability to connect with the wider community the Hub quickly shifted focus to engage remotely, forming and hosting a Gloucestershire Cancer Services Network. Meeting every 8 weeks this has been an invaluable way for services to share information about the support they are able to provide patients as well as a platform as professionals to discuss the any challenges. This meeting is consistently supported by on average 15 different support services across the county.

- Regular attendance to Forest of Dean Connectors Forum; Hospital Network Meeting; Know Your Patch Events; Bereavement Forum
- Engagement with Gloucester University; Primary Care and Social Prescribers providing information on support on Cancer Services; Trust Patient Services Carer Focus Group
- Engagement with Macmillan Projects – e.g.; Digital Exclusion, Cancer in The Workplace
- Hosted various Cancer Awareness Events including; Colorectal, Skin, Head & Neck and Gynaecological

Cancer Prehabilitation

We will support you to ensure you are prepared as possible for your treatment

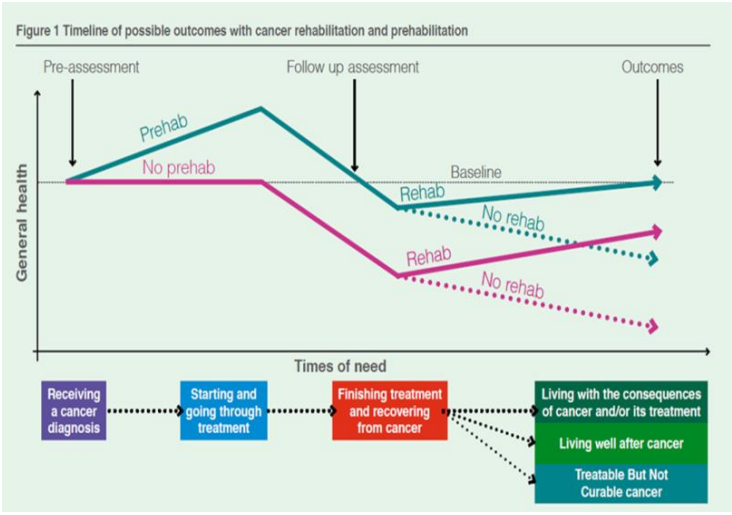
- **Primary aim for 20/21**

  Pilot cancer prehabilitation in two cancer sites

- **Secondary aim for 20/21**

  Develop a Trust wide Prehab business case and deliver to senior stakeholders

In 19/20 the Trust recruited an Allied Health Professional (AHP) Cancer Lead to work alongside the Lead Cancer Nurse. This was in appreciation of the importance of AHP's involvement within cancer patient's pathway and ensure AHP's workforce was represented within Cancer Services decision making. Scoping of AHP support across the Trust was conducted in late 19/20 and initiated several key work areas that are described below



The AHP analysis of the national picture for AHP's in cancer services identified Prehabilitation as a potential solution to many of the issues identified within the scoping. Prehabilitation has been widely used and recognised within the Enhanced Recovery after Surgery (ERAS) pathway as a way of helping patients prepare for surgery. There is a strong emerging field that these benefits also apply to patients undergoing SACT. Some of the key benefits include:-

- Offering an opportunity for patients to engage with AHP's early in the cancer pathway to improve their physical, nutritional and psychological wellbeing.

- Allowing AHP's to treat patients early in the cancer pathway.

- Providing proactive, less costly interventions.
- Focusing on self-management, personalised care and improving overall physical and mental health, increasing patient's resilience to treatments.
- Reducing the likelihood of going on to develop another cancer whilst improving overall health and wellbeing.
- Patients undergoing prehab are more resilient to treatment and restore their baseline level of function much sooner than those that do not receive prehabilitation. This means patients take control of their health and often report better patient experience.
- Allows AHP's to gain additional information on patients which can be used to inform MDT's in making treatment decisions.

A 3 month pilot was started from September to December 2021, with initial analysis looking promising (see Appendix for more information). On completion of the trial a successful Macmillan bid was placed to recruit a cancer prehabilitation team incorporating: - Physio, Dietetics and Psychology.

Upper GI Dietetic Input

Access to dietetics within the upper GI pathway was recognised as an issue by all professionals and patients in the pathway and contrary to NICE guidelines for Oesophageal and Stomach cancer. A number of patients often had to undergo more costly and intensive interventions later in the pathway, at times impacting on their cancer treatments. Following a successful business case raised through the risk register the service will soon be welcoming two dieticians into the upper GI pathway, allowing the service to meet the above guidelines.

Access to Psychology

Psychology access throughout the service is recognised as an unmet need. Referrals have been increasing year on year since 2016 and for the last 7 years there have been consistently over 300 referrals per year, demonstrating sustained demand. There were 353 referrals to cancer and palliative care psychology in 2019-2020, where the current service capacity according to professional guidelines with the current provision is 180 new referrals.

The service is therefore working at over 200% of its capacity, breaching professional guidelines for direct clinical work, and putting at risk the compliance of services with multiple NICE guidelines.

A successful bid was made to Macmillan to fund an additional Psychologist for two years. This will enable the service to review demand and trial different ways of working to support patients. The post will also review the impact on supporting our cancer workforce when dealing with cancer patients in distress.

Cancer Outcomes and Services Dataset

We will ensure we collect accurate data around your care and specifically your diagnosis to inform and improve our services

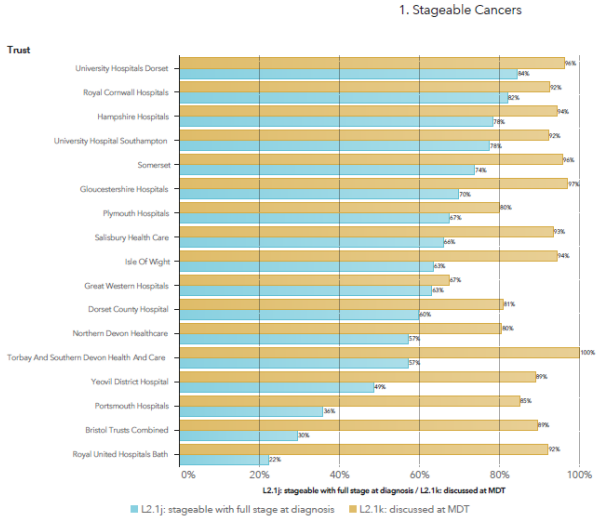
- **Primary aim for 20/21**

  Stageable cancer: 70% of records with a full stage at diagnosis.

- **Secondary aims for 20/21**

  65% of records have a CNS indication code submitted. 50% of patients discussed at MDT have performance status recorded. 50% of patients discussed at MDT with a full stage section.

The Cancer Outcome and Services Data set (COSD) has been the national standard for reporting cancer in the NHS in England since January 2013. The COSD dataset requirement is large and wide ranging, that requires MDT Coordinators to record cancer data related to patients. The Trust has identified COSD as an area for improvement as feedback from Public Health England shows we are outliers in key metrics. The Service has struggled to meet the demand in relation to COSD in 2019 and 2020 due to the pandemic, demands relating to the new 28 day Faster Diagnosis and general CWT performance. However there has been considerable improvement seen in 2021 where the Trust is now meeting the aims specified above in the latest NCRAS Performance update (May 21) . Cancer Services will continue to improve this data collection to ensure the Trust is providing the most accurate data possible.



Appendix – Impact Analysis from Covid Data tables

Number of patients diagnosed with cancer within the defined period

Specialties	2019/20	2020/21	% of expected	Number missing
Brain/CNS	1	1	100.00%	0
Breast	886	787	88.83%	-99
Gynaecological	270	314	116.30%	44
Haematological	113	163	144.25%	50
Head & neck	229	247	107.86%	18
Lower Gastrointestinal	524	557	106.30%	33
Lung	316	388	122.78%	72
Other	18	22	122.22%	4
Sarcoma	8	3	37.50%	-5
Skin	773	867	112.16%	94
Upper Gastrointestinal	391	454	116.11%	63
Urological	892	789	88.45%	-103
Grand Total	**4533**	**4616**	101.83%	83

Number of treatments delivered within the defined period

Quarters	Active Monitoring	Chemoradiotherapy	Other Treatment	Palliative care	SACT	Surgery	Teletherapy	Grand Total
Q1 19/20	59	35	3	89	229	540	53	1008
Q2 19/20	57	37	14	63	238	545	68	1022
Q3 19/20	46	19	6	71	243	509	47	941
Q4 19/20	50	27	8	90	287	538	59	1059
19/20	**212**	**118**	**31**	**313**	**997**	**2132**	**227**	**4030**
Q1 20/21	34	26	6	85	211	403	70	835
Q2 20/21	25	23	7	86	221	576	68	1006
Q3 20/21	58	34	9	115	262	538	46	1062
Q4 20/21	73	25	18	99	256	593	52	1116
20/21	**190**	**108**	**40**	**385**	**950**	**2110**	**236**	**4019**

Appendix – Annual CWT performance

Financial Year	2ww Performance	31 day new treatment Performance	62 day GP referral Performance
2013/14	93.91%	99.63%	82.94%
2014/15	91.93%	99.70%	84.33%
2015/16	90.82%	99.79%	78.47%
2016/17	89.27%	96.80%	75.60%
2017/18	82.33%	96.43%	75.50%
2018/19	90.07%	94.52%	77.80%
2019/20	92.56%	93.64%	73.80%
2020/21	94.72%	97.97%	83.10%

Appendix - Cancer Services Clinical Review Group

- A monthly Clinical Review group was formed in November 2020 to review patient cases where potential lessons learned could be discussed. Any patients for whom the delay to treatment may have direct clinical significance or potential clinical harm are discussed.
- The group comprises of senior members of the Cancer Services team.
- Pathway challenges and specific problems are scrutinised. Cases discussed to date include: identification of collective waiting time between appointments; delays in patient staging; review of clinical harm record; delays resulting from transfers out of Trust; support for patients awaiting a diagnosis.
- Resolutions have included changes in support offered to “long waiter” patients awaiting a diagnosis and therefore don’t have a CNS allocated; potential change for an early pick-up of radiology “red flag” reports.
- Positive lessons learned include the adaptation of services to expedite care during the Covid pandemic; A converse effect of being a long waiters is that the patient has more appointments where staff get to know and organise their needs. E.g. 104 patient X was seen by a Consultant the day after a LGI MDT with a CNS, family and an interpreter present.
- Actions and lessons learned are recorded and communicated to stakeholders on a case by case basis.

Appendix – 62 day Upgrades Annual and Quarterly data

	2018/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	2019/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	2020/21	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
Total Treatments	98.5	22.5	20.0	24.5	31.5	80.0	17.0	12.0	21.0	30.0	171.5	22.5	38.5	39.5	71.0
% Achieved	77.7%	82.2%	70.0%	71.4%	84.1%	72.5%	50.0%	83.3%	83.3%	73.3%	84.0%	86.7%	92.2%	77.2%	82.4%

Appendix – Hub User Feedback

I just wanted to say thank you for being there and putting my mind at ease …

A visitor to The Hub affected by cancer and worried about genetics.

Thank you for listening and being here to talk ….
Thanks received along with flowers .

A visitor to The Hub recently bereaved.

Popped by The Hub to say Thank you, I feel so well supported by you and grateful for your help…

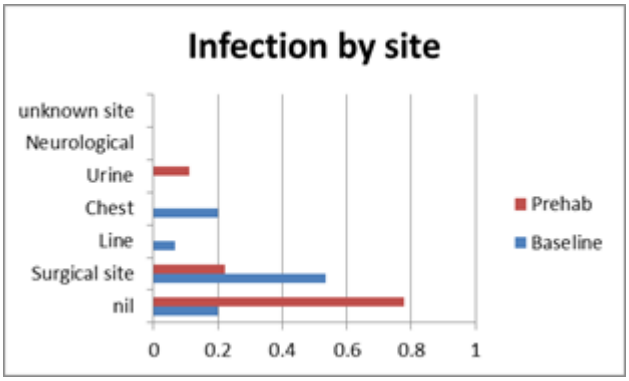
A visitor to The Hub receiving treatment for prostate cancer

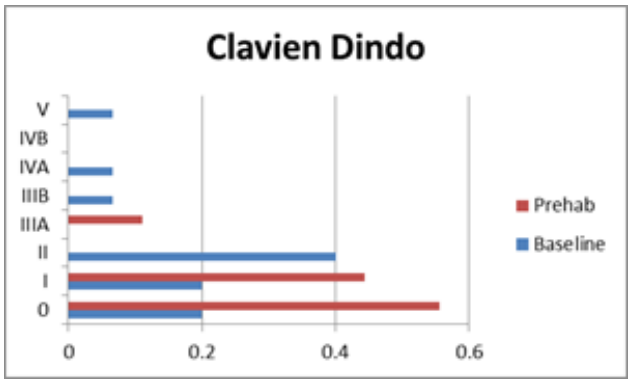
Thank you for all your help – you signposted us to Maggie's, helped us with benefits and the books you gave us were so helpful just wanted to pop by and say thank you …
A visitor to The Hub who is recently bereaved.

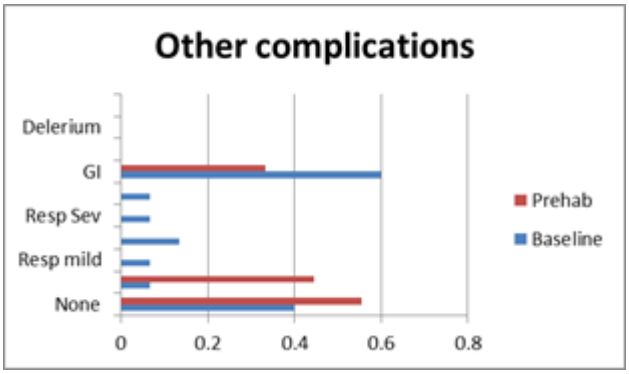
Just wanted to say thank you, you are always here and always wonderful…

A visitor to The Hub

Appendix – Prehabilitation trial results







Q4. To what extent do you feel the service helped you cope with your treatment?

Answer Choices	Responses
A lot	88.89%
A little	5.56%
Somewhat	5.56%
Not so much	0.00%
Not at all	0.00%

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC TRUST BOARD – 12 AUGUST 2021

Report Title
Feedback from our Journey to Outstanding (J2O) visits
Sponsor and Author(s)
Author: Andrew Seaton – Quality Improvement & Safety Director Sponsor: Prof. Steve Hams - Director of Quality and Chief Nurse
Executive Summary
Purpose This paper provides and update on the J2O visits completed from April – July 2021, during this time 17 visits have taken place. Key issues to note There have been 17 visits completed from April to July. The aim has been too slowly increase the rate of visits to 8 a month depending on the impact of COVID and availability lead directors. Most visits that were cancelled have been re-arranged and were due to work pressures either operational or at department level. Prior to each visit the areas are contacted to check the current position. The main themes remain the impact of COIVID and are reported in both positive and negative ways. Conclusions This brief paper provides an updated on the J2O visits completed in the last four months across the organisation. As we progress forward an increasing number of visits will be completed with a view to full restoration of visits towards the end of the autumn (subject to COVID-19 restrictions).
Recommendations
To RECEIVE the report as a source of assurance of leadership visibility and engagement with staff
Impact Upon Strategic Objectives
Outstanding Care, Quality Improvement and Involved People
Impact Upon Corporate Risks
Visits will support risk linked to engagement issues
Regulatory and/or Legal Implications
The visits will support the CQC Well led domain.
Equality & Patient Impact
Currently visits have to be virtual so some staff may not be able to engage
Resource Implications

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

Action/Decision Required

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

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Trust Leadership Team**	**Other (specify)**
Outcome of discussion when presented to previous Committees/TLT					
Not applicable.					

Gloucestershire Hospitals
NHS Foundation Trust

Feedback from our Journey to Outstanding (J2O) visits
August 2021

1 Introduction

This paper provides an update on the J2O visits completed from April – July 2021, during this time 17 visits have taken place.

2 Background

The purpose of the visit is for Executive and Non-Executive Directors to engage directly with colleagues and discuss issues associated with our Journey to Outstanding. The visits also support the Boards desire to achieve ward/department to Board reporting and is a key part of the Care Quality Commission Well Led domain.

The visit is designed to enable colleagues to share what is going well, what barriers there are to success and any key safety concerns affecting both staff and patients from a safety and experience view point.

In addition, the visits provide an opportunity for Board members to 'test' the delivery of strategy within the organisation and to actively receive feedback from colleagues.

During COVID, visits have been restricted to four per month and virtually through MS Teams, these have now been increased to eight per month and are completed in a mixed method both virtually and in person. This frequency will be continually reviewed depending on the impact and restrictions with COVID with the aim to reintroduce full in person sessions as restrictions allow.

Visits are co-ordinated and chosen based on results from the staff survey.

3 Visits completed

From April – July 2021 there were 24 booked visits of which 17 were completed.

April	May	June	July
• Ward 7b	• Mortuary services	• Antenatal services	• Rendcomb Ward
• Vascular clinics	• Histology	• Clinical Trials Unit	• Lillybrook Ward
• Chemotherapy outpatients	• Orthopaedic outpatients	• Ward 9b	• Children's Inpatient
• Bereavement services		• Lung Function	• Emergency Department, GRH
			• ACUC, CGH
			• Gloucester Birth Unit

4 Summary of key themes

The summary of the key themes are

- Recovery, restoration and staff well-being following waves one and two of COVID-19, with a recognition of increasing workload for some services.
- Responsiveness of organisational change to the changing dynamics of the pandemic was observed positively by all areas, but there was recognition that due to speed some individuals and teams felt communication could have been better.
- The need for wards to change from green to red during the pandemic was acknowledged, although many felt the process by which wards had been identified and sequencing should have been part of wider discussion.
- There was a strong sense of pride from all colleagues and a collective sense of togetherness.
- There was some sense of trepidation about what might happen in the future, with many feeling uncertain about rising case numbers and how that would impact on services.
- Ward based staffing was identified as an area of concern, annual leave and sickness during and after the first and second waves was more challenging to manage.
- There was some uncertainty from some support services about the 'Fit for the Future' programme and how that would impact on site working and specific patient pathways.
- Some frustration was expressed in the length of time it takes to get minor works completed, for example the Cheltenham vascular service have been waiting for some time to have new signage to help patients 'way find'.
- There was acknowledgement that some of services are 'Flagship' for example our bereavement service is a national demonstrator site, there was a keenness to share this wider within the organisation.
- Mortuary services and other less visible services played an important role during the COVID-19 pandemic, they have modified the way they work and have forged stronger partnerships with a range of partners to ensure families are well cared for.
- Some concern has been expressed about the availability of parking, specifically at the CGH site.
- The electronic patient record was being well received by ward teams and they recognised the benefits to patient care.

Twenty six actions were generated by the 17 visits; these are progress by respective executive directors working with divisional teams to ensure completion. The patient safety team follow up actions at quarterly intervals until they are closed.

5 Planned visits for August

The following visits have been planned for August 2021:

August

- Delivery suite
- Ward 5b
- Site management team
- Prescott Ward
- Histology clerical
- Emergency Department, CGH
- Gallery Ward

6 Conclusion

In conclusion, this brief paper provides an updated on the J2O visits completed in the last four months across the organisation. As we progress forward an increasing number of visits will be completed with a view to full restoration of visits towards the end of the autumn (subject to COVID-19 restrictions).

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – 12 August 2021

From the Quality and Performance Committee – Claire Feehily, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee held on 28 July 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	Quality Delivery Group focus on: • Update to sepsis action plan • Increase in C Diff rates • Significant backlog in children's discharge summaries with impact for GP records and compliance with Royal College requirements. Added to risk register and additional resources deployed. • Significant reduction in incidence of hospital acquired pressure ulcers.	Any reason to reassess current risk register scoring? Can we be assured that a developing backlog such as this would be spotted sooner in future? Discussion re levels of self-harm among	No Sources of assurance are QDG and divisional monitoring. Better systems of support needed prior to Acute	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		children and young people.	admission. Imminent system discussions described by CCG's rep. Outcome to be reported to Cttee.	
	Cancer reporting continued good performance and positive benchmarking for all indicators against regional and national comparators. 62 day target at 78%.	Discussion re position regarding primary care referrals.	Now seem to be back to pre-Covid levels. NB increased incidence of patients with cancers presenting in ED.	
	Planned care update with focus on RTT (74%) and numbers and actions regarding 52 and 104 week waits. Trust is performing relatively well within SW region. Confirmation of system for and progress made with communication with patients on waiting lists.	Discussion re patient comms. How far do financial considerations impact upon the recovery plans and what is the impact of continuing uncertainty about resource availability?	Website now in place and handover of responsibility in place. Confirmation of how activity is modelled against resourcing assumptions.	
	Unscheduled care briefing outlining significant ongoing demand pressures, performance remaining at 70%; significant levels of medically fit for discharge patients; staffing challenges but a new rotation in August. Improvement plan being	In light of current pressures, how is leadership team assuring itself of safety levels? Are there any further sources of support that are required?	Further support needed. Electronic Patient Record having a very positive impact. Patient Experience role being recruited to with a very specific remit. Focus is on triage. Things are very difficult in	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	developed. Ambulance service experiencing extreme pressure across region.		the department – as they are nationally. New doctors from August and new consultant appointments confirmed. Recruitment to some key nursing positions confirmed.	
		How might the thinking space be released to enable innovation in such a complex and challenging situation? How will current position impact on winter plans?	Recognition of need for specific leadership of systems flow and to focus on whole care pathway. COO leading the conversation with CCG and partners. Need for revision of plans given challenges of demand, COVID, norovirus, those at home needing treatment etc. Revised plans being worked up and will come to Cttee.	
	Maternity Delivery Group report containing updates on actions against leadership and governance review, response to Ockenden requirements and internal	Discussion regarding current RAG rating of action plans. What is the impact on morale with the level of red / ambers?	Level of Chief Nurse involvement in the service was described, together with oversight and Improvement processes / approaches. Absence of a	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	self-assessment against CQC standards.		Director of Operations has impacted adversely.	
Serious Incident Report	Report outlining numbers of new serious incidents (x1) and Never events (x0) within reporting period. Deeper look at complaints data reported.	From the case of a closed action plan, does it follow that when SI investigations are delayed that there is also a risk of delay to implementation of findings / improvements? What is the level of confidence that complaints performance improvements can be maintained?	No, in this case, while reporting was delayed, there had been earlier implementation of relevant changes. Levels of resources have been secured. Systems feel adequate at this time.	
Risk Register	Current status of existing risks including noting any emerging risks. New risk: to safety arising from nosocomial infection. Briefing regarding new initiative for Patient Safety Partners.	Discussion re context for considering whether the risk associated with >8 hr waits in ED should be added to register. Should the Covid risk associated with patients be extended to include a consideration of the risk to unvaccinated staff? What was the level of confidence relating to	Confirmed that it would be added prior to Trust Board consideration in August. CCG to consider as a system risk at its August Quality and Governance meeting. To be reviewed and brought back to Cttee. Confidence derived from experience of team and	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		the reduced score for risk of harm to patients? What are the actual intentions re recruitment of a staff member to support the IT project re sepsis patients? Is it a confirmed commitment? How many patients are within this group and potentially impacted?	data from those reviews that had been conducted. Yes, a firm commitment. Numbers unknown. To be confirmed.	
Learning from Deaths Report	Regular report for Cttee and Board including relevant comparative indicators (all within normal limits) and assessment of current performance of Structured Judgment Review (SJRs) process, feedback from families and spread of relevant learning. A positive report with some slippage in feedback from families, attributed to loss of direct contact especially with the Bereavement team, and a shift to online submission of data.	Is there confidence that SJRs were being completed openly and honestly?	Levels of quality control described together with the presentation of divisional SJRs to the Hospital Mortality Group.	
Infection Control Annual Report	Comprehensive presentation of the successes and challenges in the last year.	Confirmation that the team has been recognised nationally for		

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Recognition of expertise and leadership; analysis of incidence and trends by type; evidence of improvement in cleaning standards achieved in conjunction with GMS; response to Covid; ambitions for 2021/22.	innovation and improvement. Re Surgical Site Infection: What is known about the reasons for differential rates between Cheltenham and Gloucester and what are the intentions to address them? How is the morale in the team, given the pressures that are on this service?	Update in this aspect in next cycle of reporting. Very good, to be helped with addition of further posts. NB the outreach support that the team also provide to the wider infection control community in GHC and care settings.	

Claire Feehily
Chair of this meeting of Quality and Performance Committee
4 August 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 AUGUST 2021

Report Title
Financial Performance Report **Month Ended 30 June 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 3 to the Board.

Key issues to note

The Trust is reporting a ytd surplus of £134k, which is ahead of a breakeven position. Discussions continue with system partners to help manage the additional costs associated with RMNs.

System Position for H1

The Gloucestershire System has submitted a plan with a small surplus of £11k for H1 (April to September 2021).

Month 3 overview

Month 3 reports a £185k surplus in month, compared to £0k surplus, so is £185k better than plan in month. This is as a result of the reduction in Covid costs seen month on month.

Activity delivered 100% of the ytd 19/20 activity levels, and 106% of the June 2019 levels. This puts the Trust in a good position for Elective Recovery Fund (ERF) allocation. We expect to receive £2.371m of ERF for the YTD. This is £0.872m higher than originally planned for.

The Trust continues to experience pressure in ED and Paediatrics around mental health demand. This pressure has been raised and discussed at system level recognising the complexity of the challenge.

Conclusions

The Trust is reporting a year to date surplus of £134k, £134k better than the planned breakeven position.

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	

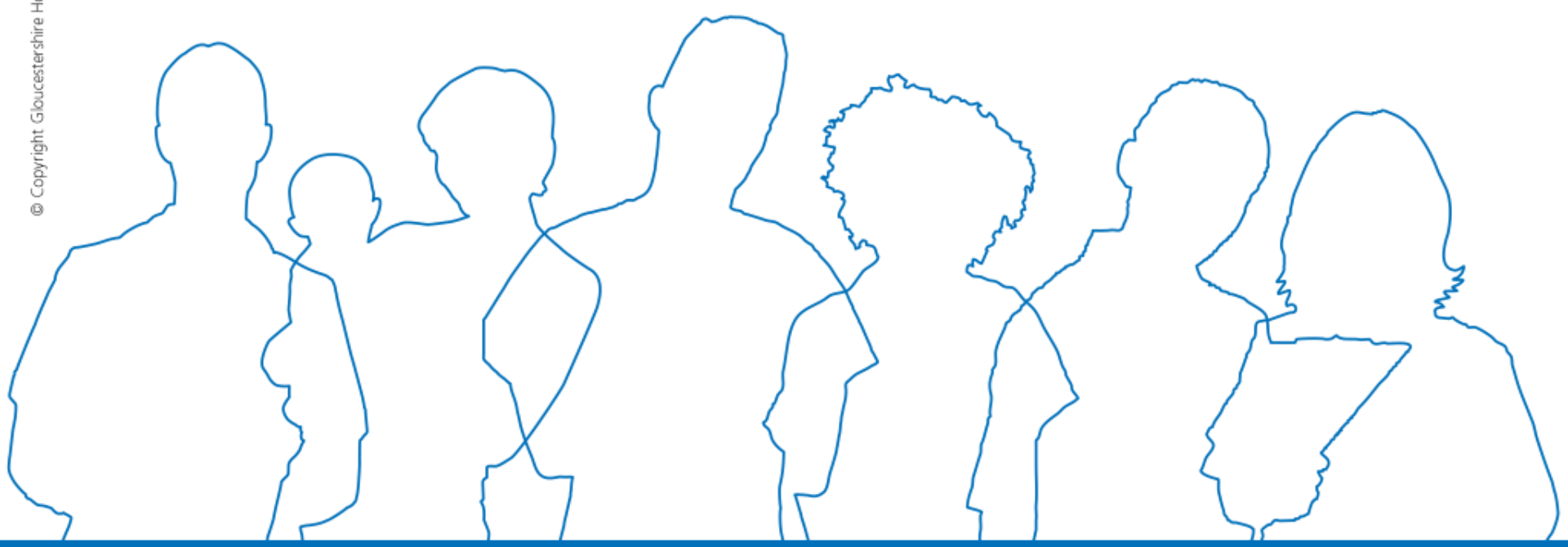
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

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)**
	29/07/2021						DOAG 15/07/2021
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 June 2021



Director of Finance Summary

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Activity delivered 100% of the ytd 19/20 activity levels, and 106% of the June 2019 levels. This puts the Trust in a good position for Elective Recovery Fund (ERF) allocation. We expect to receive £2.371m of ERF for the YTD. This is £0.872m higher than originally planned for, and reflects the additional costs of delivering levels of activity levels what for which we had planned.

The Trust continues to experience pressure in ED and Paediatrics around mental health demand. This pressure is has been raised and discussed at system level recognising the complexity of the challenge.

H1 / H2 and 2022/23 Planning update

We now understand that H1 will not be a hard close, but will continue into H2. H2 planning is expected to be complete by the end of October 2021 (already into H2), with 2022/23 planning to commence shortly after this.

Month 3 headlines

Gloucestershire Hospitals NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £134k surplus		Overall YTD financial performance is £134k surplus. This is £134k better than plan. The position reflects a reduced cost in Covid month-on-month, which has benefited the year to date pressure resulting from increased use of Registered Mental Health Nurses on agency rates. Given Covid activity increasing again, this is not expected to continue and the RMNs remain an issue being discussed in the system.
Income is better than plan at £163.2m YTD.		YTD £5.4m better than plan, predominantly due to £2.0m Salix grant funding (removed in the final reported position), £1.1m Covid (outside envelope) funding, £0.9m Elective Recovery Fund (ERF) above plan, £0.6m high cost drugs above plan, £0.5m correction to the treatment of car-parking income, where income and cost are now grossed up, £0.3m variable cost model devices (new NHSE funding flows M3 onwards) and £0.2m other income that offsets cost.
Pay costs are more than plan at £98.5m YTD.		YTD £0.6m worse than plan. Covid outside envelope were not included in the plan at £0.6m ytd, inside envelope is £0.2m underspent and the balance of £0.2m largely reflects the RMN pressures that we cannot contain within our position.
Non-Pay expenditure is more than plan at £60.5m.		YTD this is £2.7m worse than plan. The main drivers of this are the £0.9m activity-related costs that have been funded by ERF, £0.6m high cost drugs above plan, £0.4m Covid outside envelope costs excluded from the plan, £0.5m car parking costs now grossed up, £0.3m variable cost model devices, £0.3m prudent accruals for the CNST rebate, which we budget to receive but won't be confirmed until October / November 2021, less £0.1m in-envelope Covid underspends and £0.2m other underspends.
Financial Sustainability schemes are behind plan at YTD.		The Trust has a target of £2.5m efficiencies for H1 in order that the system plan breaks even. As at Month 3 the H1 forecast identifies £2.9m. For the YTD, delivery is at £0.4m, £0.4m behind plan due to the late cash transfer of a NHSSC rebate which is still expected in the coming months
The cash balance is £67.1m.		

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).

Month 2 to month 3 improved by £223k. The net value is mainly due to the Covid costs reducing month on month, as well as a slight reduction in RMNs. There were also net neutral changes month on month due to the new pharmacy system issues resolving on a year to date basis, offset by additional pass-through income, as well as Elective Recovery Fund income and cost.

6 months' Run Rate Actuals	2020/21			21/22			Month 2 to Month 3 change
	M10	M11	M12	M01	M02	M03	
Pay	(36,450)	(30,462)	(55,297)	(32,036)	(32,033)	(32,748)	(715)
Non Pay	(19,649)	(19,057)	(28,939)	(19,117)	(19,401)	(20,761)	(1,360)
Covid Costs (in envelope)	(1,447)	(1,727)	(1,504)	(682)	(671)	(481)	190
Covid Costs (outside envelope)	(820)	(553)	(531)	(458)	(349)	(261)	88
Non-operating Costs	(750)	(743)	148	(639)	(844)	(745)	99
Remove impact of Salix Grant						(1,966)	(1,966)
Remove impact of Donated Asset Depreciation / impairments	37	37	(1,158)	37	59	48	(11)
Total Cost	(59,079)	(52,505)	(87,281)	(52,895)	(53,239)	(56,914)	(3,675)
Run Rate Funding / Billable Income	58,027	55,812	86,794	51,924	52,352	55,467	3,115
Est Elective Recovery Fund Income				500	500	1,371	871
Covid Income (outside envelope)	816	568	530	458	349	261	(88)
Total Surplus / (Deficit)	**(236)**	**3,875**	**43**	**(13)**	**(38)**	**185**	**223**

M3 Group Position versus Plan

Gloucestershire Hospitals NHS Foundation Trust

The financial position as at the end of June 2021 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity, and excludes the Hosted GP Trainees (which have equivalent income and cost) each month.

In June the Group's consolidated position shows a £134k surplus. This is £134k better than plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 3 Financial Position	YTD Plan £000s	YTD Actuals £000s	YTD Variance £000s	YTD Plan £000s	YTD Actuals £000s	YTD Variance £000s	YTD Plan £000s ***	YTD Actuals £000s	YTD Variance £000s
SLA & Commissioning Income	143,561	146,850	3,289				143,561	144,478	917
PP, Overseas and RTA Income	1,044	858	(186)				1,044	857	(187)
Other Income from Patient Activities	1,658	2,064	406				1,658	2,067	409
Elective Recovery Fund	1,500	2,371	871				1,500	2,371	871
Operating Income	9,070	10,433	1,363	15,156	15,672	516	9,988	13,410	3,422
Total Income	**156,833**	**162,575**	**5,742**	**15,156**	**15,672**	**516**	**157,751**	**163,183**	**5,432**
Pay	(92,515)	(93,355)	(840)	(5,469)	(5,225)	244	(97,819)	(98,461)	(642)
Non-Pay	(62,673)	(65,477)	(2,804)	(9,117)	(9,824)	(707)	(57,844)	(60,537)	(2,693)
Total Expenditure	**(155,188)**	**(158,832)**	**(3,644)**	**(14,586)**	**(15,049)**	**(464)**	**(155,663)**	**(158,998)**	**(3,335)**
EBITDA	**1,645**	**3,743**	**2,098**	**571**	**623**	**53**	**2,088**	**4,185**	**2,097**
EBITDA %age	**1.0%**	**2.3%**	**1.3%**	**3.8%**	**4.0%**	**0.2%**	**1.3%**	**2.6%**	**1.2%**
Non-Operating Costs	(1,786)	(1,786)	0	(571)	(623)	(52)	(2,229)	(2,228)	1
Surplus / (Deficit)	**(141)**	**1,957**	**2,098**	**0**	**0**	**0**	**(141)**	**1,957**	**2,098**
Fixed Asset Impairments									
Surplus / (Deficit) after Impairments	**(141)**	**1,957**	**2,098**	**0**	**0**	**0**	**(141)**	**1,957**	**2,098**
Excluding Donated Assets & Salix Grant	141	(1,823)	(1,964)				141	(1,823)	(1,964)
Control Total Surplus / (Deficit)	**0**	**134**	**134**	**0**	**0**	**0**	**0**	**134**	**134**

* Trust position excludes £8.6m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £14.8m of inter-company transactions, including dividends

*** YTD Plan excludes ICS-agreed cost and income for ERF-related transactions. These have been removed as the profile of this is in discussion.

M3 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS Foundation Trust

Consolidated Group Summary

Month 3 Financial Position	M03 Plan £000s	M03 Actuals £000s	M03 Variance £000s	M03 Cumulative Plan £000s	M03 Cumulative Actuals £000s	M03 Cumulative Variance £000s
SLA & Commissioning Income	48,473	48,272	(201)	143,650	144,478	828
PP, Overseas and RTA Income	348	211	(137)	1,044	857	(187)
Other Income from Patient Activities	523	655	132	1,569	2,067	498
Elective Recovery Fund	500	1,371	871	1,500	2,371	871
Operating Income	2,740	6,590	3,850	9,988	13,410	3,422
Total Income	**52,584**	**57,099**	**4,515**	**157,751**	**163,183**	**5,432**
Pay						
Substantive	(29,323)	(29,450)	(127)	(87,971)	(87,130)	841
Bank	(1,523)	(1,866)	(343)	(4,917)	(5,835)	(918)
Agency	(1,410)	(1,250)	160	(4,230)	(3,984)	246
Locum	(350)	(576)	(226)	(701)	(1,512)	(811)
Total Pay	**(32,606)**	**(33,142)**	**(536)**	**(97,819)**	**(98,461)**	**(642)**
Non Pay						
Drugs	(6,487)	(7,562)	(1,075)	(19,461)	(20,220)	(759)
Clinical Supplies	(4,454)	(4,172)	282	(13,362)	(12,039)	1,323
Other Non-Pay	(8,341)	(9,371)	(1,030)	(25,022)	(28,277)	(3,255)
Total Non Pay	**(19,282)**	**(21,105)**	**(1,823)**	**(57,845)**	**(60,536)**	**(2,691)**
Total Expenditure	**(51,888)**	**(54,247)**	**(2,359)**	**(155,664)**	**(158,997)**	**(3,333)**
EBITDA	**696**	**2,852**	**2,156**	**2,087**	**4,186**	**2,099**
EBITDA %age	**1.3%**	**5.0%**	**(3.7%)**	**1.3%**	**2.6%**	**(1.2%)**
Non-Operating Costs	(743)	(745)	(2)	(2,229)	(2,228)	1
Surplus / (Deficit)	**(47)**	**2,107**	**2,154**	**(142)**	**1,958**	**2,100**
Fixed Asset Impairments	-	-	-	-	-	-
Surplus / (Deficit) after Impairments	**(47)**	**2,107**	**2,154**	**(142)**	**1,958**	**2,100**
Excluding Donated Assets & Salix Grant	47	(1,922)	(1,969)	142	(1,824)	(1,966)
Control Total Surplus / (Deficit)	**0**	**185**	**185**	**0**	**134**	**134**

SLA & Commissioning Income – Most of the Trust income continues to be covered by block contracts. Pass-through drugs income is also shown here.

Elective Recovery Income – includes over-delivery of elective recovery performance

Operating income – This includes additional income associated with services provided to other providers, including the regional Covid testing centre (excluded from the plan).

Pay – Temporary staffing costs remain high, although these do include those costs of Covid outside envelope services (offset by income). Medicine Division ward rotas are being reviewed in July to validate mix of HCA / RGNs and update budgets where necessary.

Non-Pay – above plan, mainly due to pass-through drugs (offset by income, ERF-related costs and outside envelope Covid costs).

Forecast as at M03

Gloucestershire Hospitals NHS Foundation Trust

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 achieve a surplus of £11k. As at Month 3, this forecast remains current for the bottom line, and includes our estimates of Covid-19 outside envelope income and cost. There was a requirement to exclude Covid outside envelope costs from planning, but the impact is expected to be net neutral. It relates to our SIREN Covid work, testing capacity and vaccination activity, and is reimbursed by NHSEI on validation of costs.

Consolidated Position M03	H1 Forecast
Pay	192,787
Non Pay	113,013
Pay - Covid excl RAG (in envelope)	3,300
Non Pay - Covid excl RAG (in envelope)	3,094
Covid Costs excl RAG (in envelope)	6,394
Pay - Covid (outside envelope)	1,276
Non Pay - Covid (outside envelope)	3,113
Covid Costs (outside envelope)	4,389
Non-operating Costs	4,461
Remove impact of Salix Grant	
Remove impact of Donated Asset Depreciation	(283)
Total Cost	320,761
Run Rate Funding / Billable Income	(312,506)
Estimated Elective Recovery Fund Income	(3,871)
Covid Income (outside envelope)	(4,389)
Total (Surplus) / Deficit	**(5)**

Balance Sheet

Gloucestershire Hospitals NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2021 £000	GROUP Balance as at M3 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	7,995	(285)
Property, Plant and Equipment	276,161	279,226	3,065
Trade and Other Receivables	6,149	6,116	(33)
Total Non-Current Assets	**290,590**	**293,337**	**2,747**
Current Assets			
Inventories	8,934	9,258	324
Trade and Other Receivables	18,054	24,929	6,875
Cash and Cash Equivalents	77,216	67,146	(10,070)
Total Current Assets	**104,204**	**101,333**	**(2,871)**
Current Liabilities			
Trade and Other Payables	(87,606)	(89,685)	(2,079)
Other Liabilities	(11,585)	(7,796)	3,789
Borrowings	(3,404)	(3,404)	0
Provisions	(10,824)	(10,824)	0
Total Current Liabilities	**(113,419)**	**(111,709)**	**1,710**
Net Current Assets	**(9,215)**	**(10,376)**	**(1,161)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,380)	137
Borrowings	(37,438)	(37,208)	230
Provisions	(2,892)	(2,888)	4
Total Non-Current Liabilities	**(46,847)**	**(46,476)**	**371**
Total Assets Employed	**234,528**	**236,485**	**1,957**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	332,033	0
Reserves	27,975	27,975	0
Retained Earnings	(125,480)	(123,523)	1,957
Total Taxpayers' Equity	**234,528**	**236,485**	**1,957**

The table shows the M3 balance sheet and movements from the 2020/21 closing balance sheet. The opening balances have been adjusted to reflect the final audited position for 2020-21.

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Committee is asked to:

- Note the Trust is reporting a year to date surplus of £134k.

Authors:	**Johanna Bogle, Associate Director of Financial Management** **Caroline Parker, Head of Financial Services**
Presenting Director:	**Karen Johnson, Director of Finance**
Date:	**July 2021**

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD – 12 AUGUST 2021

Report Title
Digital & EPR Programme Update
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 work streams and projects within GHFT, as well as business as usual functions. The progression of this agenda is in line with our ambition to become a digital leader.

Key Issues to Note

- TCLE, the new Pathology Laboratory Information System (LIM), went live on Wednesday 23rd June (with the exception of Blood Transfusion, which was removed from scope to facilitate the transition and will be progressed at a later date).
- Outpatient areas are now using Sunrise EPR to view new results and create patient lists, as well as some GHC staff having read only access to results.
- Cheltenham MIIU transition to consultant-led service went live on Wednesday 9th June and moved to 24-hour operating on 30th June 2021 - with additional documentation.
- GRH ED went live with full functionality Sunrise EPR on 7th July 2021.
- The latest Sunrise patch release, 'Patch 71' (the latest revision of 'Patch 69'), which fixed existing issues with EPR Tracking Boards, was applied on 27th May.
- A decision was taken to hold the launch of the Sepsis Pathway on EPR and this will go live in the autumn.
- Planning activities are continuing for the recommended upgrade of Sunrise EPR to version 20.

Conclusions

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

Implications and Future Action Required

As services continue to move on-line and with an increase in remote working, demand for digital support is increasing.

Recommendations
The Group is asked to note the report.

Impact Upon Strategic Objectives							
The position presented identifies how the relevant strategic objectives will be achieved.							
Impact Upon Corporate Risks							
Progression of the Digital agenda will allow us to significantly reduce a number of corporate risks.							
Regulatory and/or Legal Implications							
Progression of the Digital agenda will allow the Trust to provide more robust and reliable data and information to provide assurance of our care and operational delivery.							
Equality & Patient Impact							
Progression of the Digital agenda will improve the safety and reliability of care in the most efficient and effective manner.							
Resource Implications							
Finance				Information Management & Technology			**X**
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	**X**

TRUST PUBLIC BOARD – 12 AUGUST 2021

DIGITAL & EPR PROGRAMME UPDATE

1. Purpose of Report

This report provides updates and assurance on the delivery of digital projects within GHFT, as well as business as usual functions within the digital team. This includes Sunrise EPR, digital programme office, information governance and IT. The progression of the digital agenda is in line with our ambition to become a digital leader.

2. Sunrise EPR Programme Update

This report provides status updates on Sunrise EPR work-streams and interdependent digital projects. Detailed information on each work-stream, including RAG status is provided in the report.

2.1 EPR High Level Programme Plan

The programme plan below details the EPR functionality already delivered and planned for 2021/22. **Blue indicates projects already delivered.*

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 (EMIS)	April 2021	April 2021
HDS (ward handover list)	May 2021	12th May 2021
Cheltenham MIIU transition to ED (additional functionality & training)	9 June 2021	9 June 2021
TCLE – replacement lab system (replacing IPS)	23 June 2021	23 June 2021
Gloucester Emergency Department (all functionality)	7 July 2021	7 July 2021
Sepsis documentation	7 July 2021	On hold

Order Communications (theatres & outpatients)	TBC	
Electronic Prescribing & Medicines Administration (known as EPMA)	March 2022	

3. EPR Project Summaries and Status Updates

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

3.1. New pathology system (TCLE)

TCLE (the replacement pathology system, replacing IPS) went live on Wednesday 23rd June after three years of planning and preparation. This is the first go live of the InterSystems lab system – known as TCLE - in the UK. As such we have experienced a larger number of issues than in any of our EPR go lives to date - which although frustrating, is to be expected when you are 'first to go'.

Go live support from the digital team, working closely with pathology staff, particularly the lab leads, was in place for the first two weeks of go live based in the Chestnut House Command Centre. This involved 24 hour floor walking cover in both CGH and GRH labs. During this period, three issues calls took place every day to monitor system success and performance. Regular updates and liaison also took place with CCG and GHC colleagues impacted by the change.

In tandem with this, we took our first step into outpatients, with clinicians given access to Sunrise EPR (many for the first time) to view results. The old IPS system will no longer receive new results other than blood transfusion, which we hope to make available on EPR later in the year. Clinicians can still access IPS to view historic results.

Management of TCLE issues now sits with the pathology team who are working closely with InterSystems to fix remaining issues and support staff. Digital representatives (interfacing, EPR and IT) are attending daily calls to support this.

InterSystems have also provided two mini-upgrades (known as AdHocs) to fix some system performance issues experienced in the first few weeks.

3.2. Sunrise EPR in Gloucester ED

Gloucester Emergency Department went live as planned on Wednesday 7th July. A full EPR go live support team was put in place to support clinical, administrative and operational staff. ED has gone live with full EPR clinical functionality, including clinical assessment, triage, safety checklists, observations, requests and results and bed requesting.

Covering three shifts a day over 24 hours, four EPR floorwalkers and one data quality floor walker covered ED, MIU, GPAU, SAU and AMU. Between 10 to 15 digital and information staff have been involved in supporting ED on every shift.

During the first two weeks of go live, ED has experienced some of its highest patient attendances of the year so far. Despite this, staff have truly embraced the system and worked hard with the EPR support staff to make the transition from paper as smooth as possible. We will continue support for a minimum of four weeks, with a review taking place each week. In week three we were able to step down to one floor walker a shift and one issues call per day. A huge thank you to senior clinicians and operational teams for their support and commitment to making EPR a success in ED. More detail will be reported to DCDG and F&D once go live period has ended. First two weeks in numbers:

- 5,676 patients noted on EPR
- 1,704 ambulance attendances logged in EPR
- 7,752 patient documents completed
- 8,032 NEWS flowsheets completed

3.3 Sepsis pathway on EPR

Digitising the Sepsis pathway using EPR is one of a number of actions being taken to improve early identification of deteriorating patients.

It was hoped that the EPR Sepsis Pathway could be rolled out to all adult inpatient wards on 7th July, to coincide with Sunrise EPR go live in ED. The configuration and build is ready to go and user acceptance testing has taken place.

However, after reviewing the go/no go criteria a decision has been made to postpone it for the following reasons:

- Operational pressures and lack of availability of clinical teams responsible for the pathway to support training, go live and embedding of a new process.
- The need for additional floor walking resource and wider training support – at a time when the focus will be on supporting a major change in ED.
- Opportunity to brief the new intake of Junior Doctors in August before launching the tool.

It was agreed by the CCIO and CDIO that the Sepsis work stream would continue to push forward with the project and re-plan a date for launching to inpatient areas and ED. The group will report into EPR Programme Delivery Group on a weekly basis

3.4 EPR Programme RAG Status Updates

The highlight reports below provide more detail on the status of live EPR projects. This update is correct as reported to EPR Programme Delivery Group on Tuesday 20th July .

Title:	Deteriorating Patients / SEPSIS	
Current Project RAG Status:	R	Scope:
RAG status against programme:	R	• To build a solution to identify deteriorating patients in inpatient areas of the Trust and alert clinicians to assess and give appropriate treatment • Digitise the SEPSIS pathway to take the right action at the right time and record ongoing care as a result

RAG Status	Work stream	Update
G	Benefits & Clinical Engagement	Benefits assumptions in place. Comms and wider clinical engagement needs review, in line with training
G	Configuration	Configuration testing has completed.
G	Testing	UAT has been completed.
R	Training	Training QRG is ready and video produced. Feedback from clinicians was to reconsider approach and deliver via e-learning. For discussion at workstream.
G	Reporting	Usage reporting being developed by BI once metrics have been confirmed post Go-live.
G	Cutover	Cutover plan ready. OIA not completed and needs review from SEPSIS/Deteriorating patient group leads.

Overall Status:

- Decision made by Senior Leads and CCIO not to go live as planned on 7 July
- Re-planning of project underway with clinical input on training requirements
- Engagement plan will be developed to support embedding of solution once live

Title:	Electronic Medicines Management (eMM)	
Current Project RAG Status:	A	Scope:
RAG Status against Programme:	A	• Deliver a seamless flow of information between prescribing, pharmacy and administration processes.

RAG Status	Work stream	Update
G	Benefits & Clinical Engagement	Baseline data scoped.
G	Configuration	eMM module & config has been applied to the test environment and is available for testing.
G	Testing	Ward and Pharmacy test scripts written
G	Training	EMIS Super User training was delivered by 10 June, End user training to be delivered by pharmacy
G	Site Readiness	Printers ordered and site audits to be booked with CITS. Charging cabinets still yet to be ordered.
G	Cutover	The cutover approach has already been agreed, based on individual wards going live one by one.

Overall Status:

Pharmacy are currently re-assessing the resource availability to confirm whether the current full go-live timescales are achievable, with a view to re-planning. Early adopter areas can go live as planned.

Title:	SCM Upgrade to V20.0		
Current Project RAG Status:		G	Scope:
RAG Status against Programme:		G	• To upgrade Sunrise EPR to version 20, unlocking features that will enable the implementation of ePMA.

RAG Status	Work stream	Update
G	Benefits & Clinical Engagement	The Project Manager has met with the Benefits Lead – there is a need to define and agree measurable benefits.
G	Configuration	The Project Manager has requested a meeting with Allscripts to review arrangements around the internal resourcing required. Meeting to take place w/c 14 June.
G	Testing	Testing needs to be completed before ePMA testing commences, which is planned for mid-October.
G	Training	It is expected that there will be no requirement for a significant change to existing training and any revisions can be dealt with using QRGs and communications.
G	Site Readiness	An Infrastructure Design review has taken place.
G	Integration	A CCN and Outline Implementation Plan to be reviewed and signed off in order for configuration work to commence from 05 July.
G	Cutover	Cutover planning activities being confirmed for submission to PDG

Overall Status:
This project is in establishment phase and undergoing rapid development in order to ensure that the requirement to upgrade Sunrise EPR does not delay progress of the wider Digital programme. AllScripts have provided a CCN and an Outline Implementation Plan.

Title:	Onbase/VNA Document Management System	
Current Project RAG Status:	G	Scope:
RAG Status against Programme:	G	• To implement Onbase (document management system) an addition to the Trust's VNA storage platform, and integrate with Sunrise EPR and other clinical systems.

RAG Status	Work stream	Update
G	Benefits & Clinical Engagement	The Benefits Lead has met with Rob Allcock. Discovery sessions have taken place, with one remaining, scheduled to take place 18 June. The outputs of the Discovery sessions will be reviewed at the following: Project Team meeting – 24 June; Clinical Documentation Group – 01 July; PDG – 06 July.
G	Configuration	The Project Manager and Clinical Systems Lead have met to discuss resourcing, which will be required for testing, training and implementation (observation). A document assets list was reviewed at the last project meeting and a full list will be circulated to the project group for further inclusions, to be reviewed and prioritised on 22 June and shared with the group on 24 June.
G	Testing	A test plan to be developed following the Discovery sessions.
G	Training	Training will initially be delivered by Hyland for one day and then internal training will commence for end user and back office – a Training Plan will be developed based on the outputs of the Discovery sessions.
G	Site Readiness	Server set up is currently underway.
G	Integration	Plan to be confirmed.
G	Reporting	Pending approach and plan around legal services reporting and auditing.
G	Cutover	Plan to be created post Discovery sessions and agreed with Hyland.

Overall Status:
Discovery sessions are currently taking place and are due to complete on 18 June. The document assets list has been produced and reviewed. The project timeline has been reviewed and brought forwarded to December 2021 – dates to be finalised.

Title:	EPMA		
Current Project RAG Status:		G	Scope:
RAG Status against Programme:		G	• implementation of electronic prescribing and medicines administration

RAG Status	Work stream	Update
G	Benefits & Clinical Engagement	iMPACT benefits are currently being baselined. The Benefits Lead is reviewing Pharmacy data to establish appropriate data for baselining. The PID is to be taken back to work stream on 15 June, following previous feedback.
G	Configuration	Configuration progress: Design Dictionaries – 100% Build Dictionaries – 95% Load Dictionaries – 90% DC Concept Design Tranche 1 of 9 • Draft tranche – 100% • Review – 90% • Build work – 90% • Upload – 15 June DC Concept Design Tranche 2 of 9 • Draft tranche – 100% • Review - pending • Build work - pending • Upload – pending DC Concept Design Tranche 3 of 9 • Draft tranche – 15% • Draft VTM concepts – 100%
G	Testing	Testing is due to commence in November 2021. A plan is being drafted by the Test Lead.
G	Training	Training is due to commence 31 January 2022. The Project Manager and Training Lead are meeting on a monthly basis.

G	Site Readiness	Equipment and infrastructure will need to be delivered in line with the future states. Pharmacy requirements are in place. Initial discussions for ward requirements have commenced.
G	Integration	Dictionary mapping – 100% complete.
G	Reporting	This will be monitored as an ongoing activity. BCP and Reporting scope work is due to commence on 06 August.
G	Cutover	Cutover planning is due to commence 28 January 2022.
Overall Status:		
SCM dictionaries have now been fully mapped to EMIS dictionaries.		

3.5 Activity Planned for Next Period

- The HDS functionality uptake and usage will continue to be monitored and pushed.
- Order Comms theatres and outpatients planning will continue.
- Sepsis/Deteriorating work stream will continue.
- Focus on EMM, upgrade of SCM and EPMA.

3.6 Risks

Current major risks to the project timeline and successful outcomes:

- It is a pre-requisite that Sunrise be upgraded to version 20.0 prior to ePMA testing commencing (due to the bug fixes required) and any delay to the upgrade will delay ePMA testing and go live.

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 one project has been completed and closed and one project has gone into closure.

There are currently thirty new project requests in various stages of processing from receipt and triage to awaiting project launch.

- The ChemoCare Data Migration project has been closed.
- The DOCMAN10 - Transfers of Care project has moved into closure.
- Two projects are either in closure or have been closed during the last period.
- A number of projects have temporarily moved to On Hold status owing to resource commitments to EPR and TCLE go lives during June/July.

4.1 Areas of Concern & Mitigating Actions

Mindray Bedside Monitoring: Although initiated the Service has now reported that the funding allocated to this project is no longer available, having been committed elsewhere. An exception report is being prepared to escalate the issue further, with the expectation that the project will be placed On Hold until resolved.

4.2 Conclusion

The majority of our projects are progressing according to plan. We have put a number of measures in place over the course of the last twelve months to ensure that projects receive adequate scrutiny, progress in a predictable and accountable fashion and deliver products that are able to realise their forecast benefits.

5. Countywide IT Service (CITS) monthly report

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

Key issues to note

- 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 May showed 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.

- Increases in open incidents with the Server Team due to the MS Teams upgrade.

- Deployment of equipment is organised and managed in much quicker timescales. Small increase in numbers due to laptop requests and improved handover process to end users.

6. Information Governance

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

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.

One incident has been reported to the ICO during the 2021/2022 reporting period to date. A summary of the incidents together with a description of controls in place are included in the trusts annual report.
33 Confidentiality incidents have been reported on the Trust internal Datix incident reporting system during May 2021.

6.1 Data Security and Protection Toolkit (DSPT) version 3: 2020/21

The cyber security evidence requirements are dependent on whether an organisation has cyber essential plus certification. Where a trust has certification many of these requirements are automatically completed, where certification is not evidenced then a further 33 assertions are required to be completed. The trust is currently working towards renewing our cyber essentials plus certification, however this was not able achieved by the 30th June DSPT submission deadline.

The assessment undertaken of the resulting gap in evidence required, and subsequent work by both the IG and cyber security teams ensured that sufficient evidence was able to be provided. The most challenging of assertions to be evidenced were in relation to a new mandatory requirement introduced this year requiring 14 day vulnerability patching. The issue previously being that the patches were not routinely being applied for up to 30 days. CITS have undertaken a significant amount of work to compress the testing, including UAT and so for the last 3 months we have met the requirement for the critical and high-risk patches to be applied within the 14 days window. This will also be the process going forward.

If for any reason going forward this is not possible this will be monitored and escalated via the monthly cyber security reports. A follow up piece of work is required to ensure that all devices are accepting the applied patch. A second assertion where follow up action is required is to extend the scope of the penetration testing completed. This is currently being scoped.

Training Competency Compliance Report 31 May 2021

Training Competency: NHS|CSTF|Information Governance and Data Security - 1 Year|

Compliance Rate Highlight key:

Less than 95%	95% and above

Breakdown by Division

Gloucestershire Hospitals

	Compliance
GHT Total	**91%**
Corporate Division	93%
Diagnostic & Specialty Division	92%
Medicine Division	91%
Non-Division	77%
Surgery Division	91%
Women & Children Division	89%

Breakdown by Staff Group

Gloucestershire Hospitals

	Compliance
GHT Total	**91%**
Add Prof Scientific and Technic	90%
Additional Clinical Services	93%
Administrative and Clerical	93%
Allied Health Professionals	93%
Estates and Ancillary	89%
Healthcare Scientists	93%
Medical and Dental	82%
Nursing and Midwifery Registered	92%

7. Cyber Security

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

- No High Severity Advisories for the reporting period.
- Virtual Cyber Response Exercise scheduled for 4th June.
- Added patching information to Cyber Security Controls section for CITS managed WSUS installation.

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

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – August 2021

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

This report describes the business conducted at the Finance and Digital Committee held on 29 July 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
Financial Performance Report	Month 3 recorded a £185k surplus resulting in a year to date £134k surplus compared to a break even plan. Year to date (YTD) COVID-19 cost are below plan offsetting nursing costs above plan. Activity at 100% of YTD 19/20 levels. Particular pressure in Emergency Department (ED) and Paediatrics around mental health demand.	What is the difference between in and out of envelope COVID-19 costs? What would be the impact of the 3% pay change and would efficiency initiatives be required? What is the impact of pay awards in GMS? What is the accounting treatment of the Salix grant? Will the expanded scope of the Electronic Patient Record (EPR) result in intangible asset write offs of obsolete systems?	Clarification provided and assurance that both categories are reimbursed c. £9 million annual impact. Approach for the second half plan not known at this stage. 1% pay change has a c. £200k annual impact. Subsidiaries not expected to be included in national funding settlements. Accounted as capital A full asset verification exercise to be carried out later in the year which will include intangible assets.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		If very strong performance is delivered in Elective recovery activity will the Fund payments be reduced	Qualifying activity thresholds have already been increased and are not expected to change further. Overall the Trust is performing well in this area.	
Capital Programme Report	Year's capital plan now at £58.3 million from all sources including an update to charitable donations. YTD spend at £8.2 million is c. £6 million lower than plan – process in place to escalate review of projects that are off track. High level long term plan submitted showing total higher than likely approval - prioritisation process underway.	Are any key projects being significantly delayed as a result of the funding process?	Extensive discussion about project monitoring and monitoring and the national approval process provided assurance that team is well aware of all critical issues. Three smaller IT projects impacted but currently manageable	Latest prioritised list to be reviewed at the Committee and where necessary escalation of issues proposed
Financial Sustainability	YTD savings to month 3 are £1.3 million compared to a plan of c. £1.4 million. First half projected outturn is £2.9 million – c. £0.4 above plan. Focus continues on engagement, training and opportunity identification.	Is there adequate capacity within Divisions for the work required given other operational pressures?	It was acknowledged that there are capacity issues albeit the process approach continues to be well received in divisions. Clear distinction being brought out between short vs longer term opportunities.	
Review of Private Patient Offer	Committee received a presentation on a current programme of improvement projects underway with particular emphasis on	Extensive questions and discussion on the detail in the report	Overall assurance provided with confidence building answers on the detail and the thoughtful approach to next steps acknowledging the	Progress review scheduled for 4th quarter

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	governance and improved income opportunities.		sensitive nature of this subject	
GHFT Year End Action Plan	Initial presentation of the action plan proposed to address in a structured manner the improvement areas identified in the 20/21 year-end audit	Develop the report to include start and end target dates, ownership details, specific actions and RAG status.	Committee assured by seeing this initial proposal early in the year.	Quarterly update planned
Strategic Site Development	Paper laying out the basis for and detail of the Deed of Variation required in the PFI contract arising from the Strategic Site Development plan	What is the confidence level in the legal advice that this is based on? What is the attitude of our partners to this change?	High – the Trust's well respected advisers have been involved throughout the project Very positive and supportive arising from early involvement in the process	
Digital Programme Report	Project by project update focussing on the latest key actions involving the "go-live" of the Sunrise EPR system in the Gloucester site and the TCLE system	What will be the best method of gaining assurance of full and successful implementation of TCLE?	Extensive discussion of the TCLE deployment taking in to consideration it is the first deployment in the UK. The committee was assured that despite the many initial challenges the process is progressing well. Confidence reinforced by the participation of clinical staff in the discussion who gave a frank view of progress and challenges. The benefits analysis routinely prepared for the Digital update would be the best ongoing source of assurance.	
Integrated Care	Initial briefing on the latest			Full report to be prepared

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
System Update	system wide exercise to test response to a cyber attack			for the next committee meeting
Digital Risk Register	Review of current risk register status	As the EPR system is extended in terms of scope and location is there a risk of follow up and maintenance capacity within the Digital team not keeping up?		To be reviewed by the Digital and Finance Directors to ensure adequacy of resourcing

Rob Graves
Chair of Finance and Digital Committee
5 August 2021