Gloucestershire Hospitals
NHS Foundation Trust

AGENDA

Meeting: **Public Trust Board meeting**

Date/Time: Thursday 14 October 2021 at 12:30

Location: Shire Hall, Gloucester

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and apologies (AM, SH)	Chair		12:30	
1.	Patient / Staff story	Katie Parker-Roberts	Information		
2	Declarations of interest	Chair		13:00	
3.	Minutes of the previous meeting	Chair	Approval		YES
4.	Matters arising	Chair	Approval		YES
5.	Chief Executive Officer's report	Deborah Lee	Information	13:05	YES
6.	Trust risk register	Emma Wood	Information	13:20	YES
PEOPLE AND OD					
7.	DWC Report "Our Big Conversation"	Emma Wood	Assurance	13:30	YES
	BREAK (10 minutes)			13:55	
ESTATES AND FACILITIES					
8.	Green Plan	Simon Lanceley /Jen Cleary	Assurance	14:05	YES
9.	Assurance report of the Chair of the Estates and Facilities Committee	Mike Napier	Assurance	14:25	YES
QUALITY AND PERFORMANCE					
10.	Journey To Outstanding (J2O) visits - Quarterly report	Matt Holdaway	Assurance	14:35	YES

11.	Quality and Performance report	Qadar Zada / Mark Pietroni/ Matt Holdaway	Assurance	14:45	YES
12.	Assurance report of the Chair of the Quality and Performance Committee	Alison Moon	Assurance	15:00	YES
FINANCE AND DIGITAL					
13.	Digital Programme report	Mark Hutchinson	Assurance	15:10	YES
14.	Finance Performance and Capital Report	Karen Johnson	Assurance	15:20	YES
15.	Assurance report of the Chair of the Finance and Digital Committee	Rob Graves	Assurance	15:30	YES
AUDIT AND ASSURANCE					
16.	Assurance report of the Chair of the Audit & Assurance Committee	Mike Napier	Assurance	15:40	YES
STANDING ITEMS					
17.	Governor questions and comments	Chair	Discussion	15:50	
18.	New risks identified	Chair	Approval		
19.	Any other business	Chair	Information		
CLOSE				16:00	

Date of the next meeting: Thursday 11 November 2021 at 12:30 (Redwood/Teams)

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

Due to the restrictions on gatherings during the COVID-19 pandemic, there will be no physical public 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	Deborah Lee, Chief Executive Officer (CEO) Steve Hams, Director of Quality and Chief Nurse

Marie-Annick Gournet Balvinder Heran Alison Moon Mike Napier Elaine Warwicker	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 Hospitals
NHS Foundation Trust

DRAFT MINUTES OF THE TRUST BOARD MEETING HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON THURSDAY 9 SEPTEMBER 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
Marie-Annick Gournet	MAG	Non-Executive Director
Rob Graves	RG	Non-Executive Director and Deputy Chair
Steve Hams	SH	Director of Quality and Chief Nurse
Balvinder Heran	BH	Non-Executive Director
Mark Hutchinson	MH	Chief Digital and Information Officer
Karen Johnson	KJ	Director of Finance
Simon Lanceley	SL	Director of Strategy and Transformation
Alison Moon	AM	Non-Executive Director
Mike Napier	MN	Non-Executive Director
Elaine Warwicker	EWa	Non-Executive Director
Emma Wood	EW	Director of People and Organisational Development & Deputy Chief Executive Officer
Qadar Zada	QZ	Chief Operating Officer (COO)
IN ATTENDANCE:		
James Brown	JB	Director of Engagement, Involvement & Communications
Alex d'Agapayeff	AdA	Deputy Medical Director
Anoushka Duroe-Richards	ADR	Arts coordinator (Item 159/21)
Sim Foreman	SF	Trust Secretary
Katie Parker-Roberts	KPR	Head of Quality and Lead Freedom to Speak Up Guardian (Item 159/21)
Rebecca Pritchard	RP	Associate Non-Executive Director
Roy Shubhabrata	RS	Associate Non-Executive Director
Alan Thomas	AT	Lead Governor and Public Governor for Cheltenham
APOLOGIES:		
Claire Feehily	CF	Non-Executive Director
Mark Pietroni	MP	Director of Safety and Medical Director & Deputy Chief Executive Officer
MEMBERS OF THE PUBLIC/PRESS/STAFF/GOVERNORS:		
There were two Governors, three members of staff and one member of the public observing the meeting via MS Teams.		

	ACTION

159/21 STAFF STORY

KPR introduced ADR who gave a presentation on her role as Arts Coordinator for the Trust and details of a number of projects underway across the organisation and the impact they have had on patients, service users and staff.

ADR provided details on a number of established projects and their impact. These included:

- Mindful photography
- Mental health in crisis
- Voice and Body
- Hoardings (Strategic Site Development)

ADR then outlined future aspirations for a new project across a number of areas and to secure funding to ensure the role and department become permanent.

Questions and comments were invited from Board members.

RG asked if ADR was working with Art Link who supported primary care colleagues. ADR had worked with them in the past and they had been involved in the mental health in crisis project in the Emergency Department (ED). QZ commented that ED staff looked forward to the room opening, recognising the importance of colours in the room where many people will begin their treatment.

The Chair agreed to connect ADR to Dame Janet Trotter, the former Lord Lieutenant for Gloucestershire and make links into Child Friendly Gloucestershire — PL

In response to a question from EWa, ADR advised if time and funding were not constrained her priority focus would be on growing participation and environmental projects.

RP asked what part digital arts might play in this work as it felt there could be a broad scope for this. ADR agreed there is and this would be part of future project on the Children's Centre. ADR added that the digital photographs displayed at Gloucester Cathedral would be displayed across the Trust so more people could enjoy them.

DL advised that she had been in discussion with ADR in relation to securing funding to keep the role and grow its remit, particularly with regard to participation. DL also advised she had committed ADR to support Black History month in October.

BH asked if there was an opportunity to use art to represent our communities, both within the Trust's workforce and those communities which are served. ADR was working with Friendship Café to promote this recognising art as a universal language.

RESOLVED: The Board NOTED the staff story from ADR.

160/21 DECLARATIONS OF INTEREST

RP declared a standing item as Interim Non-Executive Director of Gloucestershire Managed Services (GMS).

There were no other declarations of interest.

RESOLVED: The Board NOTED and APPROVED the declaration from RP in relation to the business of the meeting

161/21 MINUTES OF THE PREVIOUS MEETING

RESOLVED: The Board APPROVED the minutes of the meeting held on Thursday 12 August 2021.

162/21 MATTERS ARISING

The Board welcomed the return of in person governor visits from October 2021.

RESOLVED: The Board NOTED the updates on the matters arising and CLOSED all items.

163/21 CHIEF EXECUTIVE OFFICER'S REPORT

DL reported that it continued to be operationally challenging for the Trust, not only from COVID-19 but also legacy issues and the pressures from more patients attending for urgent care

In relation to waiting lists, post-pandemic the Trust had started in a better place than many other areas as the Trust had continued to provide services when others had paused. However there were still over 1,000 patients waiting over 52 weeks for an operation.

The Board heard DL's view that it was not acceptable to normalise how tired colleagues were feeling and that executives had gone back to the floor to provide support and listen to concerns which had been welcomed and recognised.

Huge progress had been made on the COVID vaccination

programme and whilst transmission had not fallen as had been hoped, there was a strong relationship between double vaccination and a lower chance of being hospitalised or dying. The Trust still had work to do to vaccinate the remaining 10% of staff but would refrain for commenting on the Government consultation to mandate vaccination for NHS staff. DL assured this cohort of staff had received a personal letter from the Chief Nurse of Medical Director urging them to consider vaccination.

DL highlighted the community open days that had taken place at GRH and CGH the previous day to celebrate the £100m capital across both sites. The theme had been transformation and a song to thank the NHS which had been compiled by local charity Music Works, using performances from children throughout the county would be played at the Annual Members' Meeting (AMM).

DL informed that the Board were meeting later in the afternoon with DWC (consultants) to take forward the work on Widening Participation and determine what next. The Board had committed to share the findings of the DWC report and whilst some messages may not be easy to hear, they needed to be heard. DL thanked EW and JB in particular for their work on this.

The Board also heard an update on the "Healthy Hospitals" programme which was not yet fully defined and noted the Trust had been shortlisted for an award for the Finance team and the "board commitment to communication". The *One Gloucestershire* ICS has been nominated for ICS of the year.

DL confirmed the appointment of Claire Radley as EW's replacement adding that an appointment to the Deputy Director of People post has also been made and would be announced in due course. DL was disappointed to announce SH would be moving on and recognised his work over the past four years.

The Chair was delighted with the nomination for board commitment to communications as much had happened over the past 18 months to drive this. On a similar vein the community open days had shown the commitment to providing opportunities to engage with communities.

BH asked how far the Trust could influence primary care to deliver face-to-face appointments. DL advised capacity had increased in terms of number of appointments but it was being outstripped by the increasing number of patients presenting. It appears that the ease of virtual GP appointments has resulted in more people seeking an appointment. Conversation were

taking place across the ICS to ensure collaborative working and more advanced planning i.e. weekend plans now signed off on Thursday not Friday.

EWa referenced tired colleagues and executive directors leaving and if this had been joined up asking a number of questions; how does it feel? Is turnover a concern? Is the Trust losing key people? DL advised that MH had previously spoken about the number of people seeking to changes things in their life being particularly acute at present but stated that people were coming into the organisation, with some long standing vacancies being filled. The Board were advised that turnover was broadly the same and whilst there were pockets, there were no areas for significant concern. EW explained a small increase in turnover had moved the Trust from upper quartile to the second quartile, and reflected the national position of NHS turnover being higher than it had historically. The recruitment team continued to assure people that Gloucestershire remains a great place to work.

AM commented that it was not always possible to get people with experience and wished to commend SH for the way in which he has given his team exposure to new things and allowed the Trust to "grow their own".

AM also welcomed the news about addressing health inequalities through the healthy hospitals and asked the next steps to maintain momentum. DL confirmed there would be a future board strategy and development session in the first instance. **SF**

AM queried whether the Trust was fully in control of the communications for the capital build as there had been issues in the media nationally about definition of what new hospitals was. SL confirmed that the Trust was definitely in control of the communications as the programme was already in progress.
DL confirmed the £100m was the Trust's own investment and open days had been a great way of showing this coming to life.

RG sought assurance on whether the current front door pressures would put winter planning at risk. DL assured that the Trust and partners plan for different scenarios which truly tested beyond worst case assumptions. This includes discussions on whether the current activity will be a "normal" summer in future.

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

ACTION

164/21 TRUST RISK REGISTER

EW reported on the four changes to the Trust Risk Register (TRR) outlined in the report; the addition of three new risks and one closure.

Two of the new risks (D&S3562Path and C3565) relate to the digital work on implementing the new pathology lab system and the impact of potential delay arising from this and reduced service quality.

The third new risk (F2687Sub) relates to the view of HMRC on the tax law applicable to GMS and is included due to the size of the financial risk pending the HMRC decision on VAT treatment.

EW was pleased to report that, after four years, S2537Th (The risk to patient safety and experience due to loss of main theatre lighting impacting on ability to safely complete surgical procedures) had been closed as all lighting and backups had been installed.

DL sought assurance from AdA on actions being taken to mitigate delays in Pathology. AdA explained backlog samples were being RAG (Red, Amber, Green) rated to prioritise the most urgent above everything else i.e. 2 Week Cancer

MN referenced the GMS VAT risk and noting previous discussions at Finance and Digital committee (FDC) asked what had changed. KJ replied that the Trust has spent £15m through GMS at the end of the previous financial year which was greater than the expected contract value. The Trust's tax advisors (KPMG) had recommended that provision be made for a tax liability in the work was deemed to be out scope. KPMG were also conducting a review to determine if a risk existed and if so, to seek a view from HMRC. KJ advised the Board that the value of the contract with GMS had been increased for the current year so the risk only related to the previous year.

RESOLVED: The Board NOTED the report.

165/21 DIGITAL REPORT

MH presented the report and updated his team had provided support for the new pathology system and the launch of the Electronic Patient Record (EPR) in ED.

Sepsis pathway would be going live at the end of September

and training was underway.

The Board heard that Electronic Medicines Management (EMM) was a key enabler for electronic prescribing and that in the medium to long term, would be included within the EPR electronic document functionality.

AM asked what was missing from the report and if MH had any worries or could flag emerging risks. AM referenced the improvements in divisions (apart from Medicine) as a result of EPR and asked what more could be done to support Medicine. MH recognised the challenge for staff in Medicine; staff were working in a tough environment at the same time as learning a new system. MH felt the approach was to encourage staff to view it as a new tool that would deliver benefits and confirmed his team were working alongside nursing and ward staff (permanent and bank) to help "release time to care".

The Chair asked to what extent MH was planning implementation differently given there appeared to be no let-up in demand over the winter period. MH advised Matt Holdaway, Deputy Chief Nurse was playing a key role in helping the delivery group and teams to implement the system, using his experience from elsewhere.

RS commented he was pleased the TCLE pathology system had gone live and recognised the teething problems, but given its inclusion on the TRR, asked MH if the Trust had under estimated the complexity of the implementation or if the department had not been ready. MH advised that the TCLE product had been largely developed by the pathology team and had been developed some time ago. Intersystems had been very responsive to the issues raised. The main problem had been the speed of the system, but Intersystems had intervened to allow the Trust to view and tackle blockages in flow.

RESOLVED: The Board NOTED the report.

166/21 FINANCIAL PERFORMANCE AND CAPITAL REPORT

KJ presented the financial performance and capital reports.

Financial Performance

The Board noted that revenue to the end of Month 4 (M4) had stabilised although KJ signalled that current operational demand would impact this in future.

Elective performance was 100% year to date (YTD) although had fallen behind in month. As a result the Trust would receive £3.6m of Elective Recovery Funding (ERF) in addition to the £1.6m received to date.

Financial non-recurrent savings and variance were significantly ahead of plan, however temporary staffing costs were amongst the highest in the region, prompting dialogue with the regional team to provide assurance on Trust controls.

The forecast position was in line with the plan.

KJ advised the second half year funding (H2) had been announced the previous Monday and she was due to have a call later in the day to receive more details but it was expected that £7.9m of efficiencies would be needed across the Integrated Care System (ICS) and the Trust.

Capital

The capital report included more detail than the Board had previously seen and this had been scrutinised and reviewed by the Infrastructure Delivery Group (IDG) and FDC.

The Board noted the difficulties arising from trying to profile spending quickly at the start of the year and how quickly things seem to go off kilter as a result. KJ updated that whilst the Trust was currently behind plan, detailed month on month forecasting was in place and identified the gap was a result known issues from three schemes.

The Salix funding was a concern and due to supply chain issues. Detailed risk analysis was underway.

MN commended the detail and quality of the report and the greater accuracy of information being presented. KJ advised the regional team were seeking a four year capital plan in October and the earlier planning would help future reporting.

MN asked when the Salix scheme was due to end and KJ advised formal confirmation had been received that spending could continue through until end of March 2022 with £2m of £30m spending remaining.

The Chair asked if there was any sense or indications on the next year's funding. KJ updated from the speech by the CEO of the King's Fund which referenced support for longer term capital planning, particularly amongst those trusts who had fully depreciated their asset base.

RP asked if the Image Guided Interventional Surgery (IGIS) red rating was a result of a delay in the Board approval process or another reason. KJ explained the value of the contract had increased and that she would wish for it be included in future year's capital programme. This had delayed the process between one month and six weeks, before it went through FDC and Board, although the team were trying to recover a month.

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

167/21 ASSURANCE REPORT OF THE CHAIR OF THE FINANCE AND DIGITAL COMMITTEE

RG updated on the overall process and assurance at the August 2021 meeting. He felt that there had been good discussions which provided real assurance on current issues i.e. TCLE and the upcoming financial challenges for H2.

The Committee had taken a strategic view of the digital strategy as well the methodology used to allocate capital. In both instances the Committee was assured the executives were looking at the right things in the right way.

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

168/21 PEOPLE AND OD PERFORMANCE DASHBOARD AND ASSURANCE MAP

EW highlighted the four indicators in the report showed three GREEN and one AMBER rating. The People and OD Committee (PODC) had considered the visual dashboard but recognised the breadth and complexity of data underpinning the simplicity of the report.

The vacancy rate had increased by 2% as a result of a reconciliation of payroll against establishment meaning an increased in over 200 vacancies.

Nurse retention was comparable to peers but there were still 203 Whole Time Equivalent (WTE) nursing vacancies, which was starting to be evidenced through increased spend on bank and agency pay.

Appraisal rates were at 84% and AMBER rated although the operational pressures were a key contributory factor for this.

Statutory and mandatory training was at 91% with all divisions over 90% evidencing over 10,000 hours of training.

Absence rates were 3.5% (5% with COVID-19) and there was no evidence to suggest any spike related to psychological ill health or exhaustion.

The Chair asked if it was possible to correlate leavers with appraisal rates and EW replied this had not been done previously but took an action to do this. DL asked if themes emerged from exit interviews and was advised they largely related to career progression and flexibility. **EW**

MN expressed that the GREEN rating for retention seemed overambitious given the number of vacancies. EW referenced that PODC reviewed the detail and that the strategic measure was 95% and so GREEN/AMBER would seem fair. The team were looking to rework the visual presentation to better reflect the underpinning detail.

RESOLVED: The Board RECEIVED the report as assurance that three of the four main indicators were green.

169/21 ASSURANCE REPORT OF THE CHAIR OF THE PEOPLE AND OD COMMITTEE

The report was taken as read and BH updated on her reflections from the August 2021.

The discussion on the Widening Participation review from DWC (consultants) had led to lots of insightful conversations and the Board would have the opportunity to continue these in the confidential session following the public Board meeting.

BH advised that work of the Committee and the quality of the papers had improved significantly and continued to do so each meeting.

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

170/21 QUALITY AND PERFORMANCE REPORT

QZ reported urgent care was extremely pressurised from increased attendances as people became more confident to

return to hospital settings and "delayed" patients returned. These pressures were compounded by challenges in adult social care resulting in 157 medically optimised patients in the hospital. The inability to release patients from these beds impacted the ability to achieve good flow. QZ continued that whilst primary care capacity had increased by over 100% a lot of these appointments were virtual when patients wanted face to face service. The Board heard that it was not Trust practice to turn these patients away and often better and quicker to see them.

In terms of managing this situation QZ advised that daily meetings took place with the ED team and the Deputy Chief Operating Officer (COO) was now located at the front of ED and accessible to all staff. More rapid response teams were coming in and there was also greater use of "spot purchase" beds in adult social care to increase flow. The Executives were going into ED as well.

QZ advised that the Trust was in a better position than neighbouring trusts and it was a tough time for all. Ongoing work with the ambulance trust continues and a new area for offloading patients was opened the previous week.

Although staff were exhausted, QZ assured they all wanted to get out of this situation and they continued to have the will and desire to see patients. As part of winter planning, the role of porters, primary care and community pharmacies etc. were all being reviewed as the Trust was looking at seven different scenarios. In response to a question on how staff were feeling, QZ replied there was "frustration" that medically optimised patients couldn't go home.

SH updated on three key points;

- Clostridium Difficile (C.Diff) cases had increased in line with the national trend and this was due to antimicrobial prescribing; the governor quality meeting had received a presentation on this earlier in the week.
- Falls with harm had increased and it was known the intensity of the pathway could impact on this. The number of falls assessments on EPR had increased by 15% with almost 90% of patients now having these recorded. SH advised there was need to get better information on blood pressure to prevent patients at risk from standing up too quickly.
- The Post-Partum Haemorrhage (PPH) indicator for maternity had not improved significantly and the maternity team had given responsibility to one of the consultants to review the learning from Bristol and implement the findings

and recommendations in the Trust.

The Chair asked if it was known why the severity of falls was increasing. SH said it was not clear and explained that although there had been a particularly challenging month there was still clear focus from the team to improve things.

In response to a question from MN, QZ advised the Trust had two GPs at the front door to help triage and assess patients.

MN also sought clarification on how spot purchase beds worked and whether the number of medically fit for discharge patients was reported to try and engage system partners. QZ replied that spot purchase beds were commissioned by Adult Social Care. In relation to the medically fit for discharge patients, QZ confirmed the numbers were reported four times a day across all partners and there was a twice weekly review of every patient on the list. SH added these figures were included within the operational efficiency section of the quality and performance report. DL clarified that there were new national definitions so it was not always possible to make comparisons but work to reconcile the changes was underway.

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

171/21 INFECTION CONTROL ANNUAL REPORT

SH confirmed the report had been reviewed and considered by QPC and was presented for final approval. SH continued that the report covered a year of the pandemic and showed great insight into the work of the infection prevention and control team and colleague across the whole organisation.

There had been some real successes, particularly the lack of MRSA cases for some time but it also showed that COVID-19 was not the only disease circulating and other “bugs” were still around.

The report also included a forward look on goals for the team and the Trust and SH was pleased to report that the team were being seen as expects by both the ICS and the regional colleagues.

The Board recognised the individual contribution made by Craig Bradley as Director of Infection Prevention and Control and DL would write to formally thank him on behalf of the **DL**

Board.

RESOLVED: The Board APPROVED the Infection Control Annual report and NOTED it as a source of assurance.

172/21 ASSURANCE REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE

AM confirmed there had been excellent discussion on the infection control annual report and this had been a key part of the governor quality meeting content.

AM updated on three other key items from the meeting;

- Continuity of carer in maternity services
- An update on Pathway to Excellence and;
- Patient experience annual report (which would also be presented to governors).

The number of young people self-harming was not decreasing and the Committee had requested a review of this within the Trust and system to identify improvements to the September meeting.

The Committee had recognised the national issue of a shortage of blood test tubes, but been assured on the work of MP and team that this had been gripped and was under control.

AM shared the Committee had been given a sense of QZ's view of cancer standards noting that the indicator had been reported as RED, but this was because he said GREEN would only apply if all standards were met. There had been an improvement since July as the team looked at the end-to-end process.

AM concluded by reporting that maternity continued to be an area of focus and assurance. Two new gynaecology consultants and a new consultant midwife had been appointed and that a series of listening events were in the diary for staff in the department to meet with her, DL and Simon Pirie, the Chief of Service. SH added the Trust were the second in the region to appoint a consultant midwife and this had been achieved through collaboration with the University of Worcester who were part funding the post.

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

ACTION

173/21 LUNG FUNCTION/SLEEP STUDIES – RECONFIGURATION BUSINESS CASE

SL presented the paper which was seeking support for the proposed hub and spoke model. This had been designed by the clinical team as a new model of care as part of relocating to accommodate the Image Guided Interventional Surgery (IGIS) and SL commended their work.

The hub would be located at CGH as the Trust seeks to deliver more planned care on the site in line with Centres of Excellence strategic objective. The proposal looks at "one stop" and virtual clinics. The Board heard that it was unlikely there would be a public consultation on this but that the decision rested with the Clinical Commissioning Group (CCG) at the end of September. The response from staff and public engagement had been supportive of the approach.

EW noted that 30% of responses had been negative and asked if this was due to travel. SL explained that of 80 respondents 51% had supported, 31% had been negative and the remainder were neutral but no other themes were emerging.

AM would be interested to ascertain any links between travel and the wards impacted in terms of deprivation indices. DL said that if patients couldn't get to the service due to their ill health, they would be eligible for patient transport.

It was confirmed there was majority, rather than unanimous support from the clinical team and one administrator was wedded to the GRH site and had been redeployed.

MAG asked if there was a sense of political concern or reputational harm and SL explained the engagement had taken place to help inform the CCG decision and had been well received.

MN commended the positivity of the paper, the process followed and participation. He asked if there were other services that needed to undergo the Centres of Excellence process. SL advised this would happen as part of Fit For the Future (FFtF) phase 2 work and although not all services will be Centres of Excellence, colocation where possible was the aim. AdA added all specialities had been asked to think about Centres of Excellence as an opportunity. DL reassured that the FFtF programme was a driver for clinical transformation which would also deliver broader efficiencies, but it was possible to think differently without the need for services to move.

The Chair requested that the paper explore if it is possible to quantify the number of patients that will make fewer trips as a result of proposed service changes and include in subsequent patient communication. **SL**

RESOLVED: The Board:

- SUPPORTED the proposed reconfiguration of Lung Function and Sleep Services as described in the Business Case.
- NOTED that the service redesign process that had been followed to develop this preferred option.
- NOTED that the Governing Body of Gloucestershire Clinical Commissioning Group (CCG) would decide whether the proposal required public consultation.

174/21 EMERGENCY PREPAREDNESS, RESILIENCE, AND RESPONSE ASSURANCE 2021-22

QZ presented the paper which provided assurance on compliance with 44 of 46 standards set out by NHSE/I. The toolkit has been received at the end of July and the evidence provided had been approved through internal meeting before being reviewed and supported by the Audit and Assurance Committee (AAC). QZ explained that he was not happy to signoff the two non-areas of non-compliance but there were no significant issues that would be challenged by the CCG. Subject to CCG review and there being no differences, the final submission would be to NHSE/I.

AM confirmed her support for the paper and the approach taken. She asked for clarification on whether simulation exercises would take place and what else can be done to assure in this regard. QZ said the exercises would take place as the Trust had a duty to test plans but there was scope to do it is discrete areas. QZ wanted to test all plans, initially through table top exercises and then in discrete areas. MN commented that the contribution of the Fire and Rescue service into an exercise in 2018 had been tremendous and would encourage this continuing. QZ assured it would as the Trust plans relied on wider capacity outside the hospital sites.

DL wished to thank and credit Dickie Head, Head of EPRR on the scale of assurance provided. The Board heard that Dickie had secured real operational buy in for EPRR and DL was tasked with sending a formal letter of thanks. **DL**

RESOLVED: The Board APPROVED the report for onward submission to CCG.

ACTION

175/21 COUNCIL OF GOVERNORS MINUTES (JUNE 2021)

RESOLVED: The Board NOTED the minutes of the Council of Governors meeting held on 16 June 2021.

176/21 GOVERNOR QUESTIONS AND COMMENTS

AT thanked the Board for the privilege of being able to attend in person and would welcome more governors having this opportunity as infection control and COVID-19 restrictions are lifted. AT advised that one governor had reported technical difficulties with sound quality and was unable to observe the meeting.

AT requested further details on patient engagement and benefits from the lung function item and SL agreed to provide these. **SL**

AT welcomed the open and candid briefing on the challenges within urgent and emergency care. He asked when the clock started for a patient who might be on an ambulance for 60 minutes. QZ responded to advise that ambulance handover waits were improving but the Trust was not meeting its targets. The overall flow across the system needed to improve for this to happen. QZ confirmed the official clock start began once a patient had been registered within ED, but patients might still be triaged on the ambulance before this. It was also explained that clinical need was considered and affected wait times.

AT commented that the dementia rate benchmarking had not changed since February 2020 and SH reminded that national reporting had been paused since then. It was suggested that this be removed from the quality and performance report or explained with a footnote until reporting resumed.

AT asked where the “spot purchase” adult social care beds were located given the local authority seemed unable to provide beds to aid system flow. QZ advised these were in care homes and care facilities with DL adding the cost was usually higher than rate paid by the local authority, so the aim was to get the patients out of these beds as quickly as possible, but this was not always the case.

AT closed by thanking all involved in the open day at CGH which he and a number of governors had attended and enjoyed.

177/21 NEW RISKS IDENTIFIED

There were none.

178/21 ANY OTHER BUSINESS

RG had enjoyed the in person meeting but flagged the need to address the technology issues for observers.

There were no other items of any other business.

DATE AND TIME OF THE NEXT MEETING

Thursday 14 October 2021 at 12:30 at Redwood Education Centre, GRH (or via MS Teams).

[Meeting closed at 15:27]

Signed as a true and accurate record:

Chair
14 October 2021

Gloucestershire Hospitals
NHS Foundation Trust

Public Trust Board – Matters Arising – October 2021

Minute	Action	Owner	Target Date	Update	Status
September 2021					
159/21	**STAFF STORY**				
	Connect ADR to Dame Janet Trotter.	PL	October		**CLOSED**
163/21	**CHIEF EXECUTIVE OFFICER'S REPORT**				
	Schedule future Board Strategy and Development Session addressing health inequalities through healthy hospitals.	SF	October	Date to be fixed in 2022. On BSD list as future topic.	**CLOSED**
168/21	**PEOPLE AND OD PERFORMANCE DASHBOARD AND ASSURANCE MAP**				
	Correlate leavers with appraisal rates.	EW	October	The correlation will appear in the next performance dashboard which will go to PODC in October.	**CLOSED**
171/21	**INFECTION CONTROL ANNUAL REPORT**				
	Write to formally thank the Director of Infection Prevention and Control on behalf of the Board.	DL	October	Actioned.	**CLOSED**
173/21	**LUNG FUNCTION/SLEEP STUDIES – RECONFIGURATION BUSINESS CASE**				
	Explore if it is possible to quantify the number of patients that will make fewer trips as a result of proposed service changes and include in subsequent patient communication.	SL	October	To be included in patient communication, subject to discussion at HOSC on 14th October	***CLOSED***
174/21	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ASSURANCE 2021-11**				
	Send a formal letter of thanks to the Head of EPRR for the scale of assurance provided.	DL	October	Actioned.	**CLOSED**
176/21	**GOVERNOR QUESTIONS AND COMMENTS**				
	Further details were requested on patient engagement and benefits from the lung function item.	SL	October	Patient Engagement outcome report has been shared with Lead Governor	**CLOSED**

Last updated 29 September 2021.

PUBLIC BOARD – OCTOBER 2021
CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 In response to some challenging technology issues at our first return to a face to face public Board meeting in 18 months, I am delighted we have the opportunity to both improve the virtual experience and also meet in one of the County's landmarks this month, pending improvements to the Trust's own meeting rooms to support "hybrid" meetings.

Operational Context

2.1 Operationally, the Trust remains extremely busy with activity in urgent and emergency care more redolent of winter months. The expected surge of the paediatric respiratory illness Respiratory Syncytial Virus (RSV) has not manifested as feared, with very few children requiring hospital care although plans to respond to an increase remain in hand. Regionally, neonatal and maternity services are also under considerable pressure and this picture is replicated locally with the Trust supporting a number of tertiary neonatal units through the provision of mutual aid in the form of early step down and maternity services currently managing a peak in births.

2.2 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 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. One of the key constraints impacting on the ability of the system to support discharge is the provision of domiciliary home care. Like other sectors that rely on European workers and are characterised by low wages and sometimes poor working terms and conditions. Our Local Authority partners have the lead for managing this aspect of the care sector and are working closely with care providers and NHS partners to explore opportunities to improve the current situation, with an early focus on retention and managing the impact of the mandatory vaccination legislation which will affect care home providers from 10th November 2021.

2.3 Positively however, in the face of these pressures, elective activity levels remain very strong with the Trust continuing to outperform most other systems both with respect to activity volumes and the numbers of long waiting patients. This is testament to strong performance during the pandemic period and the continued hard work and commitment of staff across the organisation. There has been a small increase in the number of cancer patients waiting more than 62 days from referral to first treatment and all teams continue to prioritise this group of patients; relative to other Trusts and systems, Gloucestershire cancer performance remains one of the best. Thanks to the efforts of many, there have been no cancellations of cancer patients.

2.4 In the four weeks since my last report, community rates of COVID-19 continue to fall slowly overall and currently stand at 168.9 per 100,000 population, compared to 320 cases per 100,000 last month. However, rates in the vaccinated population continue to decline with the greatest prevalence now in the largely unvaccinated 10-14 years age group. The Gloucestershire position remains better than the South West average.

2.5 The County's COVID booster programme is underway and more than 2,250 staff already having had their booster and a similarly positive uptake in the wider population. The booster is available to all those in priority groups 1-9 including health and care staff, six months after their second vaccination.

2.6 Positively, the numbers of patients with COVID, in our hospitals, remains low and is plateaued in a range of 18-24 patients and at one time, and with no more than four 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 has 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.

3 Key Highlights

3.1 Since my last report the NHS has received the national Operational Planning Guidance for the second half of 2021/22. The guidance restates the six priorities described in the March 2021 annual guidance, although it is clear that elective recovery is currently being positioned as one of the most important priorities for the second half of the year. The priorities are

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate restoration of elective and cancer care and manage increasing demand on mental health services
- Extending primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care (UEC) to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities.

3.2 With respect to elective recovery, there are a number of new national milestones which all providers are expected to deliver which are:

- Eliminate waits of over 104 weeks by March 2022, except where patients choose to wait longer
- Hold or, where possible, reduce the number of patients waiting over 52 weeks
- Stabilise total waiting lists around the level seen at the end of September 2021
- Return the number of people waiting for longer than 62 days to the level seen in February 2020 i.e. pre-pandemic levels, by March 2022.
- Meet the Faster Diagnosis Standard (FDS) from Quarter 3 2021/22 thus ensuring that 75% of patients will have cancer ruled out or diagnosed within 28 days of referral for diagnostic testing.

Alongside these milestones providers are expected to deliver all of the *Elective High-Impact Changes and Transformation Opportunities* set out in the Annual Planning Guidance 2021/22. All of these form part of the Trust's approach to elective recovery.

3.3 Following the Board on the 9 September, the Executive Team (and other colleagues) alongside independent consultants DWC who led and hosted the *Big Conversation* have hosted a series of events to share the findings from DWC's work and to ensure that the dialogue between the senior team and front line staff continues. These events have been hugely positive both in respect of the findings and proposed actions but also heard from many colleagues that they feel that "things are changing". They pointed to an increase in the number of Band 6 and 7 appointments in nursing as especially positive and welcome.

3.4 This month is Black History Month and the Trust is taking the opportunity to recognise and celebrate Black colleagues and their heritage and achievements. The month will include offering coaching sessions for colleagues from an ethnic minority, our restaurants will be offering an African and Caribbean menu on the 26th October and we will be supporting the development of a Menu of Memories Recipe Booklet which will capture Black colleagues favourite African and Caribbean recipes. We will also be continuing last year's literary theme with *Desert Island Books* through which we are asking colleagues to share their favourite books by Black authors and to encourage staff to read these books. Finally, we are supporting the event being organised by the local Police Constabulary which will hear from renowned author David Olusuga who will address the audience under the title *Undaunted by Struggle, Inspired by Hope.* Details of all of this are available on the Trust Intranet.

3.5 This month we are also promoting our "speaking up" culture as part of national *Freedom To Speak Up* month and this will be a focus of this month's Board story. The number of guardians in the Trust has now increased to seven with recruitment for more underway; we have an increasingly diverse group of guardians from different professional groups with different personal characteristics. We have also agreed that in keeping with our approach to other guardians, the FSUP Guardian will also report directly to the Board.

3.6 In keeping with the Trust's commitment to our *Compassionate Culture* and the Compassionate Leadership framework of *Listening ; Understanding ; Empathising ; Acting,* members of the Board and Women's and Children's Leadership Team undertook three "listening events" in the second half of September. These events were hugely valuable and has resulted in a series of "you said : we did" responses to the issues raised in these events. It was very clear that many of the issues raised by midwives and doctors in the service have their origins in the current staffing challenges (which are being addressed) but we were also able to identify a good number of issues which are already being addressed and will improve the work load pressures being faced by the service. The service leadership team is now looking at how they can ensure these two-way feedback mechanisms are embedded into "business as usual" models.

3.7 The development of Integrated Care Systems (ICS) continues to gather momentum and this month with the closing date for the Accountable Officer recruitment and the publication of model role profiles for other Board level roles including the statutory roles of Chief Nurse, Chief Medical Officer and Chief Finance Officer. Work is now underway to develop the ICS Constitution which is expected to be agreed by the end of the calendar year, work on the vision and priorities for the "new" ICS is now underway as well as work to scope the key milestones that will require input or approval from partner organisations so that these can be programmed into our own work planners.

3.8 This month (after an initial unavoidable postponement) we will be delivering our Annual Members Meeting which, alongside our statutory pieces, will be showcasing some of the innovation and developments that the Trust has achieved in the last year as part of the developments of our two *Centres of Excellence.* As last year, the event will be virtual and I am hopeful we will secure the same level of interest as previously.

3.9 Celebrating success remains a core ingredient to our approach to valuing people and I am delighted that three of our teams were recognised and secured four national awards this month. In this year's British Medical Journal Awards, our MERIT Team won Anaesthesia and Peri-operative Team of the Year, our Respiratory High Care service was highly commended and our work on reducing surgical site infection PreciSSIon (delivered in partnership with the Academic Health Science Network) won the Infection Control Award. PreciSSion also won Quality Improvement Team of the year in the Health Service Journal Patient Safety Awards.

Deborah Lee
Chief Executive Officer

7th October 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – October 2021

Report Title
TRUST RISK REGISTER (TRR)
Sponsor and Author(s)
Author: Lee Troake, Corporate Risk, Health & Safety Sponsor: Emma Wood, Deputy CEO and Director of People and OD

Executive Summary

PURPOSE

The Trust Risk Register enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. The Risk Management Group (RMG) due to take place on 6 October 2021 was cancelled due to an ongoing Internal Incident (operational pressures).

KEY ISSUES TO NOTE

NEW PROPOSED FOR THE TRUST RISK REGISTER (TRR)

- Two new risks proposed for the TRR will be discussed at the divisional Exec Review Meetings to avoid any delay caused the cancelation of RMG

RISK SCORE REDUCED FOR TRR RISK

- None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

- None

PROPOSED CLOSURES OF RISKS ON THE TRR

- None

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)**

Outcome of discussion when presented to previous Committees
Risks will be discussed / agreed at Exec Review

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead title	Date Risk to be reviewed by	Approval status
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 to be submitted. Demand and Capacity model for diabetes	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Medical Director	31/08/2021	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 assessmentreview location and availability of hoverjacks. Set up register of ward training for falls. Discuss flow sheet for bed rails on EPR at documentation group	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	30/06/2021	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	Chief Operating Officer	31/08/2021	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;	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	Director of Finance	31/08/2021	Trust Risk Register
D&S3562Path	The Risk to the quality of pathology service provision due to functionality issues with TCLE during the implementation phase which prevents the timely booking of samples, access to, or visibility of, critical patient results.	Daily issues calls with issues log Support from Pathology, IT and Intersystems to resolve issues Weekly management meetings Oversight from Pathology Management Board and Divisional Board	Implement daily meeting to review issues with TCLE. Implement 4pm catch up meetings for TCLE Continue TCLE weekly management meetings. Obtain urgent E sign off for RA for Specialty RR Set up Task and Finish group for TCLE recovery esp in Histopathology. Arrange meeting to discuss with Lead Executive and Trust Risk Lead. Upload TCLE Issue log to datix Obtain Urgent E-Sign off from Divisional Board for Division RR and escalation to Trust. Provision of incidents where pathology have been unable to support MDTs	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of quality and chief nurse	03/09/2021	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	Director for Strategy & Transformation	22/09/2021	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	Medical Director	31/08/2021	Trust Risk Register
	The risk of non-compliance with statutory requirements to the	Air conditioning installed in some laboratory (although not adequate)	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								

D&S2517Path	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.	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	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	Chief Operating Officer	01/10/2021	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	Director of Quality and Chief Nurse	29/10/2021	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 specialiities to support f/u clearance of backlog	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	31/08/2021	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 .E-learning package. Mandatory training o Induction trainingo Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days. Ward Based Simulation. Acute Care Response Team Feedback to Ward teams. 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. 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	Director of Quality and Chief Nurse	31/12/2021	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	investigate business risks associated with closure of theatres to install new ventilation. Update busines case for Theatre refurb programme. Action plan for replacement of all obsolete ventilation systems in theatres. 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 review performance data against HTML standards with Estates and	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	01/09/2021	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. Purchase. Implementation plan	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	30/11/2021	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.	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	Chief Operating Officer	31/08/2021	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.Set up career guidance clinics for nursing staff. Review and update GHT job opportunities website. Support staff wellbing and staff engagment . Assist with implementing RePAIR priorities for GHFT and the wider ICS. Devise an action plan for NHSi Retention programme - cohort 5. Trustwide support and Implementation of BAME agenda. Devise a strategy for international recruitment	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of Quality and Chief Nurse	06/09/2021	Trust Risk Register
C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	[redacted] (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required).Both systems were operational from end March. Activity:Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care. RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position. The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required. Harm reviews suspended aside from Cancer. The RAG process described above has moved into a P category status = all patients are now being validated under this prioritisation on the INPWL - a report has also been provided at speciality level to detail the volume completed	COVID T&F Group to develop Recovery Plan to minimise harm	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	COO	06/09/2021	Trust Risk Register
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	Director of Quality and Chief Nurse	30/09/2021	Trust Risk Register
			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. Pull together complaints and compliments to understand patient/care views. Development of parallel pathway for patients who fracture NOF in hospital discuss admitting patients to 3a with site team, develop joint training and share learning to reduce issues and optimise care								

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	create SOP for prioritisation of #NOFs to 3rd floor with intention that other trauma should outlie first. Pull together any complaints or compliments to understand patient/care views for #NOF patients restart TATU to help reduce length of stay and improve discharges. Identify potential capital works and funding for TATU revisit possibility of Mayhill taking planned trauma. revisit community teams administering antibiotics engagement activities with staff on ideas for improving LOS Prioritise 3rd floor for ward rounds to aid flow creation of new inpatient clerking proforma. agree targeted approach for high volume conditions. launch pre op protocols. early escalation by trauma coordinators of any trauma backlog to prioritise hip fracture patients. progress pre op protocols through documentation committee creation of snapshot report to aid escalation. 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. Need to emphasise with trainees that access available to JUYI/SCR to inform full list of patient medication Feedback on ward care plan audit results and education of trauma coordinators and medical staff of importance. feedback on care bundle audit and feedback to nursing teams and junior Drs of importance. recruitment into vacant post for nutrition support practitioner good practice re optimisation for nutrition and hydration to be shared outside 3a. on call junior dr to be supported by 2nd registrar in MIU, freeing up on call Dr to see ward patients. Audit post op blood taking over weekends explore issue relating to complex patients not being assessed by COTE team before theatre process for escalation of DATIX to junir Dr and escaltion superviserd to aid learning. undertake time and motion study of juniors to understand pressures. work with HR to develop recruitment and retention plan for trauma nursing review feeback from nursing education programme. engagement activities across T&O nursing Explore issues around Gallery ward taking NOF patients with complex needs review TOR for hip fracture mortality meetings. Learning disability passport to be included when appropriate fro NOF patients with learning disability Identify staff to undertake silver QI course to develop QI skills Review and update transfusion policy post surgery. Review post op transfusion policy for NOF patients. 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. Therapy staff improve patient experience. Investigate options to Increase out of hours ortho geriatric cover. Continue engagement programme with nursing teams. Consider recruitment of 1 further NP for NOF ward	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	medical Director	30/09/2021	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	30/06/2021	Trust Risk Register
		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.									

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.	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	Chief Operating Officer	01/10/2021	Trust Risk Register
F2687Sub	The risk that the HMRC does not accept the treatment of the GMS transaction under tax law and the targeted savings are not delivered impacting on delivery of the trust financial plan for FY21/22	External specialist expertise has been procured to support the planning and implementation of the GMS, and their advice has been fully taken account of. The Trust has broad aims and objectives for GMS well beyond tax efficencies. Other NHS SubCo's in existence are successfully operating on the same basis.	To work with KPMG to prepare and submit the HMRC clearance position	Finance	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	Director of Finance	31/08/2021	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	Trust Risk Register
M3396Emer	The risk to patient safety relating to poorer outcomes and potential harm throughout their hospital stay as a result of spending longer than 8 hours in ED	UEC Improvement plan.Actions from UEC pathways and delivery group. POCT /Huddles. Increased transport provision to maximise green capacity at CGH. Whilst unsuccessful in adding to an ICS risk register we are proactively discussing the risk with system partners	UEC improvement plan. Audit in department of 100 patients throughout DEc 2020. Reset culture towards zero tolerance of above 8 hour waits	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	16/11/2021	Trust Risk Register
C3565	The risk of reduced service quality in all clinical areas and operational flow due to lack of timely access to pathology reports, test status and results on SUNRISE EPR.	Medical staff telephoning microbiology to request verbal updates on blood cultures, growth, incubation etc. IMT leads aware. Weekly meeting in place to resolve any technical issues. Testing was completed before 'go live' of TCLE.	Action Plan on linked Pathology Risk	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	06/10/2021	Trust Risk Register
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.	•2m distancing implemented between beds where this is viable •Perspex screens placed between beds •Clear procedures in place in relation to infection control •COVID-19 actions card / training and support •Planning in relation to increasing green bed capacity to improve patient flow rate •Transmission based precautions in place •NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control •H&S team COVID Secure inspections •Hand hygiene and PPE in place •LFD testing – twice a week •72 hour testing following outbreak •Regular screening of patients	CAFF inspections to be progressed	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Nurse	18/08/2021	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.	To create a rolling action plan to reduce pressure ulcers. 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 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. Bespoke training to DCC staff for categorisation of pressure ulcers. Education and supprt to staff on 5b for pressure ulcer dressings. Provide training to ward on completion of 1st hour priorities 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. cascade learning around cheers for ears campaign purchase of dynamic cushions. Review pressure ulcer care for patients attending dilysis on ward 7a. Proide training to 5b in the use of cavilon advance +. Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	30/06/2021	Trust Risk Register

PUBLIC TRUST BOARD
14th October 2021

Report Title
The Big Conversation: Our Widening Participation Review 2020-21

Sponsor and Author(s)

Authors: David Weaver Consulting (DWC) – DWC report
Emma Wood, Deputy CEO and Director of People – Board cover sheet

Sponsoring Director: Deborah Lee, Chief Executive; Emma Wood, Deputy CEO and Director of People and Organisational Development

Executive Summary

Purpose
The Trust as part of the agreed Equality, Diversity and Inclusion Action plan commissioned David Weaver Consulting to conduct a cultural review – known as the Widening Participation Review, termed colloquially as the 'Big Conversation.' This aimed to better understand the experiences of ethnic minority colleagues and other colleagues with minority protected characteristics who reported having a worse experience working in the Trust than their counterparts.

DWC's report is submitted to the Board for review and discussion and summarises the work undertaken by DWC and the Trust during the past 12 months. The DWC report provides an overview of the findings of their research, alongside recommendations for improvements the Trust can make to its culture and operations.

Key issues to note

- The report was first received by the People and OD Committee in August 2021.
- The report is written in a 'call and response' style, with DWC leading the call to action and the Trust responding on how it intends to meet the challenges set out in DWC's recommendations.
- The report is structured into key sections:
    - Foreword and opening statements, led by DWC;
    - Summary response, led by the Trust;
    - Overview of the brief presented to DWC, the methodology they followed to obtain insight into the Trust's culture, and an overview of the audiences they engaged with;
    - Findings, presented in five separate, interdependent themes. This includes the Trust's response to the findings and recommendations.
- The five key themes are:
    1. **Leadership Ambition** – outlining the commitment required of leaders in placing a high priority on Race and Equality Diversity and Inclusion (EDI)
    2. **Taking Positive Action** – the importance of measures that give pace to advancing the delivery of Race and EDI targets
    3. **Operating Culture and Cultural Competence** – what is required to support the Trust moving toward a compassionate and inclusive culture
    4. **Speaking Up with Confidence** – encouraging the rich feedback which can support the Trust's agenda
    5. **Governance and Accountability** – addressing the managerial and bureaucratic arrangement necessary to achieve Trust Race and EDI goals.

Conclusions
The Trust welcomes the report findings and recommendations from DWC. The report recognises the progress already made against the five themes, whilst also accepting further concerted work is

required to embed and realise these.

Implications and Future Action Required
The Trust Board to discuss findings and accept the report.
The Trust Board to note that the report has been published internally and an animation shared with colleagues describing our compassionate and inclusive culture journey and the early DWC findings. In addition feedback sessions with colleagues have been scheduled for the months September to December 2021 with DWC and Executives.

Recommendations

- Trust Board to **ACCEPT** the DWC Widening Participation Review Report.

Impact Upon Strategic Objectives

Equality Diversity and Inclusion activity impacts upon Outstanding care, Compassionate Workforce and Involved People.

Impact Upon Corporate Risks

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

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

Regulatory and/or Legal Implications

Commissioners monitor the Trust's delivery of Equality Diversity and Inclusion plans and this forms part of our contractual agreements.

Equality & Patient Impact

Work to improve equality, diversity, inclusion and human rights will have a positive impact on the broader patient experience, and improve relationships between staff and with our service users.

Resource Implications

Finance		Information Management & Technology	
Human Resources	X	Buildings	

Action/Decision Required

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

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	A & A Committee	People and OD Committee	Rem Committee	Trust Leadership Team	Other (specify)
			24th August 2021			Confidential Board 9th September 2021

Outcome of discussion when presented to previous Committees

The DWC report was presented in People & OD Committee and an overview of the work from the past year and the Big Conversation provided.
The committee reflected on one of the recommendations to focus on race as opposed to all protected characteristics and considered if the Trust's response to the recommendations and issues would feel different to staff, and how we would test success of programmes of work.
Members of the committee noted that the Trust's focus is on all protected characteristics but additional resources had meant action specifically related to race was being taken and would continue not least as the Trust recognised the issues facing ethnic minority colleagues, as also highlighted by the

disproportionate impact of COVID on ethnic minority communities and the Black Lives Matter movement.
The committee noted how colleagues have been engaged in our response to poor colleague experiences and the importance for responses to feel meaningful and not appear to be platitudes. It was noted the Trust would continue to measure the targets set and review outcomes from a quantitative and qualitative perspective and recommended the Board discuss this report in September 2021.

The Board received a briefing from DWC in September during a confidential session and welcomed the report and its findings and provided commitment to continue leading the journey to deliver Best Care for Each Other.

DWC CONSULTING

The Big Conversation

Our Widening Participation Review 2020-21

Contents

Foreword 3

1. Equality, Diversity and Inclusion is Business Critical 5
2. Trust Response 7
3. The Widening Participation Review– what DWC was asked to do? 9
4. DWC's approach 11
5. Who did DWC engage and involve? 12
6. Our Findings – What DWC heard 13

    Theme 1: Leadership Ambition 13

    Theme 2: Taking Positive Action 16

    Theme 3: Culture and Cultural Competence 19

    Theme 4: Speaking Up with Confidence 23

    Theme 5: Governance & Accountability 26

Foreword

Inclusion is a health issue.

This report is the result of a continuing conversation between Gloucestershire Hospitals NHS Foundation Trust and DWC Consulting. It culminates in an agreement about what must be done to deliver on the promise to their staff and stakeholders to be a vibrant and inclusive organisation.

This report is written in a ‘call and response’ style with DWC leading the call to action and the Trust responding on how it intends to meet the challenges set out in DWC’s recommendations.

The challenges faced by the Trust bear similarities with those facing the NHS everywhere. Our National Health Service is a national treasure to whom we all owe a debt of gratitude; its leaders and staff give of themselves to maintain the health of the nation.

The pandemic revealed once again our reliance on these dedicated courageous people and it is incumbent on the NHS organisations that employ them to meet their duty of care to these guardians of our wellbeing.

Treating them fairly, respecting their dignity and above all eliminating all forms of unfair discrimination is how we honour their service. Equality, Diversity and Inclusion speaks to how we deliver on that responsibility to every member of the NHS.

DWC has been privileged over the past nine months to be able to hear from Trust staff about the joys and pains they experience as they go about their daily routines.

In the Big Conversation we heard some things that lifted our spirits and reflected humanity at its best from managers and colleagues. However, we also learned from a group of diverse minority staff that more needs to be done to tackle their perception of challenging behaviours.

The Cultural Barometer initiative and more focused EDI elements within management training should go some way towards addressing these issues but we reinforce the importance of ongoing engagement with these diverse groups of staff as a way of increasing trust and confidence.

Mahatma Gandhi was correct in saying that “a civilisation is measured by how it treats its weakest members”. In endorsing DWC’s recommendations, we hope the Trust is declaring its intentions to stand with those who face discrimination, bullying or harassment to make efforts to repair any damage done to them and enact safeguards to prevent recurrence.

The recommendations made here go some way to establishing a blueprint for how the Trust can make progress toward being an inclusive, compassionate

organisation, where there are clear behavioural standards to which staff adhere.

We believe our proposals provide a solid foundation from which to build an organisation that reaches for excellence not only as a healthcare provider, but just as importantly, as an exemplar employer. Plans signify the organisation's intention to make beneficial changes, but it is follow-through action that will make the difference.

Key to success will be the role that Trust leaders play in holding all colleagues to account on the exacting standards required to demonstrate a high level of ambition and dedication to becoming a model employer.

1. Equality, Diversity and Inclusion is Business Critical

We live in a world where discrimination and abuse are far too commonplace. This is amplified through social media and often reflected in political discourse.

It is not acceptable for anyone to experience bullying, harassment and discrimination but sadly this is a daily occurrence for too many staff, in particular, Black, Asian and Minority Ethnic colleagues.

The disparities in the experience between staff are of serious concern to the Trust. The paramount reason is that it runs contrary to 'the business case' which shows a direct link between having high-quality diverse representation at every tier of an organisation and high levels of productivity and high-quality care.

We understand that managed well, affording issues of equality, diversity and inclusion 'business-critical' status, delivers a diversity dividend that will bring many benefits to the Trust.

The murder of George Floyd in May 2020 and the Black Lives Matter movement laid bare significant truths about racial inequalities and discrimination in this country and across the globe.

The disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic communities deepened the concerns. Many institutions responded to these events by undertaking a critical evaluation of their practices and processes in an effort to understand what might be done to eliminate racism and discrimination from their practices - the Trust was no exception to this.

A cursory examination of the status quo showed that despite the many achievements and changes adopted in the Trust since 2017, progress to achieve and sustain demonstrable change for colleagues holding minority protected characteristics has been slower than the Trust would like.

The Trust was particularly concerned that the reported poor experience of Black Asian and Minority Ethnic colleagues had not improved significantly over many years.

From this assessment it was very clear there was much work needed to be done to gain an appreciation of the reasons for inertia and remedy them.

In July 2020 the Trust agreed to:

1. Commission, design and deliver a Trust-wide cultural review – known as the Widening Participation Review, termed colloquially as the "Big Conversation" – to better understand the experiences of ethnic minority colleagues and other colleagues with minority protected characteristics who reported having a worse

experience working in the Trust than their counterparts; and

2. Deliver an EDI action plan to address and expedite the Trust's response to known barriers and amend existing areas of practice in need of significant improvement and reform.

The Trust commissioned DWC Consulting to conduct the 'Big Conversation' to help give focused attention to the issues faced by Black, Asian and Minority Ethnic staff. It wanted to hear about the lived experiences of all staff who identify with a minority 'protected characteristic', to acknowledge them and take 'business critical' action to improve their experience.

This report by DWC Consulting summarises the findings and provides a view of how the Trust is planning to advance Equality, Diversity and Inclusion.

David Weaver and Joel O'Loughlin
DWC Consulting

2. Trust Response

We welcome the report from DWC and the findings and recommendations they have made. We commissioned this work as we want our hospitals to be outstanding places to work and to be cared for and we want to be recognised for our compassion towards patients, their families and to each other. Whilst this is the experience of very many, it is not the experience of all.

We have heard from colleagues from black, asian and ethnic minorities that far too often they do not have the positive experience at work that they have the right to expect. This less positive experience has also been highlighted by colleagues with disabilities and those who are LGBTQ+.

We absolutely recognise that, in spite of the many achievements and changes adopted in the Trust over the last five years, progress to achieve and sustain demonstrable change for our colleagues holding protected characteristics has been slower than we would like.

The last 18 months has also shown the stark reality of the inequalities in society, and there is an ever greater need for urgency to tackle these issues.

As this report outlines, if we embrace equality, diversity and inclusion, it will make a tangible difference to the quality of health care we provide, the experience of colleagues, and the quality of our partnership with communities.
The report highlights five key areas for action:

1. Leadership Ambition
2. Taking Positive Action
3. Operating Culture and Cultural Competence
4. Speaking Up with Confidence
5. Governance & Accountability

We are already working to address all of these areas with many positive initiatives in hand which have been described by DWC throughout their report, but success goes beyond initiatives to ensuring that as an organisation we share a common purpose and take collective responsibility for this being a Trust where everyone feels valued, is able to realise their potential and most importantly feel safe to be themselves and speak up whenever they are not. This call to action for a wholly inclusive culture will benefit us all, not just those who are in the minority..

We have set ourselves some ambitious milestones so we are clear on the progress we are making; we may not get it right all of the time but this will not be for the lack of ambition or trying. When we do get things wrong we hope that our culture will be one where, increasingly, you feel able to tell us, so that we can find the solutions together.

This is still only the start of our journey, and we will continue to work with a wide range of colleagues and

DWC as we embed their positive recommendations to ensure we can achieve our guiding ambition of Best Care for Everyone and Best Care for Each Other.

Deborah Lee and Peter Lachecki

3. The Widening Participation Review – what DWC was asked to do?

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) commissioned DWC Consulting between October 2020 to June 2021 to act as a critical friend, sounding board and change catalyst in relation to our performance on Equality, Diversity and Inclusion (EDI) – with an emphasis on race equality.

Under the scope of a 'Widening Participation Review', the Trust highlighted two priority themes for DWC's intervention and support:

a) Progressing the Trust's explicit aim of 'improving the reported experience of Black, Asian and minority ethnic colleagues and, implicitly therefore, other marginalised groups';

b) Reviewing the EDI action plan and interventions planned by the Trust to support its commitment to achieving Equality and Inclusion.

The key imperative for DWC's work was the need for external challenge and support to ensure that the Trust makes marked improvements and material changes in its approach to race equality and EDI in general.

It was also seen as important for DWC to recommend ways that enables EDI to become embedded / mainstreamed into the Trust's overall strategic thinking and direction.

To facilitate their review DWC's team was given wide-ranging access to senior leaders, managers and employees at all levels within the organisation and from across the range of protected characteristic groups.

The Trust accepts that some of the indicators reflected within the NHS Staff Survey and Workplace Race and Disability Equality Standard (WRES and WDES) were disappointing and traction to improve slow and wanting.

Equally concerning is that Black, Asian and Minority Ethnic people are under-represented in the Trust's senior leadership teams and there are disparities in terms of their positioning in management and higher banded roles in general.

To complement this, a high premium was placed on the need for an 'in real time' partnering approach to ensure that DWC's suggestions and recommendations could be taken forward during the tenure of their work with the Trust.

This approach meant that where progress could be made on some issues it was not held up awaiting the outcome of the review.

Further information on how the Trust monitors and reports on Equality and Diversity can be found on the public website: Equality, Diversity and Inclusion.

4. DWC's Approach

Undertaking the Commission, we were pleased that the Trust recognised the benefit of having a 'critical friend' to hold up the mirror to the organisation and act as a 'sounding board' to explore fresh ideas with staff.

We were particularly pleased to be encouraged to provide an honest, impartial perspective on the Trust's performance and culture as it relates to race equality and other equalities issues.

The Trust has a large workforce of some 8,000 colleagues and over 450 volunteers, who work across a range of specialties and sites. Understanding the dynamics of such a large organisation requires more than desk-research and poring over past reports.

For us at DWC the involvement and engagement with the people who work across the Trust was the critical factor guiding our suggestions for change.

Listening and understanding what matters most to people gave us and the Trust valuable insights into the lived experience of staff and provided the rich insights needed to shape the operating culture in such ways as to achieve a happy and productive workforce. This process was termed a 'Big Conversation'.

The main elements of our approach were:

i. Facilitation of 'Big Conversations' throughout the organisation with attendance and presentations to the non-executive / executive directors, 100 Leaders network, People & OD committee and directorate management teams.

ii. One-to-One meetings with directors and where requested, One-to-One meetings with middle managers and front-line staff.

iii. Engage with Staff Led Networks (SLNs), including the Diversity Networks, to address and resolve key operational / strategic issues; and to advise the Trust on how their work can be integrated into its corporate governance mechanisms and structures.

iv. Analysis of themes relating to organisational culture and their relationship to Equality, Diversity and Inclusion (EDI).

v. Testing of various hypotheses with cross sectional groups and departments in the Trust - including front-line staff, senior management, trade unions (Staff Side), staff led networks and Gloucestershire Managed Services (GMS) staff.

vi. Quantitative analysis based on WRES data and consideration of a range of other datasets provided by the People and OD department.

vii. Dialogue with the trade unions throughout the tenure of the assignment.

viii. Make recommendation on policy and practice changes and where necessary seek to influence key decision making on issues related to the brief.

5. Who did DWC engage and involve?

Our approach to listening to colleagues' experiences was critical to ensuring that we gained important understanding of the challenges facing a range of internal stakeholders, including Staff-Side, Diversity Networks, 100 Leaders, Trust Board, GMS staff and Trust staff.

To achieve this, we facilitated a number of 'Big Conversations' exploring the lived experience of staff on a number of EDI topics. These events were held with a wide cross-section of staff and were augmented by four Facebook Live events which were broadcast publicly.

The aim of this multilevel engagement was to understand the lived experience of colleagues on how Equality, Diversity and Inclusion is managed in the Trust and what remedial action could follow.

Altogether there were 31 'Big Conversation' events, attended by 121 staff, consisting of more than 65 hours of listening to their experiences. In addition, there were:

- 18 one-to-one confidential interviews.
- Four public 'Facebook Live' events with over 9,500 views.
- Over 250 colleagues engaged in discussions with DWC including: 100 Leaders, Board, Staff Side and Staff Diversity Networks.

It is important to note that the findings emerging from the Big Conversations do not stand in isolation, they were congruent with the larger sample of staff views that were reported in the annual staff surveys and the data collated in the Workforce Race Equality Standard (WRES) and Disability Equality Standard (WDES) 2019/20.

Our findings are organised thematically as follows:

Theme 1: Leadership Ambition – outlining the commitment required of leaders in placing a high priority on Race and EDI.

Theme 2: Taking Positive Action – the importance of measures that give pace to advancing the delivery of Race and EDI targets.

Theme 3: Operating Culture and Cultural Competence – what is required to support the Trust moving toward a compassionate and inclusive culture.

Theme 4: Speaking Up with Confidence – encouraging the rich feedback which can support the Trust's change agenda.

Theme 5: Governance & Accountability – addressing the managerial and bureaucratic arrangement necessary to achieve Trust Race and EDI goals.

6. Our Findings – What DWC heard

Theme 1: Leadership Ambition

A pent-up passion for change emerged from the Big Conversations. Many colleagues expressed to us that they wanted to see 'change and action, not action plans'.

Trust leaders are therefore challenged to act with pace and raise the level of confidence that progress will be made commensurate with the urgency being expressed by colleagues. As with any major 'sticky' organisational challenge, confident and competent leadership is an essential ingredient to making progress.

Responding to the call for urgent action, DWC recommends that the Trust promptly and publicly declares its Race and EDI 'ambition status'. We go further and also encourage Trust leaders to match a 'high priority high ambition' commitment to EDI with publicly announced stretch targets that demonstrate an increased urgency for change at corporate and – divisional levels.

It is recommended that whilst a holistic EDI context is embedded within the Trust approaches, there should also be continuous focused attention given to race issues to improve the reported experiences of Black, Asian and Ethnic Minority staff as reported in the 'Big Conversation' and NHS Staff Survey. To support this process, we recommend that 'purposeful mechanisms' are put in place to ensure that 'diverse voices' are represented at decision-making tables.

It is important that those supporting 'diverse voices' have the right level of subject expertise when key business decisions are being made. This may mean engaging diverse external expertise if required. This critical friend relationship must also extend to Disabled, LGBTQ, Women and Faith groups.

In any event, Race and EDI should be treated as 'business critical; and 'best-practice' mechanisms should be put in place commensurate to producing a holistic, purposeful, and measurable Race and EDI strategy. To be fit-for-purpose the strategy must be fully aligned and integrated with the Trust's corporate business plans.

We recommend that performance on these objectives should be closely monitored, reviewed annually by the Trust Board and corrective action taken for failure to achieve results.

Leadership behaviours are just as critical to success, so strong, visible and strategic leadership is essential to addressing the Race and EDI challenges before the Trust. How leaders conduct themselves in the workplace and present as exemplars of the behaviours

they wish to see in their departments is critical to making progress.

Leaders overall approach to addressing race discrimination and specific concerns expressed by Black Asian and Minority ethnic colleagues will determine what is reported in future WRES and staff surveys.

Furthermore, senior leaders must focus on 'zoning-in' on locations where there are consistent reports from groups with protected characteristics that there are detrimental practices and bring intensive approaches to raising behavioural standards.

DWC strongly supports the introduction of a dual focus on inclusive leadership and institutional change that empowers Trust managers to act in accordance with the high ambition, high priority status which the Trust places on Race and EDI.

We advise that the Board undertakes a strategic leadership session that explores the fuller implications of our findings and comprehensively considers the steps required to address the recommendations of this report.

This should also provide an opportunity for the Board to further consider its leadership role in navigating this important and increasingly complex terrain.

What has the Trust done?

The Trust Board has listened carefully to all the findings and recommendations from DWC and remain committed to improving the culture to one that is compassionate and inclusive, celebrating the diversity of staff and the local communities.

The Board has agreed a statement of ambition for the strategic period 2019-2024 using the framing "Best Care for Each Other" to deliver upon this approach to build an Inclusive and Compassionate Culture. This will be measured through the new national NHS Staff Survey, which from 2021 will include a focus on the compassionate and inclusive workplace.

In addition, The Board agreed to measure and improve upon seven themes within the annual staff survey and linked to the 'Insights' programme.

These measurements through the staff survey would include achieving an upper decile performance by 2024 in line with the new national People Promises:

- Promise 1: We are compassionate and inclusive
- Promise 2: We are recognised and rewarded
- Promise 3: We each have a voice that counts
- Promise 4: We are safe and healthy
- Promise 5: We are always learning
- Promise 6: We work flexibly
- Promise 7: We are a team

The Trust will also continue to measure the experience gap to measure performance and ensure parity for ethnic minority, disabled and LGBTQ+ colleagues and work directly with colleagues to drive improvements.

Each division has a focused programme of work and targets to meet in relation to the promotion and treatment of ethnic minority colleagues inclusive of recommendation to the Accelerated Development Pool (ADP), representation at senior levels and a view of the protected characteristics of colleagues who enter into discipline and grievance processes.

By the end of 2021/22 the Trust will update the People and OD strategy to reflect these new ambitions around EDI and associated metrics to ensure these are embedded into business-as-usual practice.

The Trust will continue to explore the racial disparity ratios across job roles and work with divisions to target action to improve the progression of ethnic minority staff across all bandings.

Finally, the Trust is working to develop a new Cultural Barometer, providing more regular insight and feedback to services and managers directly to provide support to colleagues in resolving the issues which arise in a manner which is recognizable as business critical. This includes running a pilot scheme with a number of areas, including those that DWC have suggested the Trust ‘zone in on.’

Theme 2: Taking Positive Action

DWC carefully examined the Trust's performance on Race and EDI issues over recent years. Based on this examination and our extensive interventions with the Trust, we conclude that even if the Trust successfully implements all of its existing initiatives, progress will remain uneven and slow.

A more strategic and systemic approach is needed; something different needs to be introduced to ward off the inevitable crawl towards the same outcomes. Positive Action allows the Trust to step on the gas, 'level up' and redress past inequalities at pace.

Positive Action encompasses the steps that the Trust can legally take to support groups that traditionally experience disadvantage in the workplace. It can take many forms, but essentially, they are all compensating for the impact that patterns of discrimination have on these groups.

To avoid misunderstanding it is important to make the distinction between positive action and positive discrimination. A key difference is that positive action is lawful, provided that the Trust meets the conditions set out in section 158 or 159 of the Equality Act 2010. On the other hand, positive discrimination is generally unlawful, often relating to quotas and has limited legal application in terms of accommodating for disabilities or where an occupational requirement applies.

The unprecedented challenges for Black, Asian and Minority Ethnic communities resulting from Covid-19, alongside the reported results of the results of the Workforce Race Equality Standard provide ample justification for the introduction of positive action measures.

The business case for the Trust pursuing a Positive Action approach to addressing race inequalities is clear:

- 35.1% of Black, Asian & minority ethnic staff recorded they had experienced bullying, harassment or abuse from colleagues*
- 23.6% of Black, Asian & minority ethnic staff reported discrimination from colleagues*
- 60.7% of Black, Asian & minority ethnic staff believe the Trust provides equal opportunities for career progression*
- Some colleagues described their perception of recruitment as unfair and nepotistic. Success was based on 'who you knew'; some ethnic minority colleagues did not see enough diverse representation at a senior level and felt they were passed over for white colleagues. Frustrations about career development and where to find support were heard.
- Some colleagues reported racism from patients and their families.
- Some new ethnic minority nurses held a view that they were placed in wards which were 'more difficult and challenging.' These colleagues wished to access more support as part of their transition into the Trust.

*Data from the Workforce Race Equality Standard Report 2019/20 is available on the Trust website: WRES Report

For the avoidance of doubt, our recommendation here is the Trust applies a 'broad-spectrum positive action approach' to tackling systemic inequalities experienced by Black, Asian and minority ethnic and groups with another protected characteristic.

This approach is particularly apposite to tackling the under-representation of groups with protected characteristics at the senior and Very Senior Management (VSM) levels of the organisation.

The legislation allows the Trust to encourage people from disadvantaged groups to apply for work and to provide targeted training opportunities that give them the skills that enables them to compete for roles where they are under-represented.

To support this, the default position for all interview panels should be that they include panels members from diverse backgrounds and guidance is issued to interview panels to consider wider use of the positive action 'tie-breaker' which could be a 'game-changer' if applied on a case-by-case basis, especially at Bands 6 and above.

The important thing to bear in mind is that DWC is not advocating going beyond the boundaries of the law which requires the Trust to make job appointments on merit alone. By "broad spectrum" we mean not just limiting positive action to recruitment and selection but actively employing it as a tool to encourage, support and develop under-represented groups.

That is not to say we do not value the role Positive Action traditionally plays in recruitment, on the contrary it should be placed at the forefront of all recruitment efforts at every level of the organisation.

The Trust is therefore encouraged to be creative in the use of Positive Action; for example, introducing a targeted approach to career development for Black Asian and minority ethnic staff linked to talent management and succession planning.

What has the Trust done?

The Trust has welcomed the recommendations from DWC and have already made some progress. This has included developing strong, robust and innovative approaches to recruitment and selection to ensure criteria for roles are impartial and do not indirectly discriminate colleagues with protected characteristics.

The Trust has also worked closely with colleagues to co-design a new recruitment and selection policy, which has now been launched. This includes positive action processes, the introduction of new recruitment training, values based and compassionate competency recruitment tools and the introduction of 'Inclusion Champions' on selection panels.

Trust Divisions are also working to ensure 'placement' and 'allocation' decisions are transparent and meet individual skills and organisational needs and these are reviewed to ensure no bias is involved in decision-making.

The Board has set out its ambition and helped shape a plan to meet the Model Employer Aspirations to achieve representation of ethnic minorities in senior roles by 2024, four years earlier than the national requirements.

New career clinics have also been set up for ethnic minority colleagues, to describe and support them through their career path and introduced Application Form and Interview Skills training which is targeted at ethnic minority colleagues who have asked for further support. In addition positive action has been taken to improve the diversity of the Trust's coaching and mentoring faculty.

Across Gloucestershire the Trust continues to work with our partners at the Clinical Commission Group and Gloucestershire Health and Care NHS Foundation Trust to develop a system-wide Positive Action Development programme aimed at disabled, ethnic minority and LGBTQ+ staff (bands 3-7) and their line managers. This will be launched under the banner 'Flourish.'

There is now a process to ensure all ethnic minority colleagues that have been selected to attend national leadership academy development programmes are invited to join the Trust's Accelerated Development Pool. Divisions are held to account monthly on the diverse applications they are supporting to apply to join the ADP.

The Trust has also created a new Ethnic Minority Excellence Council to discuss and make recommendations on matters relating to career progression, education and learning, bullying and harassment. Further progress is being made to create equivalent Excellence Councils for our Disability and LGBTQ+ networks.

However, the Trust recognises that there is still more to do and are working on a number of key milestones. This includes embedding the new Model Employer aspiration targets into the executive review process to monitor quarterly.

The Trust will also review new racial disparity ratios which have highlighted the gap in progression across bands, zoning in on the roles and departments where these gaps are the largest and in need of positive action.

Further work is taking place across all divisions to extend the international buddy scheme for overseas employees to all colleagues with minority protected characteristics to offer support when transitioning into the Trust and to establish means to improve support.

All new colleagues with automatically be invited to join the diversity network, relevant sub-networks and Councils, so that they have immediate support and the opportunities to be directly involved in shared decision making.

Theme 3: Culture and Cultural Competence

The Trust's culture denotes how it does business, how staff behave to one another and includes its institutional values, and core beliefs. The Big Conversation provided us information and clues about the culture of the organisation and uncovered staff views in relation to this.

It is fair to say that many people we spoke to reported enjoying working in the Trust and felt supported and valued. However, some of these individuals were also saddened to hear about the negative experiences of their Black, Asian and minority ethnic colleagues and welcomed the improvement journey the Trust was on.

Some voices reflected that managers seemed to lack the confidence to lead on EDI in a complex fast-paced environment. They wanted managers to be more confident in recognising and tackling issues impacting diverse colleagues such as insensitivity toward disabilities, homophobia and transgender issues.

The calls were for managers to become 'culturally competent' and assertive in tackling incivility and discrimination. A helpful suggestion to move this shift in culture along might be to empower managers to hold discussions on these issues with their teams as a standard part of the performance conversation in appraisal.

There was a desire from staff to have the barriers to being their true and authentic selves removed. These voices wanted the Trust to embed a workplace culture rooted in fairness and inclusivity.

For instance, more should be done to raise awareness of the different working styles of individuals with 'hidden disabilities' and eliminate the micro-aggressions experienced by disabled people. For example, some disabled people stated that they were often ignored and felt patronised on a regular basis.

Similarly, whilst there was a general level of contentment from the LGBTQ+ staff we spoke to, it was clear that the workplace conditions were not such that everyone felt comfortable revealing their sexual orientation. An encouragement for all staff to add their pronouns to their email signatures was suggested as an excellent way to embrace the recognition of transgender employees.

As we have said elsewhere in this report, leadership holds the key to organisational culture change. We note that the Trust has embarked upon a 'compassionate leadership' training programme and strongly recommend that this programme be augmented with modules that specifically speak to cultural competency and cross-cultural communication skills.

In addition, we recommend that learning and development programmes are reassessed for their potential to make a contribution to the formation of a more inclusive and welcoming culture.

Focused learning and development interventions of an 'action learning' type should also be put in place to support senior leaders and managers to manage race equality and EDI from a personal and organisational leadership perspective.

These initiatives should be supported by one-to-one coaching for the managers to incorporate leadership on race equality and other diversity issues within the context of their corporate and directorate leadership roles.

We fully endorse the Cultural Barometer initiative which the Trust has embarked upon in response to DWC's suggestion that it should zone-in on parts of the organisation that require focused attention and support due to concerns or issues being identified.

The aim of this is to introduce remedial actions to these areas and bring them into line with the expected behavioural and performance standards. It is important that the learning that emerges from the Cultural Barometer is well documented and used to customise packages of support to other underperforming divisions.

What has the Trust done?

The Trust has begun work to develop and pilot a new 'cultural barometer', supporting services to directly listen to colleagues' experiences and act upon them together.

This will enable teams to gain access to more real-time information, which is often a challenge in the annual staff survey process. The work will also aim to provide leaders with guidance and other support to address problems and issues relating to EDI and colleague experience.

The Trust has set up a new 'Compassionate and Inclusive Culture' section on the staff intranet, promoting a range of courses, training and support for individuals and managers.

As part of the feedback from the Big Conversation the Trust co-designed a short, animated film, which openly acknowledges the parts of the culture they want to change and the steps being taking to do this. The animation has been shared with all staff, managers and is now part of the Corporate Induction programme.

In addition, a development programme of compassionate leadership has been launched for all leaders and managers, and plan deeper interventions to meet the recommendations DWC have made for action learning sets and coaching.

The Trust will continue to develop the 'respectful resolution' programme as a means to manage rude and bullying, behaviours, introducing mediation as a key stage in resolving conflict. The Trust has also adopted a zero-tolerance approach to proven bullying and harassment cases.

They have established a new EDI Training Specialist role to embed inclusion in educational content and commence cultural competence training and coaching.

Over the last few months, a new 'check and challenge' panel has been established, for potential disciplinary panels with diverse panellists to test the fairness of decisions.

The Trust has invested in a new permanent EDI team to support the Trust to build upon its EDI action plan and cultural initiatives.

The Trust has been selected to commence the NHS Leadership Academy Reciprocal Mentoring programme for Board members and senior leaders, which will match leaders with colleagues identifying with minority protected characteristics to engage in reverse mentoring. The long-term plan is to introduce reverse mentoring across the Trust.

As an organisation they have also joined the NHS Employers Diversity and Inclusion Partners programme, which will provide the Trust with valuable insights into best practice and support programmes of activity to address EDI issues. An increased number of diverse 'Freedom to Speak-up' Guardians have been recruited to improve listening and provide confidence to colleagues to speak up.

There is still more to be done. The Trust aims to embed the 'respectful resolution' approach and learn from other NHS organisations, including the successful 'Just and Learning' culture training designed by Mersey Care.

More work is being done to implement a wide range of development interventions to support managers and colleagues including:

- Human factors and bystander training to upskill colleagues to speak out when they see poor behaviours;
- New training opportunities around cultural competence and disability awareness, allyship;
- Use the compassionate behaviours framework more robustly in appraisals; and
- Develop leadership training to ensure EDI is embedded in all content and programmes connect to the theme of diversity and inclusion

The Trust remain committed to continuing the programme of engagement and hold 'conversations' with colleagues at a divisional and local level to embed EDI actions, which will support change. One approach will be to invite colleagues to describe their lived experiences as part of a 'This is me' series of mini documentaries.

And finally, the Trust will take action to reinforce where patients or the public are racist or discriminatory towards colleagues and implement the ‘Red Card’ approach, adopted by a number of other NHS organisations.

Theme 4: Speaking Up with Confidence

Some staff we spoke to described experiencing a culture of bullying and harassment in their workplaces and these behaviours being overlooked. This has featured in a number of the Big Conversations and affects individuals regardless of the backgrounds.

We note the excellent work being done by the Trust on this issue as exemplified by the Respectful Resolution initiative and are confident that this focused attention supplemented by the Cultural Barometer programme will yield positive results.

Notwithstanding this, we feel it is important to ensure that effective mechanisms are put in place for sense checking the views and experience of minority protected characteristic groups on an ongoing basis.

There were also reports of micro-aggressions such as the mispronunciation of names and not being greeted with a 'good morning'. Of course, the impact of some of these behaviours were often intensified by cross-cultural dynamics – some cultures place more importance on them than others.

There are fine cross-cutting lines between rudeness, incivility, prejudice and cultural misunderstandings. The worrying factor here is the number of individuals reporting that they felt inhibited about speaking out for fear of retribution or reprisal. Alternatively, many welcomed the opportunity to share their lived experiences in the 'Big Conversation' which was seen as a safe place to air their views.

The response to the Big Conversations was in general positive. Many of those participating reported that they hoped that sharing lived experiences would result in change and that the Trust would respond with action that provides reassurance that it is against paying lip service to the feedback received. In view of this we are recommending that the Trust seeks ways to keep the conversation going and empowers leaders and manages to lead courageous conversations on issues that are challenging yet 'business critical'.

Some staff expressed concerns about the time lag in DWC coming on-site for face-to-face meetings (impacted by COVID secure requirements) and warned that this could be misconstrued as a loss of momentum behind the initiative. Others described how experiences of COVID and poor behaviours towards them had impacted their mental health.

To respond to these valid concerns, we recommend the Trust rolls out a programme of re-engaging staff on the findings and recommendation of the Widening Participation Review. This will offer an ideal opportunity to fine-tune and calibrate the Trust's intended responses and approaches.

Staff Led Networks and the Diversity Networks in the Trust continue to grow and offer a safe space for staff to offload and articulate their concerns about how they are being treated in the workplace. It is good practice to support these groups and embrace their potential; for being a sounding board for the Trust on EDI matters.

It is notable that over the life of this review that there were not many voices expressing dissention to the focus on race and addressing under-representation of staff with protected characteristics. To some extent that has led to complacency that the argument has been won and liberal values prevail. It was a timely reminder that a participant in the Big Conversation felt able to express their concerns that raising race issues may prove 'divisive' and threatening to the interest of the majority.

Whether or not one agrees with that position, it is important that individuals are able to express their viewpoints, and in implementing our recommendation, care and attention must be given to properly explaining the reason behind them and their implications for everyone's prospects.

What has the Trust done?

Over the last few months, Divisions have developed programmes of work to replicate the 'Big Conversation' to continue to listen to the lived experience of colleagues, through facilitated conversations and workshops. This has also helped build the visibility of leaders and their commitment on building an inclusive workplace.

Divisions have also embedded EDI as part of their business-as-usual framework reporting on progress, including how they are developing staff, how they are tackling complaints of poor behaviours and how many ethnic minority colleagues are being promoted into our talent pools.

A wide range of forums have been established, supporting colleagues to join and share their experiences and ideas for improvements such as the Divisional, service line and ward-based nursing Councils, the diversity network and sub-networks, and the Ethnic Minority Excellence Council. These groups are now formally supported by the EDI team and report into the Equality Diversity & Inclusion Steering Group.

Further work will support the development and engagement with shared professional decision-making councils to build engagement and involvement across all staff groups.

A Peer Support Network has been launched, with volunteer supporters from diverse backgrounds to act as additional support for colleagues who may be experiencing difficulties or would like someone impartial to talk to.

The Trust has also strengthened the Staff Health and Wellbeing service, retaining the services of Clinical Psychologists and promoting new online counselling platforms known nationally for their take up across ethnic

minority communities.

A dedicated intranet page has been set up, which will serve as the Compassionate and Inclusive Culture ‘hub’ and provides a one stop shop of support and resource for colleagues and managers. It provides access to the cultural animation and all supporting information to give colleagues confidence in next steps.

Further work is under way to ensure Clinical Psychologists are able support colleagues, particularly where they are experiencing racism and discrimination and build opportunities to connect with the diversity networks.

The Peer Support Network and Freedom to Speak up Guardians will continue to develop, enabling colleagues to have a safe space to share issues or concerns.

Finally, the Trust will continue to embed the Compassionate and Inclusive Culture through our leadership programmes, including the compassionate framework and the desire to establish ‘Best Care for Each Other’.

Theme 5: Governance and Accountability

In an organisation as large as the Trust, ensuring good governance of the commitments made and objectives set is essential. DWC recommends the Trust establishes a robust governance structure to bring co-ordination to its Race and EDI programmes.

We recommend that this begins with the construction of a holistic, purposeful, and measurable EDI strategy which is fully aligned and integrated with its corporate business plan.

Accountability for the timely delivery of the strategy should ultimately rest with the Trust Board and be delegated down through departmental leaders and team managers.

To support the corporate EDI strategy, we recommend that each department is tasked with developing a SMART EDI Action Plan which has a distinct race-equality strategy within it. Departmental management teams should be required to discuss and agree equality targets with specific elements that cover race equality.

Managing diversity is an especially complex matter and will signify different things to different managers. Performance can be hit and miss depending on life experiences and previous exposure to diversity in and out of the workplace. What is important in the Gloucestershire context is that the learning and development strategy is fashioned in such a way it generates a common understanding of EDI and supports the Trust's direction of travel.

We welcome that the Trust is assembling additional staff resources to bring focus to its EDI efforts. It is vital that the new EDI team has the critical insights and lived experience to facilitate their understanding of Black, Asian and Minority Ethnic, Disabled, LGBTQ+ and female staff.

Positive Action should be applied in the selection of the team to support this outcome. Of paramount importance is the access and influence the EDI Lead role has to decision-makers.

We strongly recommend that there is direct oversight of the EDI agenda at Board level, with an executive and non-executive lead for Equality, Inclusion and Diversity. There is an opportunity to demonstrate the commitment for EDI, from Board to Ward, and critically to the communities across Gloucestershire and the compassionate, just and inclusive culture the Trust is building. We envisage this as an essential element of the governance and accountability framework.

Staff Led Networks (SLN) have emerged in the Trust and the Big Conversation has likely stimulated the desire for others. These groups present an ideal opportunity for Trust leaders to engage diverse staff and develop

effective working relationships with them. It would be a missed opportunity if the Trust ignored the value of these SLN in contributing diverse voices to the strategy and policy-making process. In order to take advantage of this opportunity it would be important to formally invite these SLN into the governance framework for EDI management.

The governance structure must be supported by comprehensive data capture and monitoring processes for assessing departmental EDI performance against targets.

What has the Trust done?

The Trust already has in place an Equality Diversity and Inclusion Lead role which has now been made substantive, and has named Executive Directors with responsibility for supporting the diversity sub-networks and championing minority protected characteristics. Work is underway to support the diversity networks to strengthen them and give them the space and tools to engage with colleagues across the organisation. These networks are supported by the EDI team and report into the Equality Diversity & Inclusion Steering Group.

The Trust has also created space during the monthly public Board meetings to listen to colleague experiences and to understand where we need to continue to improve.

All the Chiefs of Service are invited to the Board Development Sessions and assurance committees to increase the Board's visibility of the staff voice as represented by them.

Greater investment is being made for new EDI resources to lead the programmes of work to support the EDI Lead, Head of Leadership and OD, and to provide and equip leaders and diversity champions with the information, data and tools to progress the EDI agenda and articulate its business criticality.

A number of ways for colleagues to get involved and contribute to decisions have been set up, including an area on the staff intranet, on-going engagement events and support through the Diversity Networks.

However, there is more work to be done, including additional mapping of the current opportunities for engagement to improve the visibility of listening at Delivery Group and Board settings, ensuring the staff experience is heard from Ward to Board.

The Trust plans to thoroughly review the Board and Committee structures and terms of reference to identify meaningful opportunities to engage and involve colleagues in decision making. Finally, greater options for how the Board - as the ultimate champions for EDI - can engage and listen to staff, exploring new opportunities and including use of Trust Members and Governors.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

DRAFT

Widening Participation Review 2020-2021

Communications and Engagement Action Plan 2021

1.0 Introduction and background

Colleagues across the Trust have told us that they do not always have positive experiences in the workplace. This is also reflected in what individuals from disabled, LGBTQ+ and ethnic minority communities experience and is evidenced within the annual Workforce Race Equality Standard data (WRES), Workforce Disability Equality Standard (WDES), NHS Staff Survey and regular colleague engagement.

We have worked with an independent organisation, DWC to undertaken an objective and transparent review and make recommendations to ensure we are truly inclusive and support diversity.

DWC held a series of 'Big Conversations', interviews and discussions with a wide range of colleagues, including Staff Side, Board members, Diversity Networks and co-hosted four Facebook Live events with staff to discuss experiences.

Equality, Diversity & Inclusion are at the heart of the compassionate care we provide every day. However, it is clear that despite our best efforts the Trust is not as inclusive as we would pride ourselves to be and there too many examples where collectively we tolerate or fail to address behaviours which have no place in our workplace or community.

The "Big Conversation" helped us better understand the different experiences of working in our Trust, and the behaviours behind them. It was clear that staff had concerns in several areas but especially around:

- Fairness in recruitment and access to career development opportunities;
- Working where culture is built on trust and respect;
- Work in a place that is inclusive for all.

In order to engage colleagues further, an animation and call to action has been developed, to ensure that we all make changes, making the Trust a compassionate and inclusive place to work.

2.0 Communication and engagement objectives

Inform: To be open and honest with colleagues in what we have heard and how we will work with them to build a compassionate and inclusive culture.

Engage: To bring colleagues with us on building our compassionate and inclusive culture and support people to share their experience.

Reputation: To challenge poor behaviours or where individuals do not live our values. To be open and honest with stakeholders about the gap in experiences and what we are doing to build our compassionate and inclusive culture.

2.1 Inform

Sharing knowledge, expertise and information will help to build trust and drive change across the organisation. Communications and engagement activity will help to:

→ To share the findings from the DWC Widening Participation Review and the actions we are taking as a Trust.

→ Better understand how data and staff experience is being used to improve our culture.

→ To highlight where the experiences of colleagues falls short of a compassionate and inclusive culture ;

→ Ensure information is readily and easily accessible for colleagues to access this as they need it.

2.2 Engage

Ensuring good engagement with colleagues is essential. There is a collective responsibility to build our compassionate and inclusive culture, and we need to continue to build trust that what matters to colleagues is being listened to and action is being taken together.

→ Colleagues are able to share their lived experience and shape how we build and maintain a compassionate and inclusive culture.

→ To support colleagues to understand the inclusion is a collective responsibility;

→ To involve and actively listen to what matters to colleagues;

→ To support colleagues to understand that inclusion is a collective responsibility;

2.3 Reputation

Our reputation consists of the perception that staff, partners and stakeholders gain through their experience working with us. This includes direct contact with staff and services and through the information shared on media and social media.

A good reputation ensures higher workforce morale and an increased ability to recruit and retain staff. It also improves our ability to implement change as staff embrace our vision and values.

→ Be open and transparent in the findings from DWC with staff and key stakeholders.

→ To outline the ambition and actions we are taking as a Trust to meet the recommendations.

→ To demonstrate how we will build a compassionate and inclusive culture that is representative of the diverse communities we serve;

3.0 Key messages

- ***Inclusion is a health issue.*** The impact of discrimination, bullying, harassment and poor behaviour is not acceptable.
- Creating an inclusive culture is a collective responsibility.
- When we work together, we make a real difference to our patients and each other, every day. At our best, we create a culture that reinforces our values of Caring, Listening and Excelling.
- However, by continually engaging and listening to colleagues we recognise that many do not always have a good experience at work.
- We also know that many of our colleagues with disabilities, long-term health conditions, and those from LGBTQ+ or from ethnic minority communities are often more likely to experience discrimination from patients and other staff.
- We are working to ensure our recruitment processes and access to career development opportunities is inclusive and more transparent, including greater diversity on panels.
- We continue to build a compassionate and just culture that values everyone equally and a workplace that is inclusive for all.
- We have a collective responsibility to maintain a compassionate and inclusive culture

4.0 Risks and issues

Area	Risk	Mitigation
Staff engagement	Individuals and teams are not able to share their lived experience or key issues.	A strong programme of communications and engagement, with Divisional support
	Staff unable to engage in the programme due to other competing operational pressures.	Ensure senior clinical/operational leads are engaged and contributing to the programme at the earliest stage.
	Intranet pages not updated and difficult to search/navigate	New compassionate and inclusive cultural section developed: https://intranet.gloshospitals.nhs.uk/departments/corporate-division/compassionate-and-inclusive-culture/ .
	Information in complex and difficult to convey	New intranet section and short animation outlining what we have heard and what actions we are already taking.
Patient and public	Staff experiencing racism or discrimination from patients or the public	A strong zero tolerance approach. Red Card to Racism
Reputation	Spotlighting the Trust at a time of significant operational pressures.	Consistent messaging focusing on how we are proactively supporting colleagues and listening to lived experiences.
	Media enquiries on the Staff Survey results as the Trust featured within the lowest 10% for ethnic minority colleagues.	A strong programme of communications and engagement.
	Misinterpretation on social media / media channels regarding the findings from DWC report.	A proactive watching brief on Trust social media channels will enable any issues to be quickly addressed and responded to.

5.0 Stakeholders

1. Strategic partners

GHFT Internal

- Chair
- Board (Execs and NEDs)
- Council of Governors

External partners

- ICS chair and Board
- GHC CEO and Chair
- DWC Consulting

2. Closest to the work

GHFT Internal

- People and OD Team
- Communications & Engagement Team

External

- DWC Consulting

3. Proactive two-way communication

GHFT Internal

- 100 Leaders / Extended Leaders Network
- Staff & volunteers
- Divisional Tri's
- Staff Side
- Diversity Networks : Ethnic Minority, LGBT, Disability
- GMS staff

External partners

- NHS England & Improvement
- Press and Media

4. Keep informed

GHFT Internal

- Trust Members

External

- Patients, carers and the public
- Partnership Involvement Network
- MPs & HOSC
- Healthwatch

6.0 Methods, materials and channels

Internal communications and engagement:

→ Publication of the report - Intranet: Homepage (quick link)

→ Series of engagement workshops, facilitated by DWC in September/October 2021

→ Development of Compassionate and inclusive cultural intranet section:

→ Culture Animation – short 5 min film which articulates the current position and action being taken

→ You said, We did – circulate updates on what has been achieved since WPR started and immediate priorities

→ Links to the Diversity Networks

→ Staff global message (Vlog & dedicated email)

→ Update to Governors (at CoG & stakeholder briefings)

→ Operational comms: Regular update email advising of disruption in advance

→ GMS specific communication channels (Newsletter and Teamphoria)

External comms:

→ Website – publish report on Trust website – under 'Get Involved' section

→ Briefing for MPs and stakeholders

→ Media management: reactive briefing

7.0 Communications and engagement action plan

Date	Channel	Action	Objective	Lead	Status
16 Aug 2021	Exec Team	DWC Report to Exec Team for discussion and confirmation on key actions	Inform / Engage / Reputation	Emma Wood	In progress
24 Aug 2021	People & OD Committee	DWC Report to PODC for discussion and confirmation on key actions	Inform / Engage / Reputation	Emma Wood	In progress
9 Sept 2021	Board Development Session	DWC Report and presentation to Board for discussion and confirmation on key actions	Inform / Engage / Reputation	Emma Wood	In progress
w/c 13 September 2021	Staff Engagement Events	Deliver staff engagement workshops to feedback and share the DWC Report and explore any emergent themes	Inform / engage	James Brown Abigail Hopewell DWC	In progress
w/c 13 September 2021	Website / intranet	Publish DWC Report and share with colleagues	Inform / Engage / Reputation	James Brown Comms	In progress
w/c 13 September 2021	Stakeholder Briefing	Publish DWC Report and share with Governors and key stakeholders	Inform / Engage / Reputation	James Brown Comms	In progress
w/c 20 September 2021	Staff Engagement Events	Deliver staff engagement workshops to feedback and share the DWC Report and explore any emergent themes	Inform / engage	James Brown Abigail Hopewell DWC	In progress
w/c 27 September 2021	Staff Engagement Events	Deliver staff engagement workshops to feedback and share the DWC Report and explore any emergent themes	Inform / engage	James Brown Abigail Hopewell DWC	In progress

8.0 Evaluation

The Communications and Engagement Team will use a range of approaches outlined below to evaluate/monitor communications and stakeholder engagement.

9.1 Analytics

The following electronic/digital communication platforms can be evaluated using analytics (and numbers reached can be measured).

Internal communications:

→ Intranet – Compassionate and INcludisve Culture
→ Analytics – views of Animation
→ Analytics on global emails.
→ Analytics on members' emails.

External communications:

→ Social media.
→ Website.
→ Media reports.

Engagement:

→ Numbers attending engagement workshops
→ Numbers contacting Diversity Networks
→ Feedback on the report and emergent themes
→ Tone of events

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Email us: ghn-tr.comms@nhs.net

Version 1.0

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD, 14 OCTOBER 2021

Report Title
Green Plan 2021-2025
Sponsor and Author(s)
Author: Jen Cleary, Head of Sustainability Sponsors: Professor Steve Hams, Director of Quality and Chief Nurse Keith Hamer, Managing Director, Gloucestershire Managed Services
Executive Summary

When the Trust declared a climate change emergency in December 2019 it sent a clear message as to the importance it places on the threat that climate change poses to public health. The Trust is keen to be a leader in climate change action, helping and encouraging others to make a positive long-term shift towards sustainable behaviour. Gloucestershire Managed Services (GMS) is fully supportive of these aims and as such the Green Plan is issued as a joint document between both organisations.

This Green Plan is our key document for the sustainability agenda and commits the Trust and GMS to a range of actions, initially between 2021 and 2026, but also longer term, which will help move us forward on our pathway to net-zero by 2040. It provides a comprehensive and structured framework to show how we will work to embed sustainability into the organisational culture so that sustainability becomes part of how we think and everything we do. As we recover from the pandemic we must take care to ensure our actions do not increase climate risk or lock-in greenhouse gas emissions, and that we are as environmentally, economically and socially sustainable as possible.

The Green Plan outlines three green objectives:

1. Healthy environment – managing and reducing our negative environmental impacts, developing and enhancing our natural environment
2. Health for all – improving the health of our patients, staff and local community
3. Embedding sustainability – sustainability must underpin all actions and decisions, becoming part of how we think and what we do within the organisation. Staff are empowered and leading the change.

There are three targets:

- Meet the NHS targets - NHS Net Zero Carbon Footprint of 80% reduction by 2032 and net zero by 2040. NHS Net Zero Carbon Footprint Plus by 2045
- Develop sustainable care models and use digital technologies to benefit our patients with 50% of our follow-up OPD appointments to be virtual by 2025
- Be recognised as a leader in sustainable healthcare and climate change action

The Green Plan is accompanied by a Green Action Plan. These initial actions take us to 2026 and are sub-divided into ten Areas of Focus – these cover all aspects of sustainability including Sustainable Use of Resources, Travel and Logistics, Sustainable Care Models, Carbon and Greenhouse Gases and Green Space and Biodiversity.

There are six key initiatives for the next three years:

1. Drive decarbonisation with specific partners and available Public Sector Decarbonisation Scheme funding with 20% of our energy consumption from renewable sources

2. Sustainability embedded in decisions for corporate investment and key decision making
3. Sustainability on every meeting agenda
4. 100% food waste recycled and 100% non-clinical waste recycled by 2025
5. Implement digital management techniques on critical infrastructure services to support target to 80% carbon footprint reduction by 2040
6. Increase recycling on clinical product base by 20%

We are very aware that this ambitious agenda will require the vision, collaboration, support and efforts of all – not only our staff, patients and visitors, but also our suppliers, Integrated Care System partners and external organisations.

The Trust's Sustainability Lead and the Climate Emergency Response Leadership group will monitor, implement and manage the delivery of this Green Plan and associated Green Action Plan, working with our colleagues across the Trust and GMS to implement the actions contained within the plan.

Recommendations

Board is asked to endorse the adoption of the Green Plan.

Impact Upon Strategic Objectives

The Trust wishes to embed sustainability into the organisational culture. Sustainability must underpin all actions and decisions, becoming part of what we think and how we do things. As such the Green Plan and sustainability links to all ten strategic objectives.

Impact Upon Corporate Risks

A detailed delivery risk assessment will be completed prior to presentation of the Green Plan to the GHT Board.

Regulatory and/or Legal Implications

The Trust is required to have a Green Plan and needs to meet the national NHS carbon emissions target – for the emissions we control directly net zero carbon by 2040 and for the emissions we influence net zero by 2045.

Equality & Patient Impact

Climate Change is recognised as the greatest threat to health in 21st century (The Lancet and University College London Institute for Global Health 2009). The Green Plan will promote sustainable models of health and introduce adaptation and mitigation measures. It will contribute to the reduction of health inequalities and the climate change impact felt by many vulnerable and disadvantaged communities.

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	

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

Audit &	Finance &	Estates &	People &	Quality &	Remuneration	Trust	Other

Assurance Committee	Digital Committee	Facilities Committee	OD Committee	Performance Committee	Committee	Leadership Team	(specify)
		23rd Sept 2021				July 21 & Sep 21	

Outcome of discussion when presented to previous Committees/TLT

Draft Green Plan was presented to TLT in July and comments received on the content. These have been incorporated into the version that was approved by TLT and E&F Committee in September.

Green Plan
2021–2025

Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Managed Services

Contents

Our mission 3
About our Trust 4
Our green plan 5
Our vision 6
Overview 7
Climate emergency declaration 8
Sustainability in healthcare: drivers for change 9
United Nations Sustainable Development Goals (UN SDG) 14
Timetable of sustainability actions 15
What we have achieved to date: results and progress 16
Forecast and targets 19
The impact of COVID-19 20
Areas of focus 22
Governance and reporting 44
Engagement 46
Communications 47
Summary 48
References 49
Glossary 50
Appendix 1: Green Action Plan 52
Appendix 2: Sustainability Communications Plan 53

Our mission

Gloucestershire Hospitals NHS Foundation Trust's (GHNHSFT) ambition is to become a leader in sustainable healthcare i.e. act sustainably, lead by example and embed sustainability into the organisational culture. This will support the targets of the NHS Long Term Plan, help us take the opportunity to improve what we do and how we do it and ensure our Trust is as environmentally, economically and socially sustainable as possible.

As a Trust we recognise the enormous challenge that the issues of climate change, air pollution, flooding, extreme heat and waste present to Gloucestershire and the impact that these issues have on our patients, colleagues and communities. In December 2019 we were one of the first NHS organisations in the United Kingdom to declare a Climate Emergency; we have joined a growing number of health organisations globally to deliver reductions in the carbon footprint generated by healthcare delivery.

We have already undertaken excellent work to address these issues through our previous Sustainable Development Management Plan (SDMP) and we welcome this new Green Plan, which builds upon our progress so far. This Green Plan details a proactive approach that our Trust will take to ensure we do our part to reduce the impact that climate change will have on the people of Gloucestershire.

In 2020 we were awarded a £13.7 million grant from the Public Sector Decarbonisation Scheme. This has funded a number of infrastructure improvement projects which will make significant contributions to the reduction in carbon emissions from our buildings. We will seek further funding of this type when opportunities arise.

For the Trust to be a truly sustainable organisation, we need all of us to play our part, and work together with our partners and communities to deliver this Green Plan. Our Green Champions network will support everyone in the Trust to work together to address the climate emergency and achieve zero carbon by 2040.

We strongly encourage all of us to build a green social movement to deliver a safer, more environmentally sustainable future.

Professor Steve Hams
Director of Quality and Chief Nurse Executive Lead for Sustainability, GHNHSFT

Keith Hamer
Managing Director, Gloucestershire Managed Services

About our Trust

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute elective and specialist health care for a population of more than 633,000 people.

Acute hospital services are provided from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital.

Maternity Services are also provided at Stroud Maternity Hospital.

The Trust is the largest employer in Gloucestershire with over 8,000 colleagues.

Gloucestershire Managed Services (GMS) is a wholly owned subsidiary company set up by GHNHSFT on 1st April 2018. GMS provides the estates, facilities, sterile services and materials management services for the Trust.

Our green plan

This Green Plan outlines the steps which our Trust will take to reduce carbon emissions and improve sustainability over the next five years as we head toward net zero in 2040.

The links between human health and climate change and biodiversity loss are clear and we have a responsibility to take action. The Climate Change Act (2008) and the NHS targets (Delivering a Net Zero NHS, 2020) oblige the Trust to reduce carbon emissions.

We must act now to embed sustainability into our organisational culture; make changes to how we operate and deliver services, choose differently in regard to how and what we procure, and upgrade our infrastructure. These actions will enable us to meet the NHS targets of net zero carbon emissions by 2040 on the emissions we directly control, and reach net zero carbon by 2045 on those we influence.

This Green Plan builds upon the success of the previous Sustainable Development Management Plan (2015-20) which this Green Plan replaces.

The Green Plan sets out our goals and shows how sustainability is incorporated into our strategic objectives and visions for the future. The plan outlines some of our progress to date and highlights aims for the future, covering all aspects of sustainability including adaptation to climate change, travel, green space, new models of healthcare and improvements to infrastructure and resource efficiency.

The involvement of colleagues, patients and visitors will be vital. Many of our colleagues want to be involved and have enthusiasm and ideas and are already taking action to make a difference. We will support and encourage their assistance with this programme through our Green Champions network. We will also work with our stakeholders e.g. local councils, One Gloucestershire (the Integrated Care System) and our suppliers, to drive the sustainability agenda and reach our targets.

Sustainable healthcare will improve the health of the local population and reduce demand on NHS services. As we recover from the COVID-19 pandemic the Trust can look to the future, not merely returning to business as usual but taking the opportunity to do things more sustainably.

We will take the opportunity to improve what we do, how we do it and consider the wider implications of our actions. All decisions must consider the impact on sustainability – social, environment and economic, and how they contribute to climate change and the overall reduction in carbon emissions.

Our vision

To become a leader in sustainable healthcare, act sustainably and lead by example.

GHNHSFT wants to embed sustainability into the organisational culture. Sustainability must underpin all actions and decisions, becoming part of what we think and how we do things. All staff have a role to play in this change.

Every decision and project, especially those linked to long term strategy or business planning, must consider how the planned action will contribute to sustainability – not just environmental but also social and economic.

This sustainability vision aligns with our organisational values of 'Caring', 'Listening' and 'Excelling' and the Trust's overall vision of 'Best Care for Everyone, Best Care for Each Other'. Sustainability supports these values and will help us achieve them.

Our Trust's ten strategic objectives 2019–2024 all link to sustainability values and benefits.

Strategic Objective	Sustainability benefit
Outstanding care	Good health and wellbeing for all
Compassionate workforce	Skilful workforce with good recruitment and retention levels as part of a compassionate, just and inclusive work culture
Quality improvement	Improvement at the heart of everything that we do
Care without boundaries	Reduced inequality and greater partnership working
Involved people	Staff who are enabled and encouraged to make a difference
Centres of excellence	Best care locally with a focus on local resources
Financial balance	Using available finance for best investments for long term sustainable benefit
Effective estate	Reducing carbon emissions in our workspaces
Digital future	Virtual appointments saving patient travel to our sites
Driving research	Preventing illness, creating a healthier community and supporting provision of sustainable healthcare for all

Overview

Our vision

To become a leader in sustainable healthcare, act sustainably and lead by example

Our green objectives

Healthy environment

managing and reducing our negative environmental impacts, developing and enhancing our natural environment

Health for all

Improving the health of our patients, staff and local community

Embedding Sustainability

sustainability must underpin all actions and decisions, becoming part of how we think and what we do within the organisation. Staff empowered and leading the change.

Our Targets

Meet NHS targets

Net Zero Carbon Footprint:

- 80% reduction by 2032 and net zero by 2040.

Carbon Footprint Plus:

- Net Zero Carbon by 2045
- Sustainability

Develop sustainable care models and use digital technologies to benefit our patients.

50% of our follow-up OPD appointments to be virtual by 2025

Be recognised as a leader in sustainable healthcare and climate change action

Key initiatives for the next three years

- ✔ Drive decarbonisation with specific partners and available Public Sector Decarbonisation Scheme funding.
- ✔ 20% of our energy consumption from renewable sources
- ✔ Sustainability on every meeting agenda
- ✔ Sustainability embedded in decisions for corporate investment and key decision making
- ✔ 100% food waste recycled and 100% non-clinical waste recycled by 2025
- ✔ Create sustainable infrastructure to support transition to electrical vehicle fleet by 2025.
- ✔ Improve digital monitoring and management on infrastructure services
- ✔ Increase recycling on clinical product base by 20%

Areas of focus

Corporate Approach

Adaptation

Sustainable Care Models

Carbon and Greenhouse Gases

Asset Management and Utilities

Capital Projects

Our People

Travel and Logistics

Green Space and Biodiversity

Sustainable Use of Resources

These Areas of Focus identify our initial actions on our sustainability journey. They are supported by the Green Action Plan.

Climate emergency declaration

In December 2019 GHNHSFT declared a climate emergency.

This declaration sent a clear message that our Trust recognises and gives weight to the threat that climate breakdown poses to public health, and that we lead other healthcare organisations in committing to fast track plans to achieve carbon neutrality and improving the health of our population in the process.

Planting a tree at GRH to mark the declaration of the climate change emergency in December 2019

(Left to right)

Steve Hams
Director of Quality and Chief Nurse, GHNHSFT

Keith Hamer
Managing Director, Gloucestershire Managed Services

Deborah Lee
Chief Executive, GHNHSFT

Elaine Warwicker
Non-executive Director, GHNHSFT

Sustainability in healthcare: drivers for change

Sustainability has been defined by the United Nations Brundtland Commission (1987) as: "development that meets the needs of the present without compromising the ability of future generations to meet their own needs…"

As an NHS organisation we have an obligation to work in a way that has a positive effect on the communities we serve. The three pillars of sustainability – society, environment, and economy are interconnected and reliant on each other (Figure 1, p10).

The Sustainable Development Strategy for the NHS, Public Health and Social Care System (2014) says: *"A sustainable health and care system works within the available environmental and social resources, protecting and improving health now and for future generations. This means working to reduce carbon emissions, minimising waste and environmental pollution, making the best use of scarce resources, building resilience to a changing climate and nurturing community strengths and assets."*

Gloucestershire Hospitals NHS Foundation Trust acknowledges the impact we have on the local economy, society and environment and are therefore committed to continually work to actively integrate sustainability into our core business.

Climate and Health

Climate change is the greatest threat to health of the 21st century (The Lancet and University College London Institute for Global Health, 2009). Humans have already caused irreversible climate change, the impacts of which are being felt around the world.

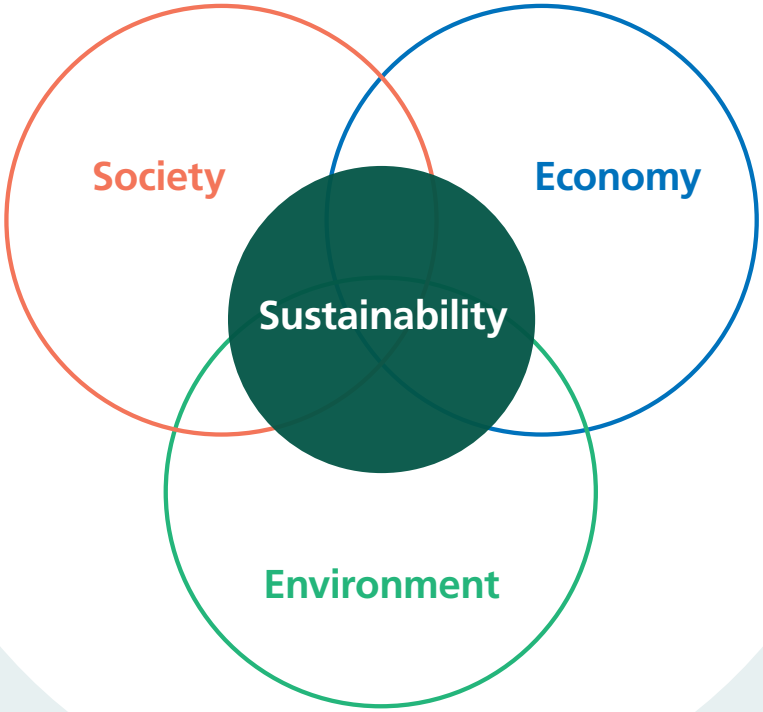
The United Kingdom was the first country in the world to commit to legally binding carbon emissions reductions of 80% by 2050, from 1990 levels. However even alongside plans from across the world this is not enough.

The World Meteorological Organisation report (State of the Global Climate 2020, World Meteorological Organization [WMO]) noted that the global mean temperature for 2020 was around 1.2°C warmer than pre-industrial times, which means time is running out to avoid climate breakdown i.e. exceeding the Paris Agreement's safe limit of 1.5°C (Intergovernmental Panel on Climate Change Special Report on the Impacts of Global Warming of 1.5°C, 2018).

The Health Care Climate footprint report published in September 2019 by Healthcare without Harm, noted that globally, healthcare's climate footprint accounts for 4.4% of the world's net C02 emissions. If healthcare were a country it would be the fifth largest emitter on the planet.

The report also finds that the NHS produces higher emissions than the

Figure 1: Three pillars of sustainability



Society	Environment	Economy
Includes health and social equality, social responsibility and justice, and a compassionate and inclusive workforce	Where processes, systems and activities reduce the environmental impact of the organisations facilities and operations	Where efficient and responsible use of resources can support the local economy, fund investment in sustainable projects and also create savings from reducing consumption

global average for healthcare and is responsible for 5.4% of the UK's total carbon emissions, equivalent to the greenhouse gas emissions of 11 coal-fired power stations. Its emissions are not much lower than those for both aviation, and agriculture, forestry and land use in the UK (each 6.5% according to Committee on Climate Change figures).

In the United Kingdom, climate change has a detrimental impact on health, for example heat related mortality in persons older than 65 years increased by 21% between 2004 and 2018. 2020 was the third warmest year on record in the United Kingdom. Winter 2019–2020 was particularly warm and wet with three named storms delivering widespread flooding damage and disruption. Together, storms Ciara, Dennis and Jorge contributed to the wettest February on record.

The Climate Coalition report (The impact of climate change on public health, 2021) notes that about 1.8 million people in the UK are at risk of flooding, with almost 1 in 3 suffering from poor mental health and post-traumatic stress disorder after their homes have been flooded. Unfortunately various areas of Gloucestershire are prone to regular flooding and climate change has increased flood risk. The same report notes about 12 million people in the UK are vulnerable to summer heatwaves, especially those with heart or circulatory disease.

The NHS Long Term Plan and Targets

The NHS Long Term Plan published in January 2019 reaffirmed the NHS's commitment to reducing its carbon footprint. Specifically the NHS Long Term Plan noted:

A commitment to the carbon targets in the UK government Climate Change Act (2008), reducing carbon emissions (on a 1990 baseline) by 34% by 2020; 51% by 2025 and 80% by 2050.

Air pollution contributes to almost a third of preventable deaths (Clean Air Hospital Framework). Switching to low carbon vehicles and active travel will reduce greenhouse gas emissions and air pollution related to transport. This is particularly important as there are three Air Quality Management Areas within Gloucester and Gloucester City Council have an action plan in place.

The NHS is committed to improving air quality by cutting business mileage by 20% by 2023/24; ensuring that at least 90% of the NHS fleet uses low-emissions engines (including 25% ultra-low emissions) by 2028; and phasing out primary heating from coal and oil fuel on NHS estates.

The NHS will ensure that all trusts adhere to best practice efficiency standards and adoption of new innovations to reduce waste, water and carbon, in addition to reducing single-use plastics.

The plan also outlines the idea of the NHS as an 'anchor institution', which is an important concept to promote an understanding of the NHS' contribution to the local economy, society and environment.

The idea of prevention and more efficient working is threaded throughout the plan, e.g. by promoting earlier detection of illness. Preventing illnesses from happening in the first place is the best possible way for the NHS to become the most sustainable health and care system it can be.

The NHS is responding by focusing on:

- Improving air quality (fleet emissions and reducing outpatient attendances at site)
- Reducing carbon, waste and water (estates, inhalers and anaesthetic gases)
- Reducing single use plastics (plastics and recycling)
- Procurement and supply chain
- Innovation and technology
- Communications and engagement.

In October 2020 NHS England published the NHS Net Zero report. This introduced new targets for the reduction of carbon emissions:

For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032

For the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ax`mbition to reach an 80% reduction by 2036 to 2039.

(See figures 2 and 3, previous page)

The NHS Carbon Footprint emissions include gas and oil for heating, hot water and steam, fuel for fleet vehicles, emissions from business travel, electricity (both on-site generation and that supplied via the national grid) and emissions associated with waste, supply chain and other services.

The NHS Carbon Footprint Plus emissions include the above, plus emissions from patient and visitor travel to and from our services and medicines used in the home.

The Trust will adopt these new targets and will aim to be net zero carbon in our directly controlled emission by 2040.

Figure 2: Greenhouse Gas Protocol scopes

From Delivering a 'Net Zero' NHS, NHS 2020

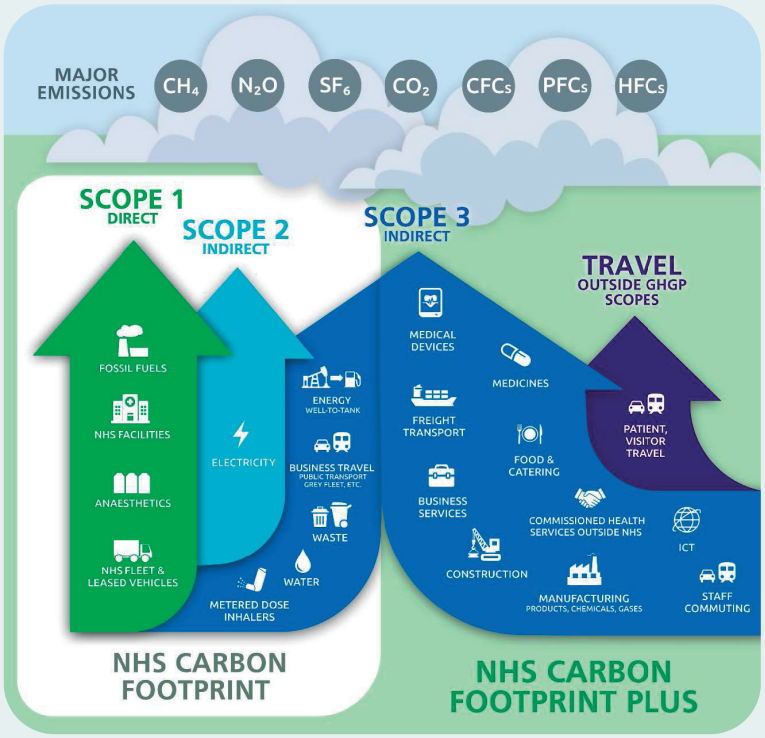
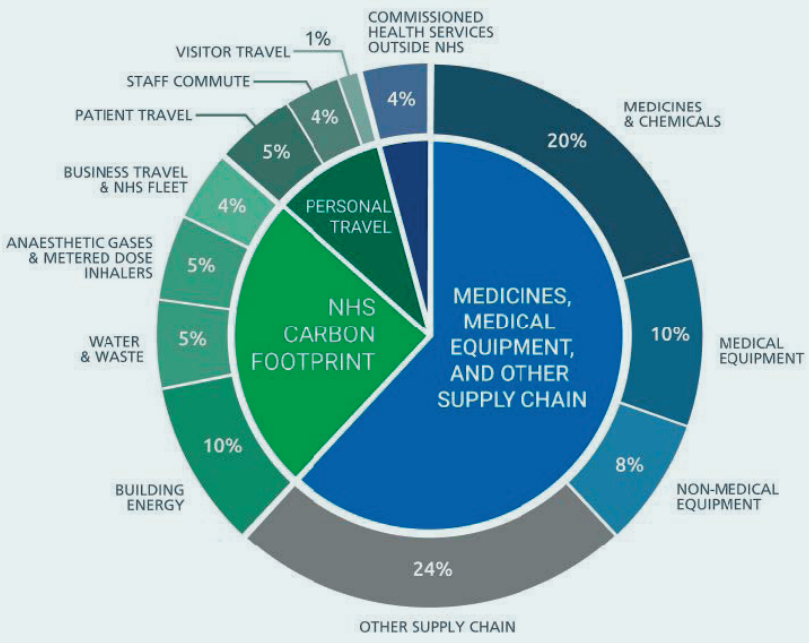


Figure 3: Sources of carbon emissions by proportion

From NHS Carbon Footprint Plus (from Delivering a 'Net Zero' NHS, NHS 2020)



United Nations Sustainable Development Goals (UN SDG)

This Green Plan is aligned with the 17 United Nations Sustainable Development Goals.

These global aims intend to end all forms of poverty, fight inequalities and tackle climate change. They were agreed at the UN in 2015 and as a signatory the UK has agreed to work for a "more inclusive, sustainable and prosperous world that leaves no-one and nowhere behind by 2030"(https://www.ons.gov.uk/economy/environmentalaccounts/articles/sustainabledevelopmentgoalstakingstockprogressandpossibilities/december2020)

As part of the NHS we need to identify how we can help meet these goals and so our Green Plan shows how our actions will support some of these goals.

Timetable of sustainability actions

2007
Shuttle bus service starts

2014
Bicycle User Group formed

Nov 2014
CHP at CGH comes on-line

Jul 2015
Trust Sustainable Development Management Plan 2015-20 launched

Jan 2016
Black waste diverted from landfill – Energy to Waste plant

Jul 2016
Fosters farm shop opens

Jul 2016
Can crushing machine at GRH

Feb 2017
£20,000 grant for bike sheds

2018
Trust declaration on Modern Slavery

2018
£600,000 grant for LED

May 2018
CHP at GRH comes on-line

2019
NHS sustainability Award for Anaesthetics team for reduction of Desflurane gas

Nov 2018
New compactor for cardboard at GRH

Dec 2019
Trust declares Climate Change Emergency

Nov 2019
Trust signs NHS Single Use Plastics Reduction pledge

Jan 2020
Sterimelt machine on-line

Mar 2020
Attend Anywhere system introduced for out-patient appointments

Dec 2020
£13.7m grant for decarbonisation infrastructure schemes

Feb 2021
Fleet and Grey Fleet reviews conducted

Apr 2021
Grid electricity 100% renewable

Apr 2021
Green Champions launched

Aug 2021
Green Council launched

Autumn 2021
Green Plan launch

What we have achieved to date: results and progress

The organisation reports its carbon figures and greenhouse gas emissions each year.

The Trust spent £3.05m on gas, oil, electricity and water in 2020–21.

The increase in gas consumption is due to the running of the Combined Heat and Power units, which use mains gas to generate electricity.

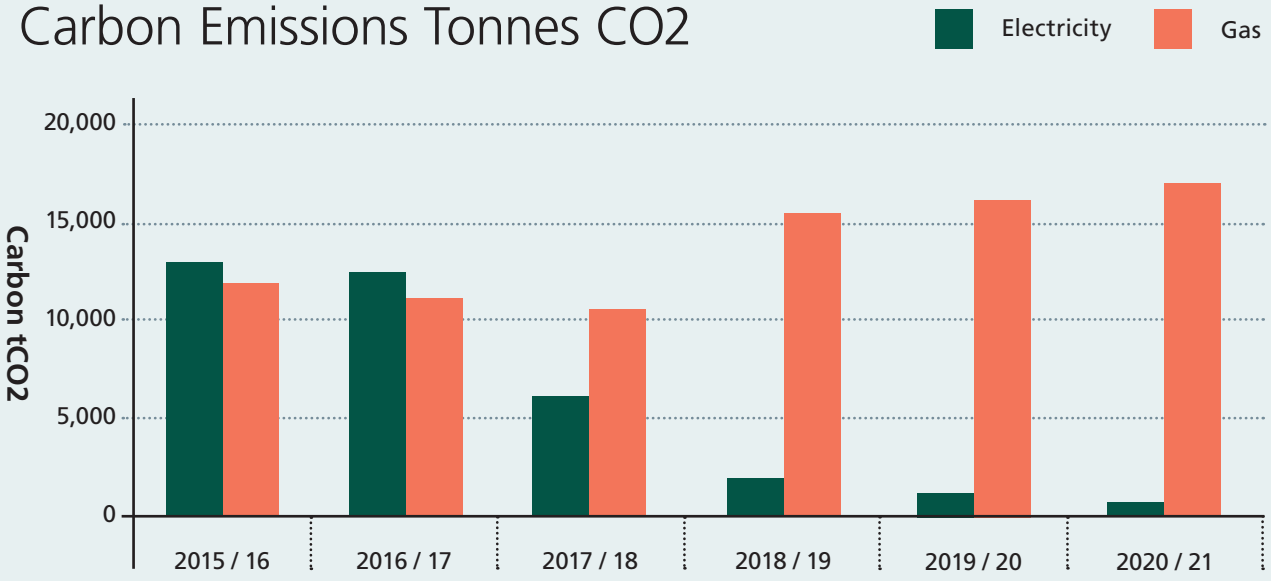
Heat is produced as a by-product and is used for the creation of steam and hot water. There is therefore a corresponding decrease in the electricity taken from the national grid. Oil is used to heat one building at GRH and to fuel the back-up generators on both main sites.

Since April 2021 all our electricity taken from the national grid is from 100% renewable sources.

Energy usage

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Gas						
Use (kWh)	59,520,043	60,062,487	56,854,097	85,965,330	87,932,803	90,503,442
tCO2e	12,487	11,085	10,471	15,814	16,176	16,641
Oil						
Use (kWh)	31,060	103,061	42,435	71,280	351,200	224,560
tCO2e	8	26	10	18	89	57
Electricity						
Use (kWh)	22,273,744	22,633,386	17,791,983	7,027,940	5,528,742	3,717,545
tCO2e	12,806	12,066	6,255	1,989	1,565	867
Total CO2						
Total Energy CO2e	25,301	23,177	16,736	17,821	17,830	17,565

Carbon Emissions Tonnes CO2



Scope 1, 2 and 3 emissions

In compliance with Greenhouse Gas protocols the Trust reports its scope 1, 2 and 3 emissions in the annual report. In 2020-21 the Trust declared the following:

Greenhouse Gas Emissions

Type	Unit	Cost
Scope 1 (gas and oil consumption, fleet vehicles and anaesthetic gases)	19,031 tCO2e	Total Scope 1, 2 and 3 emissions (not including anaesthetic gas) £2,925,595
Scope 2 (electricity consumption)	867 tCO2	
Scope 3 (business travel, water supply and treatment)	439 tCO2	

Water

Type	Unit	Cost
Water consumption	300,845m3	**£578,791**

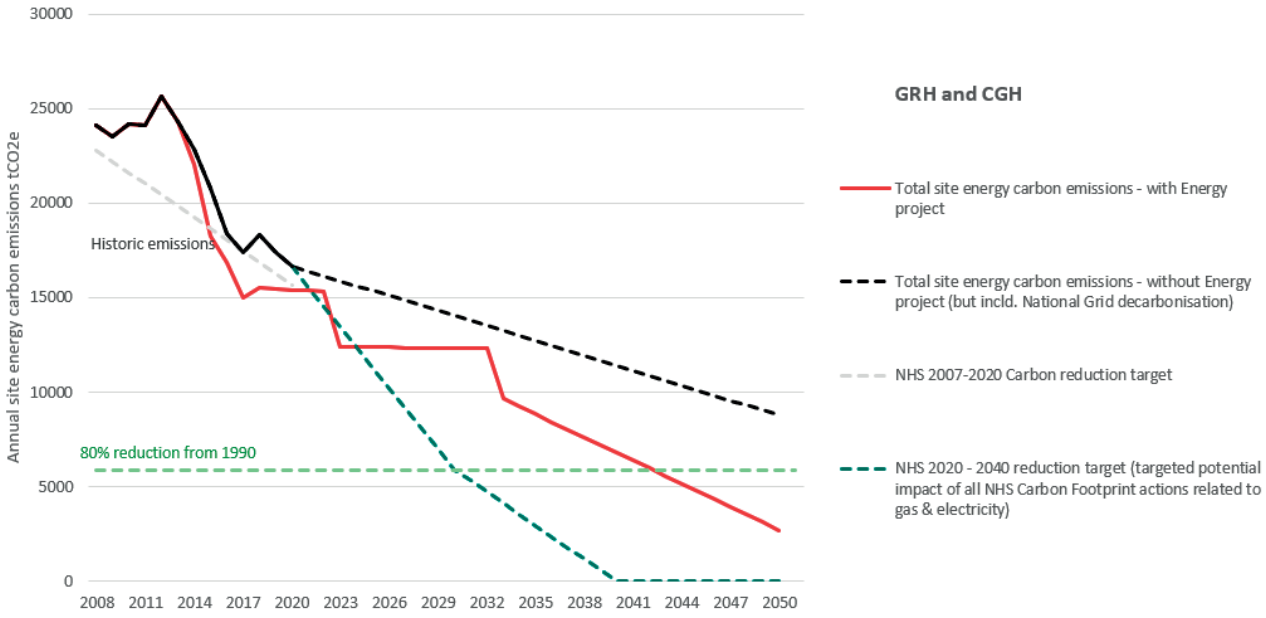
Waste minimisation and management

Type	Unit	Cost
(a) total waste arising	2,399 tonnes	**£649,586**
(b) waste to energy	904 tonnes	
(c) waste recycled/reused	534 tonnes	
(d) waste incinerated	228 tonnes	
(e) waste sent to landfill	25 tonnes	
(f) waste sent to an AT plant	698 tonnes	

Overall waste tonnage decreased by 34 tonnes from 2019–20.

Forecast and targets

Pathway to net zero for NHS Carbon Footprint Scope (energy only)



This is a model of what could happen in the future, so can only be used as an indication of future carbon emissions. There are a number of assumption, these are:

1. Department for Business, Energy and Industrial Strategy carbon factors for electricity that reduce in line with future predictions

2. 2023 shows full impact of short medium-term projects:
   Public Sector Decarbonisation Scheme Round 1 savings occur as planned (projects complete by 2021)
   Potential impact for de-steaming of sites, cladding of Tower Block and optimising combined heat and power (CHP) units

3. 2033 end of existing CHP scheme with a heat pump at CGH.

Note: the financial impact of this has not been modelled, however work is starting on 2b.

The Greener NHS National Programme will calculate and release regional and ICS (Integrated Care System) baseline carbon footprints by the end of 2021. They will then calculate these for individual trusts. We will act on this trust specific data when it becomes available and will include this baseline footprint information in the next review of our Green Plan.

The impact of COVID-19

The COVID-19 pandemic has impacted on sustainability in both positive and negative ways.

The Trust now uses more personal protective equipment (PPE) and has seen an increase in clinical waste tonnage. This additional PPE also generates more deliveries and more packaging for disposal. However fewer staff working on site and the absence of visitors led to a decrease in domestic waste.

Additional uniform, scrubs and coveralls were needed during the initial months of the pandemic. All items were reusable and sent to the laundry. Demand for these items has since returned to normal levels. Disposable coveralls are only used by exception.

The Trust will continue to look at ways to dispose of PPE in the most environmentally friendly (but safe) ways. It will ensure that the sustainable impact of PPE usage is kept to a minimum.

The Trust is fully supportive of staff continuing to split their working week between days in the office and days working at home (where possible). Home working has reduced the number of staff travelling to site and this will have had a positive impact in the surrounding areas with reductions in traffic congestion and air pollution.

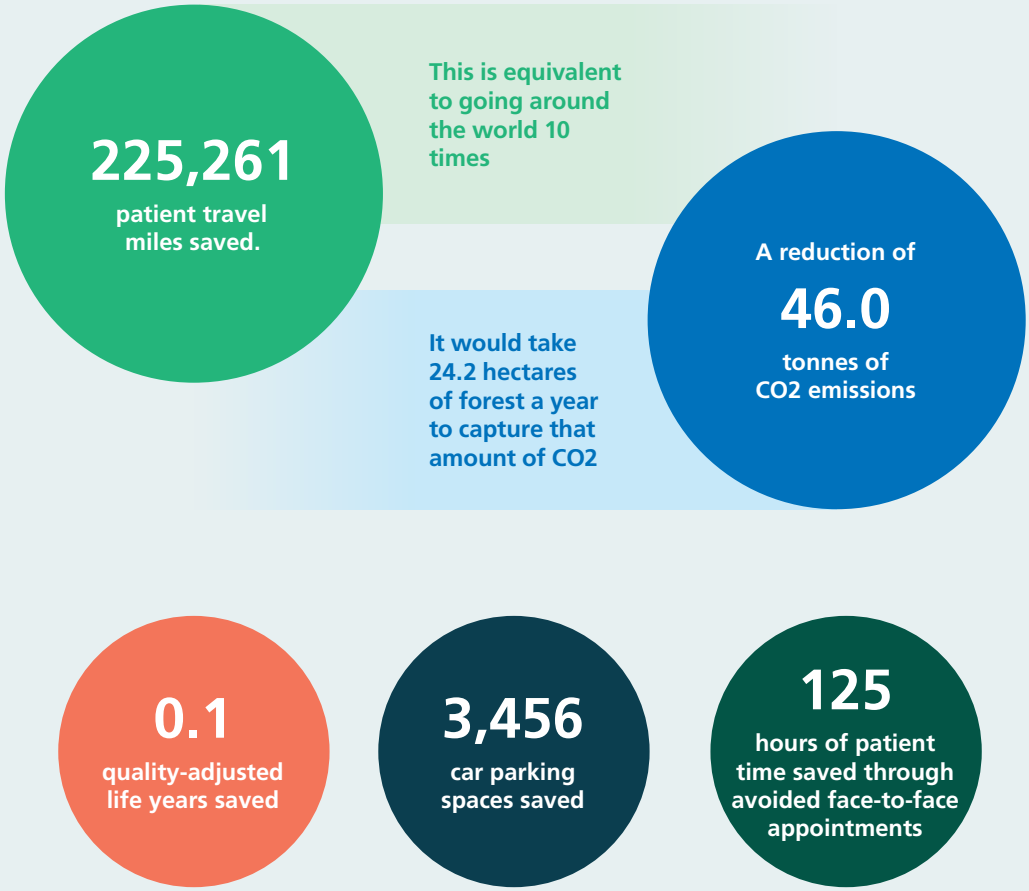
Similarly the introduction of video consultations has saved many patients from needing to travel for out-patient appointments. The use of this system will continue as patients and staff have responded favourably to this and it has removed the need for many journeys to hospital facilities.

The Trust will ensure that any positive sustainable development initiatives identified during the changes in working practice necessitated by the pandemic will be considered and acted upon. This is a time to innovate and develop – not just returning to the old ways of doing things but taking the opportunity to do things differently.

However some uncertainty will continue as future COVID-19 surges are likely.

Outpatient Transformation: Impact of avoided face-to-face appointments

Benefits based on the avoidance of 7,471 appointments



Methodology and source information
Calculation methodology is based on the Sustainable Development Unit's Health Outcomes of Travel Tool (HOTT).

1. Taken from the Journey Time Statistics publication, 2017. https://www.gov.uk/government/collections/journey-time-statistics
2. Taken from methodology used by US Environmental Protection Agency: https://www.epa.gov/energy/greenhouse-gas-equivalencies-calculator
3. Taken from NASA: Solar System Exploration – Earth by the numbers. https://solarsystem.nasa.gov/planets/earth/by-the-numbers/

Areas of focus

The Sustainable Development Assessment Tool (SDAT) from the NHS Sustainable Development Unit has been used to assess where we are and where we want to be.

The SDAT forms the basis of the Green Action Plan (Appendix 1) which supports this Green Plan.

It divides into ten sections covering different aspects of sustainability:

- Corporate Approach
- Asset Management and Utilities
- Travel and Logistics
- Adaptation
- Capital Projects
- Green Space and Biodiversity
- Sustainable Care Models
- Our People
- Sustainable Use of Resources
- Carbon and Greenhouse Gases

These Areas of Focus can be linked to different aspects of the 17 United Nations Sustainable Development Goals.

The activities the Trust has done and the actions we will take in the future support these goals.

Due to its size, the Green Action Plan is not presented in this document, however, it is a crucial aspect of the Green Plan and is available as a separate appendix (appendix 1). overview of each of the key sections is presented across the following pages.

Our alignment with the UN Sustainable Development Goals

Corporate approach	
Asset management and utilities	
Travel and logistics	
Adaptation	
Capital projects	
Green space and biodiversity	
Sustainable care models	
Our people	
Sustainable use of resources	
Carbon and greenhouse gases	

Corporate approach

Embedding sustainability into organisational culture	Timescale
Decision makers, procurement teams and budget holders understand their role and responsibilities towards the requirements of the Public Sector (Social Value) Act 2012	Awareness and training sessions 2021 / 2022
We will develop a sustainability quality improvement training programme linked to the Gloucestershire Safety and Quality Improvement Academy	April 2022
Board papers will include a standing section on sustainability	April 2022
Senior staff, stakeholders and governors are engaged in, and accountable for, delivering our Green Plan	Ongoing

Engagement and partnership	Timescale
Trust is a member of the NHS Net Zero System Leadership Sub-group: a key part of the 'Greener NHS' programme	September 2020
Work with One Gloucestershire Integrated Care System (ICS), the county and district councils and other stakeholders as an integrated and coordinated approach is vital in tackling climate change	Ongoing
Embed Green Champions network for staff	April 2021
Communications plan for promotion of sustainability	Ongoing

Future aims	Timescale
Sustainability and social value are a material consideration in all business cases and in tender specifications	April 2022
Our sustainability and social value commitments are reflected in our procurement policy	September 2022

Delivering sustainability benefits	Timescale
Monitor and evaluate the Green Plan, adjusting it accordingly to maximise value and benefit	September 2022

Measuring and reporting progress	Timescale
Annual sustainability report to detail achievements and report on progress towards targets	Annual report submitted in June
Completion of the Greener NHS Data Collections	May 2021
We will use the Greener NHS Dashboard to identify opportunities to further reduce our carbon footprint and benchmark with comparable organisation	September 2021

Supports UN Sustainable Development Goals

Asset management and utilities

Embedding sustainability into organisational culture	Timescale
We evaluate energy and water consumption as a factor in whole life costing during procurement of goods and services	Will be included in new Procurement policy 2022
Educate, inform and support staff to conserve energy and water at work, managing energy usage, reporting leaks etc.	December 2021

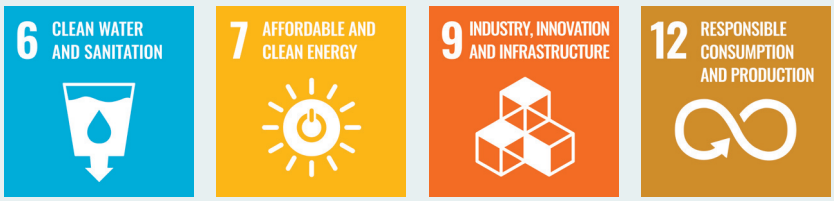
Engagement and partnership	Timescale
We will seek collaboration and funding from external organisations so we can complete large energy related infrastructure projects to deliver significant carbon savings	Ongoing
Work with PFI partners to maximise energy and water efficiency across sites	Ongoing

Future aims	Timescale
Review building stock with a Six Facet Survey of Trust property	August 2021
Use Six Facet Survey data to develop a sustainable buildings action plan	August 2022
Ensure the estates strategy clearly demonstrates our commitment to sustainability	Estates strategy launch 2021 / 2022
Encourage innovation and support new technologies which reduce our carbon emissions	Ongoing
Develop an Energy policy to promote sustainable use of energy and the introduction of new technologies	Sep 2022

Delivering sustainability benefits	Timescale
Demonstrate a continual reduction in absolute levels of energy and water use	Six monthly reports to Trust and in annual report
Improvements to metering to allow better measurement, monitoring and analysis of energy use within buildings	April 2022
Electricity purchased from national grid is from 100% renewable sources	April 2021

Measuring and reporting progress	Timescale
Report energy and water use and performance to the Board	Ongoing
Set targets for reduction in water and energy consumption	April 2022
Annual ERIC returns	May 2022
Use of national Model Hospital benchmarking tool	Ongoing

Supports UN Sustainable Development Goals



Travel and logistics

Embedding sustainability into organisational culture	Timescale
New Travel Plan to support colleagues in active travel and use of public transport	April 2022
Update of all travel related policies to favour sustainable travel options and promote less polluting vehicles	July 2022
Promotion of active travel especially cycling and walking	April 2022

Engagement and partnership	Timescale
Work with local councils and transport providers to improve walking and cycling routes around the hospitals and to improve the provision of public transport	Ongoing
Work with major suppliers to reduce carbon emissions associated with delivery of goods to our sites	First report in 2023 / 2024
Ensure staff can access discounts on public transport and for cycle purchase and seek new discounts with local suppliers	Ongoing

Future aims	Timescale
Install EV charging points on our sites	2023
Meet the NHS Long Term Plan (2019) target to have at least 90% of the fleet using low and ultra-low carbon emissions engines by 2028	December 2027
Cut business mileage by 20% by 2023/24	March 2024
Review and implement options on car sharing and car pooling	Complete by April 2022

Delivering sustainability benefits	Timescale
Work with ICS and local stakeholders to improve air quality and encourage active travel, with the associated health and wellbeing benefits	Ongoing
Improvements to cycling facilities across sites	Links to Travel Plan: Complete works by March 2022

Measuring and reporting progress	Timescale
Report business travel and fleet related carbon emissions	In sustainability annual report April/ May each year
Annual assessment against the Clean Air Hospital Framework	Complete annually each April
Staff travel survey to measure progress on, and impact of travel policy changes	September 2022
Monitor number of cycles on site and use information to target cycle promotions and ensure bike stand supply meets demand	Quarterly

Supports UN Sustainable Development Goals

Adaptation

Embedding sustainability into organisational culture	Timescale
Staff receive training on local emergency and resilience issues	Ongoing
Heatwave plan in place and acted on each summer Trust utilises Public Health England Heatwave Plan supported by local action cards	Ongoing

Engagement and partnership	Timescale
Trust participates in local emergency / resilience testing exercises with local partners	Ongoing
Work with major suppliers to understand resilience and continuity issues within the supply during any extreme weather event	2022/ 2023
Will share the Climate Change Adaptation Plan with staff	July 2022 once plan developed

Future aims	Timescale
Write a Climate Change Risk Assessment to highlight risks to continuity and resilience of supply. This will be recorded on the Trust's risk register	March 2022
Write a Climate Change Adaptation Plan which will outline the actions and interventions we take to mitigate the risks	June 2022

Delivering sustainability benefits	Timescale
Conduct an assessment of flood risks to our sites, access routes and supporting infrastructure and workforce based on current and future projected climate conditions	Issue report by Dec 2022

Measuring and reporting progress	Timescale
Review and improve our monitoring process for over-heating events	Included in quarterly Greener NHS Data Collection
Regular review and updates of the Climate Change Risk Assessment and Climate Change Adaptation Plan	June 2023

Supports UN Sustainable Development Goals

Capital projects

Embedding sustainability into organisational culture	Timescale
All capital projects will consider a whole-life approach, from initial concept, through design, construction, commissioning, operation and final decommissioning/demolition	Introduce from 2022 / 2023
Capital Projects Procedure Manual will help the Strategy and Capital teams to include sustainability throughout the project	Complete end Dec 2021

Engagement and partnership	Timescale
Our design process and estate strategy is informed by the views of staff, patients and local community	Public and staff engagement on large projects when required
On occupation of a new building we inform staff on the energy efficiency and control measures which are designed to improve its sustainable performance	New practice to introduce in 2022

Future aims	Timescale
We have a set of clear sustainability aims and objectives which are scaled and applied to all capital projects and major refurbishments	Included in Capital Projects Procedure Manual Dec 2021
Resource efficacy is embedded into the design specifications for new builds and major refurbishments	Introduce from 2022 / 2023
The Trust will consider accreditation schemes such as BREEAM or the Royal Institute of British Architects sustainability standards for major refurbishments and new builds	Ongoing: part of design process

Delivering sustainability benefits	Timescale
Projects will seek to prioritise access to natural light and ventilation and maximise energy and water efficiency	Ongoing: part of design process
Our design briefs invite low carbon, low environmental impact proposals / solutions from suppliers and partners	Ongoing: part of design process
Project design will consider any impacts on green space and will aim to enhance / add to available green space	Ongoing: part of design process

Measuring and reporting progress	Timescale
After occupancy we will assess energy/carbon performance of the building in use to ensure design parameters have been met and take any necessary remedial actions	From 2022

Supports UN Sustainable Development Goals

Green space and biodiversity

Embedding sustainability into organisational culture	Timescale
As members of the NHS Forest we will continue to maintain our existing green spaces and trees	Ongoing
We will develop more green space on our sites, including a wildlife garden at GRH and developing courtyards into green space to be enjoyed by staff, visitors and patients	Ongoing
Help improve the physical and mental wellbeing of staff, patients and the local community through access to green space and biodiversity on our sites	Ongoing

Engagement and partnership	Timescale
We will work with local green space and biodiversity partners to improve biodiversity on our estate in line with local strategic plans	Start in 2022
We encourage colleagues and patients in local sustainable food sourcing and growing their own	February 2022
We will develop maps of CGH and GRH highlighting the grounds, areas of interest and suggested walking routes. To include interpretation boards at key locations to aid understanding and inclusion of staff, patients and public	June 2022

Future aims	Timescale
Develop a biodiversity strategy and associated action plan	Launch by Sep 2022
Food waste composting will be adopted where feasible, especially in the main kitchens as part of Catering development	Introduce 2022 / 2023
Appoint a biodiversity lead to develop the biodiversity strategy	April 2022

Delivering sustainability benefits	Timescale
Work to maintain and enhance biodiversity on our sites	Ongoing
Our Trust will move to the purchase of recycled photocopy paper (following a reduction in the number of printers and printing demand)	Currently purchase sustainably produced paper. Will consider recycled paper by Dec 2022
Catering and food contracts follow Government Buying Standards and ensure food is from sustainable sources e.g. Red Tractor scheme, dolphin friendly, sustainable fish etc.	Ongoing

Measuring and reporting progress	Timescale
Annual report on activities and progress	In sustainability annual report each April / May
Surveys on biodiversity	Annual survey reported to Estates and Facilities Committee

Supports UN Sustainable Development Goals

Sustainable care models

Embedding sustainability into organisational culture	Timescale
We will work with public health partners to ensure prevention is embedded in development of all models of care to encourage healthy lifestyles e.g. tobacco dependency, exercise and dietary advice	By end of 2021–22
The principle of Getting It Right First Time is embedded to ensure we have a system approach for best use of all resources e.g. staff, infrastructure, products etc.	September 2020
We will secure funding so that two wards can participate in the Green Ward programme led by the Centre for Sustainable Healthcare	April 2022

Engagement and partnership	Timescale
Staff and patients are involved in service design so care models are realistic, appropriate and aligned to expectations	Ongoing
We will work with ICS partners to offer more care closer to home using the latest digital technology	Ongoing
We will continue to work with Gloucestershire partners to deliver the Gloucestershire Health and Wellbeing strategy, to reduce health inequalities and social injustice	Ongoing
We will work with public health and other Gloucestershire organisations to tackle health inequalities, focusing on our communities with the highest deprivation. We will develop a Health Inequalities Plan so that we can amplify our contribution to health and wellbeing	April 2022

Future aims	Timescale
Identify carbon hotspots e.g. pharmaceuticals, and form action plans to mitigate adverse environmental impacts	April 2022
We will work with ICS partners across the Clinical Programme Groups and calculate the carbon footprint of new models of care, we will develop plans to reduce the carbon footprint and ensure care pathways are as sustainable as possible	April 2022

Delivering sustainability benefits	Timescale
Continue to develop video conferencing system to facilitate more patient consultations to be held virtually	March 2020
Improved healthy life expectancy for Gloucestershire residents, with a specific focus on those in our most deprived communities	Ongoing

Measuring and reporting progress	Timescale
Report on number of virtual appointments and patient feedback on this approach	Include in sustainability annual report each April / May
Public health annual report provided by the Director of Public Health	April 2022

Supports UN Sustainable Development Goals

Our people

Embedding sustainability into organisational culture	Timescale
We will ensure that sustainability is part of our staff annual appraisals	Summer 2022
Staff personal development objectives will be adapted as our staff are expected to demonstrate sustainable behaviours in practice throughout their role	Summer 2022
Green Champion category in staff annual awards	2021 / 2022
Training materials (e.g. webinars and power points) will be developed to cover a range of sustainability topics	April 2021
Sustainability to be incorporated into Quality Improvement training and development programme	2022

Engagement and partnership	Timescale
Work with local partners to improve access to employment opportunities in our organisation	2023
Establishment of Green Champion network across Trust	Introduced April 2021
Launching and embed our Green Council to support engagement and involvement on decision making on green matters	Launched August 2021
Continual development of Staff Advice and Support Hub (health and wellbeing)	May 2019
Continue to offer colleagues incentives and encouragement to make sustainable choices on transport, vehicle type, active travel e.g. salary sacrifice bicycle purchase scheme	Ongoing

Future aims	Timescale
Develop an active communications strategy to raise awareness about sustainability at every level of the organisation	Ongoing
Sustainability training and awareness raising programme focusing on increasing knowledge and understanding of sustainability and social value amongst our staff	April 2022

Delivering sustainability benefits	Timescale
Green Champions will work across the organisation on sustainability projects helping to reduce carbon emissions	Ongoing

Measuring and reporting progress	Timescale
Staff surveys include section on health and wellbeing	Annual staff survey each autumn

Supports UN Sustainable Development Goals

Sustainable use of resources

Embedding sustainability into organisational culture	Timescale
Green Champions to help reduce resource use at local level by working on projects in their areas	Ongoing
Provide healthy and sustainable catering choices that meet and exceed national guidelines	Ongoing
Promote whole life costing approach to procurement	Part of new procurement policy 2022

Engagement and partnership	Timescale
Existing 'swap shop' for furniture and equipment will be formalised into a system where unwanted items can be shared with partner organisations	Summer 2022
Our Trust signed the NHS pledge for reduction of single use plastic items and will continue to take actions to fulfil this commitment	Complete
Work with major suppliers on sustainability to start measuring carbon impact	Complete by 2023 / 2024

Future aims	Timescale
New food service system for patients including electronic ordering to deliver improvement in quality and service and a reduction in waste	Start summer 2022
Take advantage of new technologies to divert waste from landfill and waste to energy plants by increasing reuse and recycling	Ongoing but will be supported by new waste contracts starting February 2022
New waste training programme	Introduce 2022 / 2023
New food service system for retail – improvement in quality and service and reduction in waste	Start by April 2022
Reduce food waste from catering services run by GMS to 5%	Introduce in 2022

Future aims	Timescale
Work with other onsite catering services to reduce their food waste to 5%	Introduce in 2022 / 2023

Delivering sustainability benefits	Timescale
Reusable sharps bins will be introduced across the Trust to reduce amount of plastic that is sent for incineration	Introduce 2021 / 2022
Implement a new Inventory Management System to improve stock management and streamline product lines as a way of reducing waste	Introduce by Oct 2022
Review theatre instrument packs for standard procedures and remove unused items	Complete by summer 2022

Measuring and reporting progress	Timescale
More monitoring of waste volumes within the waste streams will allow us to target reduction. Investigate new software package to enable better recording.	Introduce 2022 / 2023

Supports UN Sustainable Development Goals

Carbon and greenhouse gases

Embedding sustainability into organisational culture	Timescale
Inform colleagues of our carbon reduction targets and how they can help achieve these	October 2021
Installation of sustainable energy systems e.g. Solar PV	Initial 400kWp solar to be installed by Feb 2022
Inform colleagues of water and energy usage within their buildings	New metering being installed Oct 2021 which will allow data capture, analysis and sharing

Engagement and partnership	Timescale
Reduce carbon impact of inhalers by 50% by 2030 (NHS target) by switching patients away from meter dose inhalers (where clinically applicable). Scheme led by Pharmacy team in conjunction with ICS colleagues	Ongoing

Future aims	Timescale
Develop further plans and seek external funding for carbon reducing projects	Continual work with Energy Performance Contractors and other stakeholders
Develop plans to reduce water and energy demand	Targets to be set by April 2022
Calculate and report on core carbon emissions, identify hotspots and take targeted action to reduce emissions year-on-year	Ongoing

Delivering sustainability benefits	Timescale
Anaesthetic team will continue to look at ways they can minimise use of the anaesthetic gases and nitrous oxide	Report in March 2022
New battery energy storage system will increase the hospital resilience to external power failure and provide grid services revenues to the Trust	April 2022
Reduction of desflurane (an anaesthetic gas) to 10% of all volatile gas by volume in 2021/22	By April 2022

Measuring and reporting progress	Timescale
Develop further benchmarking on sustainability and social value	2022
Measure and monitor impact of projects funded from the Public Sector Decarbonisation Scheme (2021)	Included in regular energy reports and in sustainability annual report
Measure and report volumes and associated carbon from anaesthetic gases	Part of annual sustainability report
Measure and report volumes and associated carbon from Pharmacy (asthma and COPD inhalers)	Part of annual sustainability report

Supports UN Sustainable Development Goals

Governance and reporting

Clear leadership is essential to ensure we will deliver the commitments in this Green Plan.

The Trust structure for sustainability includes:

- Head of Sustainability: Jen Cleary
- Head of Leadership and Organisational Development: Abigail Hopewell
- Lead Executive Director: Steve Hams, Director of Quality and Chief Nurse
- Lead Non-Executive Director: Elaine Warwicker
- Managing Director, Gloucestershire Managed Services: Keith Hamer

The two key groups for sustainability are:

- **Green Council:** operational group which receives ideas and initiatives, supports the Green Champions and is generally involved in all sustainability projects.
- **Climate Emergency Response Leadership group:** makes key decisions, considers strategy and oversees progress towards net zero carbon by 2040.

Clear reporting is required to monitor progress and ensure actions are delivered.

Sustainability Annual Report: included within the Trust's annual report. Reports carbon emissions, progress towards targets and highlights key sustainability activities throughout the year.

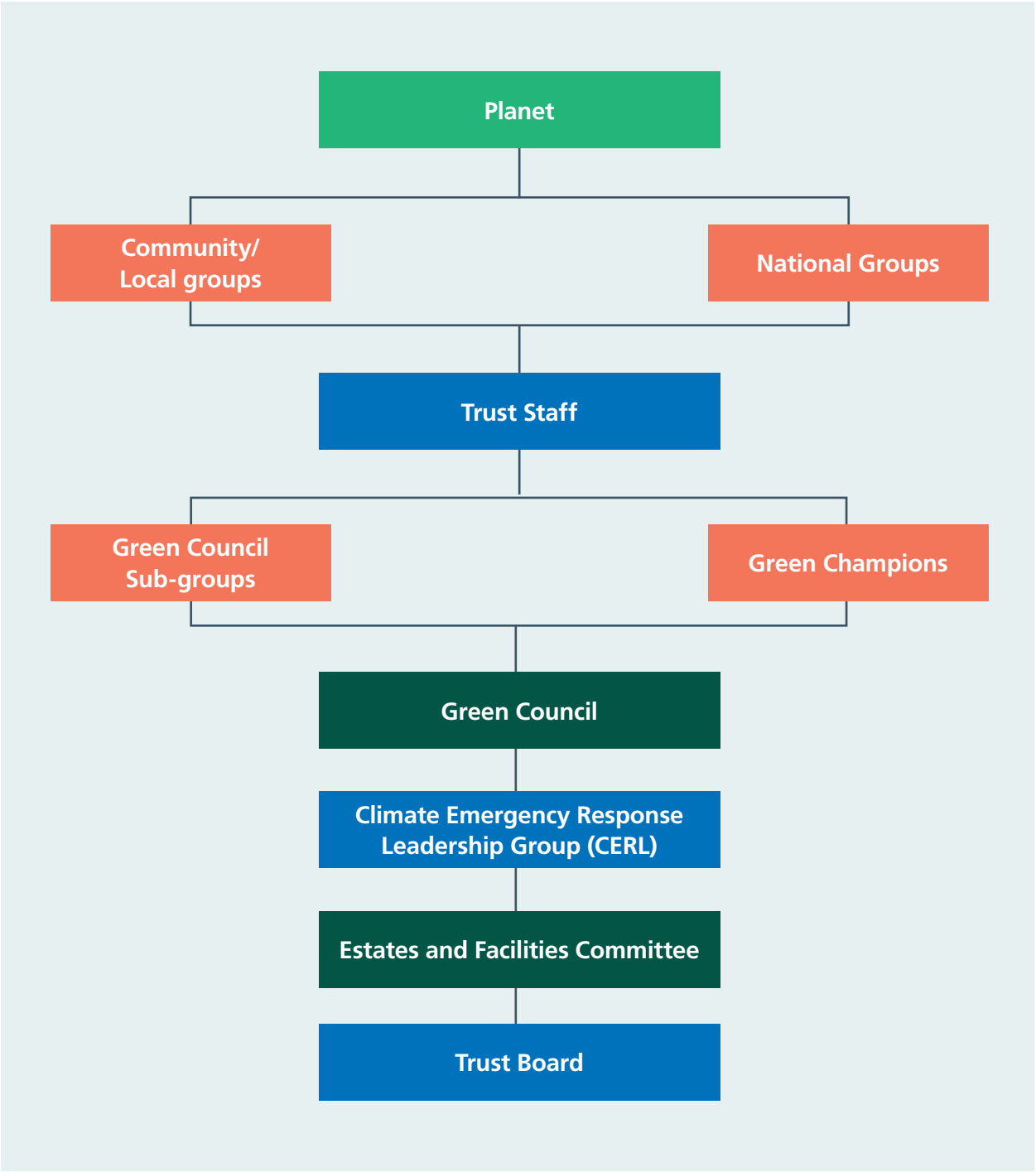
ERIC (Estates Return Information Collection): mandatory data return for all NHS trusts, provides benchmarking information for estates and facilities related data.

Progress reports: internal bi-annual report produced for Estates and Facilities Committee and monthly data / reports on waste, water and energy and associated carbon emissions. Climate Emergency Response Leadership group receives updates from the Green Council meetings. The Green Council receive updates from the Green Council sub-groups which cover our ten Areas of Focus and the associated Green Action plan.

We also report through other national frameworks such as the Greener NHS data collection.

This Green Plan is supported by a variety of other strategies, policies and documents. These include the Waste Management Policy, People and Organisational Development Strategy 2019-2024, Engagement and Involvement Policy 2020-2024, Green Travel Plan and associated travel policies. As further documents are developed e.g. the Climate Change Adaptation Plan, they will be related to this Green Plan and will help to underpin our approach to sustainable behaviour and support our actions towards zero carbon.

Investment in infrastructure and technology to enable the Trust to reach its core targets will require funding individual initiatives, each of which will be subject to business case and approval through the agreed governance route and are a priority



for the five year capital programme. In particular, electrical infrastructure, recycling and renewable energy are areas of focus for future investment. In addition we will take advantage of Government funding opportunities to further enable and enhance investment in the green future for our Trust.

In light of this Green Plan we will be continually reviewing our staff resources to enable us to achieve our core targets and objectives.

Engagement

In order to achieve our vision 'to become a leader in sustainable healthcare, act sustainably and lead by example", we need to work together. We need to build a green social movement which will deliver a safer, more environmentally sustainable future.

Colleagues within the organisation are concerned about climate change and want to take action. It was the 'Big Conversation' event in September 2019 (attended by over 80 staff) which prompted the GHNHSFT Board to declare a Climate Emergency at the second 'Big Conversation' event in December 2019.

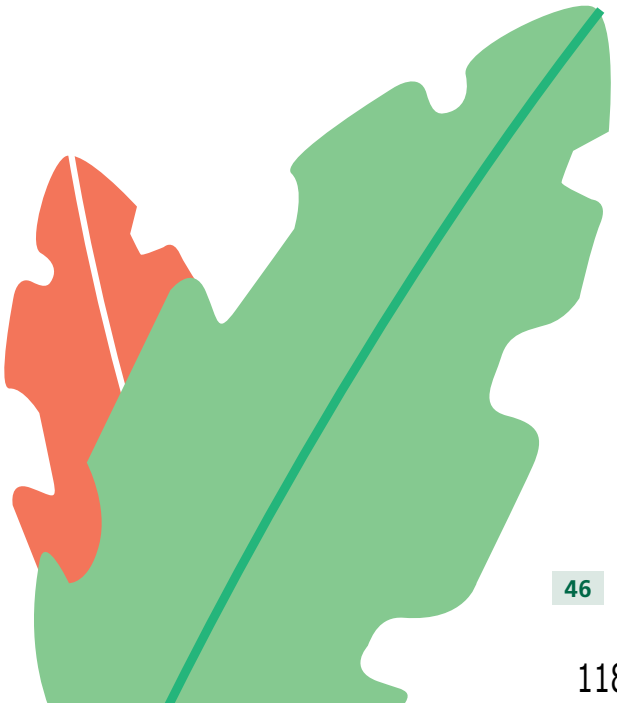
The support of both GHNHSFT and GMS Boards and senior staff demonstrates our commitment to achieve the national carbon reduction targets and develop sustainable healthcare. However the involvement of all colleagues, patients and visitors will be vital if we are to achieve this vision.

Our Green Champions were launched in April 2021 and represent all divisions and cover a wide variety of staff roles, both clinical and non-clinical. This network is a way of encouraging, enabling and empowering colleagues to take action at local or trust level and make a difference. They are supported by the Green Council and its network of sub-groups. This operational group receives ideas and initiatives and also provides a voice to all Green Champions, allowing them to contribute to decision making and steer sustainable development policies.

Webinars and training sessions educate and inform all staff on sustainability topics and Green Champions are encouraged to run these events, developing their own skills and sharing their knowledge. Our ICS partners join us for some of these events. Further information is available for all on the intranet and internet.

We will work with our Foundation Trust members, the GHNHSFT Youth Group and other public groups to get their involvement in our sustainability journey. We will continue to work with our ICS partners to take a countywide approach to sustainable development and support the work of the regional and national Greener NHS teams to help ensure the NHS become the world's first 'net zero' national health service.

We ask all readers of this Green Plan to consider how they can help us meet our aims and achieve our vision and objectives.



Communications

The Communication Plan for our Green Plan shows what we are doing both within and outside of the organisation, highlights our priorities and demonstrates what we are achieving.

The plan ensures we share our progress on carbon reduction and sustainability, engage with stakeholders and community and show staff how they can get involved a have a positive impact on sustainability.

Use of media

Our Green Plan and Annual Sustainability report are on the Trust public website.

Our sustainability intranet pages provide information, training materials and action plans for staff.

Social media and press releases inform every one of our sustainability achievements.

Engagement

Our Green Champions network unites staff from across the whole organisation who will work together to make a difference in their area. They also share ideas through the Green Champions What's App group.

The views of Green Champions, patients, public and staff will be sought on future sustainable policies, targets and in the review of this Green Plan.

We will promote local and national campaigns and sustainability action days.

Awards and Rewards

We will apply for national sustainability awards.

The annual staff awards include one for sustainability.

For the outline Sustainability Communications Plan see Appendix 2.

Green champions logo

Summary

When our Trust declared a climate emergency in December 2019 it sent a clear message as to the importance it places on the threat that climate change poses to public health.

This Green Plan is the Trust's key document for the sustainability agenda and commits the Trust to a range of actions, initially between 2021 and 2025, but also longer term, which will help move us forward on our pathway to net-zero by 2040.

It provides a comprehensive and structured framework to show how the Trust will work to embed sustainability into the organisational culture so that sustainability becomes part of how we think and everything we do. As we recover from the pandemic we must take care to ensure our actions do not increase climate risk or lock-in greenhouse gas emissions.

Our Trust is keen to be a leader in climate change action, helping and encouraging others to make a positive long-term shift towards sustainable behaviour. However, it is very aware that this ambitious agenda will require the vision, collaboration, support and efforts of all – not only our colleagues, patients and visitors, but also our suppliers, Integrated Care System partners and external organisations.

The Trust's Sustainability Lead and the Climate Emergency Response Leadership group will monitor, implement and manage the delivery of this Green Plan and associated Green Action Plan, working with our colleagues across the Trust to implement the actions contained within the plan.

We ask all readers of this Green Plan to consider how they can help us achieve our ambitions.

If you are a staff member please contact ghn-tr.climateemergency@nhs.net and become a Green Champion.

Members of the public, suppliers and other stakeholders please see our website for further information.

Above all please remember that small actions count and you can make a positive contribution to sustainability.

References

Climate Change Act, 2008

Delivering a 'Net Zero' NHS, NHS 2020

United Nations Brundtland Report, 1987 – World Commission on Environment and Development

Sustainable Development Strategy for the NHS, Public Health and Social Care System 2014–2020. NHS England 2014

Managing the health effects of Climate Change. The Lancet and University College London Institute for Global Health 2009

State of the Global Climate 2020 WMO-no.1264. World Meteorological Organisation, 2021

Intergovernmental Panel on Climate Change Special Report on the Impacts of Global Warming of 1.5°C, 2018. Intergovernmental Panel on Climate Change.

Healthcare Climate Footprint report. Healthcare Without Harm, 2019

The impact of climate change on public health. The Climate Coalition, 2021

NHS Long Term Plan, NHS 2019

Clean Air Hospital Framework. Global Action Plan and Great Ormond Street Hospital for Children NHS Foundation Trust

Gloucester City Air Quality Annual Status Report 2020. Gloucester City Council, 2021

United Nations Sustainable Development Goals, 2015. United Nations

Public Sector (Social Value) Act, 2012

BREEAM Sustainability Assessment, BREEAM

RIBA Sustainable Outcomes Guide, 2019. Royal Institute of British Architects

Government Buying Standards 2017, Department for Environment, Food and Rural Affairs

Glossary

Active Travel: Walking, cycling or using some other physically active way to travel. Can include public transport if you walk or cycle etc. to the bus stop or railway station.

Adaptation: Processes which adjust our infrastructure and system so we can continue to operate effectively as the climate changes.

Anchor Institution: Large, public sector organisation whose long-term sustainability is tied to the wellbeing of the population it serves.

BEIS: Department for Business, Energy & Industrial Strategy

BREEAM: Set of standards, assessment methods and tools to help construction professionals understand and mitigate the environmental impacts of construction developments.

Business Mileage: Mileage travelled by staff in their own cars whilst on Trust business. Mileage costs are reimbursed via travel claims.

Carbon Emissions / Carbon Footprint: Amount of carbon dioxide released to atmosphere by an organisation or individual as a result of their activities.

CGH: Cheltenham General Hospital.

CHP: Combined Heat and Power unit.

Climate Change: A change in global or regional climate patterns and attributed largely to the increased levels of atmospheric carbon dioxide produced by the use of fossil fuels.

Climate Change Emergency: A call for action. A situation in which urgent action is necessary to reduce or stop climate change and avoid any irreversible environmental damage associated with climate change.

CO2: Carbon dioxide is the most prevalent of the greenhouse gases.

CO2e: Carbon dioxide equivalent. For simplicity of reporting the mass of each GHG gas is commonly translated into CO2e so that the total impact from all sources can be summed to one figure.

Economic Sustainability: Supporting the local economy, savings from reducing consumption, investment in sustainable projects.

ERIC: Estates Return Information Collection. Annual data submission enables analysis of estates and facilities information.

EV: Electric vehicles and associated EV Chargers.

GHNHSFT (the Trust): Gloucestershire Hospitals NHS Foundation Trust.

GHG: Greenhouse Gases (GHG) include carbon dioxide, nitrous oxide, methane, hydrofluorocarbons, perfluorocarbons and sulphur hexafluoride.

GMS: Gloucestershire Managed Services. A wholly owned subsidary company providing estates and facilities services to GHNHSFT.

Green Champions: A network of GHNHSFT and GMS staff who take sustainable actions and projects within their work area.

Green Plan: Sustainability strategy.

Greener NHS: National NHS programme to deliver NHS target on net zero emissions by 2040 / 2045.

Grey Fleet: Staff vehicles which are used on Trust business.

GRH: Gloucestershire Royal Hospital.

Health Inequalities: Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society.

Integrated Care System (ICS): The partnerships between the organisations which provide health and social care in the area - 'One Gloucestershire'.

Model Hospital: Benchmarking tool produced by NHS Information unit.

One Gloucestershire: Integrated Care System for Gloucestershire.

NHS Fleet: Vehicles owned or leased directly by the Trust.

NHS Forest: Links the green spaces of NHS organisations to encourage tree planting and development of green space and promote the health benefits of green space.

PFI: Private Finance Initiative used to fund major capital projects. Part of the GRH site and the multi-storey car park are PFI schemes.

PSDS: Public Sector Decarbonisation Scheme. A series of grants to public sector bodies for infrastructure works which will reduce carbon emissions.

Six Facet Survey: A set of six surveys which form the core of estates information - includes physical condition and environmental management.

Social Sustainability: Includes health and social equality, social responsibility and justice and decent working conditions.

Sustainability: "Meeting the needs of today without compromising the ability of future generations to meet their needs" (United Nations Brundtland Report 1987).

Sustainable Development Management Plan (SDU): Sustainable Development Management Plan now replaced by the Green Plan.

Travel Plan: A package of actions that will promote safe, healthy and sustainable travel options.

Ultra-low Emission Vehicle (ULEV): ULEV is any vehicle that uses low carbon technologies and emits less than 75g of CO2/km.

Whole Life Cost (WLC): Also know as Life Cycle Cost. A calculation to establish the spend profile (cost) of a product or service over its anticipated life span.

Zero Emission Vehicle (ZEV): ZEV is any vehicle that emits no exhaust gas from the onboard source of power.

Appendix 1: Green Action Plan

Due to its size, the Green Action Plan is not presented in this document.

View the Green Action Plan on our website.

Appendix 2: Sustainability Communications Plan

What	When	Channels/ details
Green Champions	May	On a quarterly basis, reminder of how to become a Green Champion will go in the Trust internal global email. Promote networking sessions for Champions to share ideas and best practice.
Awareness day: World Environment Day	5 June	Encourage staff to make a pledge (and quantify saving where possible for the organisation at large). Internal communications and social media.
Awareness day: Bike Week	Early June	Promote Bicycle User Group (BUG), any facilities upgrades, bike marking events. Internal communications and social media. Quotes from BUG lead.
Awareness day: Plastic free July	July	Focus of reducing plastic in the Trust through catering and other initiatives. Internal communications and social media.
Update papers to Estates and Facilities Committee	Quarterly	Internal distribution only.
Awareness day: Cycle to work day	6 Aug	Promote BUG, any facilities, bike marking events and sustainability. Internal communications and social media.
New green plan launch	September	On website (document and story) and on social media including LinkedIn. Press release. Internal global email and with a dedicated section in the Vlog with Steve Hams and Deborah Lee.
£13.7 m Salix funding follow up (Public Sector Decarbonisation Scheme December 2020)	Ongoing and by September	Articles, local and trade media and internal communications when significant milestones are reached. Particularly around solar panels. Potential for green awards.
Awareness day: WRAP – Recycle week	Late September	Promoting our recycling rates. Internal communications and social media.
Awareness day: World vegetarian day	1 October	Focus on catering. Internal communications and social media.
Awareness day: No disposable cup day	4 October	Create and purchase reusable branded cups to sell in onsite restaurants and promote internally and externally.

What	When	Channels/ details
Awareness day: World habitat day	7 October	Promote wildlife garden and landscape team. Internal communications and social media. Possible staff/ community volunteering initiative.
Awareness day: National clean air day	8 October	Promoting our renewable energy credentials and sustainable transport. Internal communications and social media.
Awareness day: World energy conservation day	21 October	Promoting our renewable energy credentials and sustainable transport. Internal communications and social media.
Green Champion staff award	November	Reintroduce a green award and promote
Green facts graphics	Ongoing	Develop a suite of eye-catching green facts and quotes that we can use as social graphics. Use these for awareness days.
Green blog	Bi-monthly	Bimonthly articles written by specialists giving insight into a selection of topics. To be hosted on the GMS website. This requires regular committed content creation from the sustainability team.
Wildlife garden open day	tbc	Feature on sustainable gardening practices with head gardener
Recycling PPE and masks	tbc	Video and press release if we can start to recycling disposable masks.
Sustainability innovations/ projects and good news stories as required.	ongoing	Press releases/ website articles, social media and internal communications as appropriate.
Awareness day: Big energy saving week	Mid-January	Raise awareness of how we are saving energy, tweet with facts. Internal communications and social media.
Awareness day: Fairtrade fortnight	Mid-February	Focus on catering. Internal communications and social media.
Awareness day: World wildlife day	3 March	Focus on wildlife in our estate, peregrine falcons? Internal communications and social media.
Awareness day: NHS Sustainability day	19 March	Awareness tweet campaign. Opportunity to launch a new initiative or celebrate with a particular focus on a good outcome. Internal communications and social media.
Awareness day: World water day	22 March	Focus on Estates and catering with key water facts. Internal communications and social media.

What	When	Channels/ details
Awareness day: National gardening week	Late April	Focus on the grounds team. Internal communications and social media.
Awareness day: Stop food waste day	29 April	Focus on catering and waste services. Internal communications and social media.
Awareness day: Earth day	22 April	Awareness tweet campaign. Opportunity to launch a new initiative or celebrate with a particular focus on a good outcome. Internal communications and social media.
Awareness day: Community garden week	Early April	Focus on any garden initiatives taking place at the time. Internal communications and social media.
Green plan: one year on (including Green Champions)	Spring	Video celebrating all that has been achieved in the past year, key initiatives and the difference it has made to the hospitals and the wider community.
Awareness day: Water saving week	Mid-May	Focus on estates and catering with key water facts. Internal communications and social media.
Awareness day: Global recycling day	18 May	Focus on waste services. Internal communications and social media.
Sustainability annual report	Early June	Publish as part of Trust annual report. Website and internal communications.

Green Plan
2021–2025

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – October 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 23rd September 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	Recent NHS pay award has been implemented by GMS Board for all GMS staff, at a cost of £400k over budget.	How was this decided?	GMS are obligated to match NHS award forA4C staff, but it was a discretionary decision for other GMS staff. The justification was equal treatment of all staff and to maintain a competitive offer.	
	GMS Board received the GMS Annual Performance Review. Overall, it was a positive report with some areas for improvement now being considered by the Board.	What were those areas for improvement?	Relationship management with key stakeholders on the Trust and how to make better use of emerging technology. These will be investigated further as part of GMS' innovation agenda.	
Contracts Management Group Exception Report	It was report that all monthly KPIs for July '21 were met with the exception of planned preventative maintenance metrics.			To be monitored in case of repeats or emerging trends.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	It was also reported that there has been a decrease in cleaning audits.	Are cleaning standards being maintained?	There are no data to imply that cleaning standards are falling. With respect to the audits, GMS Board will monitor this and have committed to intervene if the lower numbers of audits continue.	Future scores and audit numbers to be monitored by Committee.
Gloucestershire Cancer Institute	A paper was presented on the options for the GCI development with a recommended option amounting to some £18.8mln of new build and £5.9mln for refurbishment. While the plan is to fund the development by charitable contributions, the Trust has submitted a speculative request for central capital funding.	While the preferred option was supported by Committee, there was concern over the increase in development costs. Are we confident that this new sum can be met through charitable giving?	Alternative funding sources will continue to be explored (such as sustainability funding if it's a "green building"). However, the Charitable Funds Committee also believe that the target is achievable. Funding options and scheme design/phasing will continue to be reviewed.	Proposal to be submitted to full Board.
Green Plan	The Trust's Green Plan, which is a collaborative effort between Trust and GMS, was presented. It is a comprehensive and ambitious document and was submitted to Committee for approval ahead of submission to full Board.	It is very ambitious – are we trying to do too much? There are also many actions of a clinical nature, is it aligned with clinical leaders? Have we engaged with ICS partners?	It was stressed that sustainable strategies and actions should be embedded in all the Trust's strategy documents, but there is obviously a timing issue so this is a larger plan than we would expect to see in future years. Also, quick wins will be	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			progressed as quickly as possible to maintain positive momentum. A communications strategy is being developed and ICS partners have been, and will continue to be, actively engaged.	
6-facet survey output	The survey was carried out in May/June this year. The initial report indicates that backlog maintenance has increased in value to c. £72mln, subject to verification.	This represents a significant increase and is a large number – how can we act upon it given capital funding restraints? If we make prioritised choices, what are the risks and regrets of works deferred?	The Trust needs to do further analysis, with the aim of developing a 5-year plan. Risks and regrets will be reviewed as part of that work.	Further committee discussions are required on the risks to the Trust that this backlog represents, especially the statutory and high risk categories of the backlog works.

Mike Napier
Chair of Estates and Facilities Committee
7th October 2021

Gloucestershire Hospitals
NHS Foundation Trust

TRUST PUBLIC BOARD, 14 OCTOBER 2021

Report Title
FEEDBACK FROM OUR JOURNEY TO OUTSTANDING (J2O) VISIT
Sponsor and Author(s)
Author – Andrew Seaton, Quality Improvement & Safety Director Sponsor – Steve Hams, Director of Quality and Chief Nurse
Executive Summary
Purpose To provide assurance of senior management engagement with wards and departments and Board visibility. Key issues to note There have been 38 visits completed from April to Sept. The aim has been to increase the rate of bookings 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 trend within the recorded notes relates to concerns about staffing levels, skills mix including medical and therapy staffing and the delays and process for recruitment. Conclusions Although there is considerable workload pressure the visits will continue to be planned with a final check on the day to assess the department's workload. Implications and Future Action Required None
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, 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		**X**	Information Management & Technology				
Human Resources		**X**	Buildings				
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	√

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

FEEDBACK FROM OUR JOURNEY TO OUTSTANDING (J2O) VISIT

1. Introduction

This paper provides and update on the J2O visits completed from July - September 2021, during this time 12 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 enables 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.

The Trust executive team have been completing six visits; these are now being slowly increased to eight a month. This frequency will be continually reviewed depending on the impact and restrictions with COVID with the aim to reintroduce face to face sessions in the future for some services.

3. Actions from visits

Following the visit, notes from the visit are shared with the visiting executive and the team for accuracy checking. Once an approved set of notes have been agreed, these will be sent to the visiting team manager, the divisional risk/governance manager and the Divisional Director of Quality and Nursing.

Immediate actions relating to safety should be escalated to the Divisional Director of Quality and Nursing for resolution. The Quality Improvement and Safety Director will follow up with the visiting team manager three months following the visit to review actions.

4. Visits completed

Rendcombe Ward, Lilleybrooke Ward, Children's Inpatient, Emergency Department (GRH), ACUC (CGH), Birthing Unit (GRH), 5b, Site Management Team, Prescott Ward, Emergency Department (CGH), Gallery Ward, Tissue Viability/Falls and NAAS Team,

5. Summary

From April to end of September 38 visits booked or rebooked with 26 actual visits completed, visits are prioritised based on the staff survey results. There were 5 visits cancelled by the area. The completion and approval of meeting notes are confirmed with the visiting executive within four weeks of the meeting. The aim is to book seven to eight visits a month, increasingly these will become face to face, unless a team specifically requests a virtual meeting to support wider participation.

6. Summary of main themes

- TCLE implementation and delays in reporting results.
- Staffing levels, skill mix and recruitment delays.
- Car Parking at Cheltenham General Hospital.
- Communication especially with Site Management Team.
- Staff changes throughout the teams and at senior level since COVID.

7. Planned visits for October and November

Planned visits	Virtual – On site	Date	Lead
Mental Health Liaison Team, GRH	virtual	12/10/21	Emma Wood
2A annexe, GRH	On site	12/10/21	Deborah Lee
Cheltenham Birth Centre, CGH	Virtual	14/10/21	Alex D'Agapeyeff
Orthopaedic Theatres, CGH	virtual	20/10/21	Qadar Zada
Delivery Suite, GRH	virtual	28/10/21	Mark Hutchinson
Pathology, GRH	virtual	29/10/21	Simon Lanceley
CCU/HASU, GRH	virtual	9/11/21	Karen Johnson

8. 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).

Andrew Seaton - Quality Improvement & Safety Director
October 2021

Gloucestershire Hospitals NHS Foundation Trust

Trust Board – 14 October 2021

Report Title
QUALITY AND PERFORMANCE REPORT
Sponsor and Author(s)
Author: Neil Hardy-Lofaro, Deputy Chief Operating Officer and Matt Holdaway, Deputy Chief Nurse & Deputy Director of Quality Sponsor: Qadar Zada, Chief Operating Officer & Steve Hams, Chief Nurse and Director of Quality
Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance for the August 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

Clostridium Difficile

A new trust wide C. Difficile reduction plan is being created to address issues identified through post infection reviews and outbreak meetings. This plan will concentrate on cleaning, antimicrobial stewardship, hand hygiene, glove use identification and isolation of patients. Key stakeholders will be involved in the creation of the plan. The plan and associated actions will be monitored through the infection control committee.

MDT antimicrobial stewardship ward rounds continue across the trust, making interventions, providing feedback, teaching and feedback for ward based teams to improve understanding.

Work is ongoing to support an integrated care system approach to the review of CDI cases. This work will ensure broader learner and trend analysis and will influence the development of a system wide strategy around reduction of CDI

MSSA

There have been 5 MSSA cases during August. This is slightly above the baseline rate and has not been investigated in detail as the IPC Team have only been able to focus on COVID-19 and C. difficile. This approach will be reviewed during September.

Number of falls per 1,000 bed days

Falls have risen in month slightly; falls resulting in moderate or severe harm have remained stable but higher than our planned reduction. Falls leading to harm have been associated with patients that are medically safe for discharge but remain in hospital, more often occur on wards with adverse RN to HCA ratios and in patients that have not had falls risk reassessed since admission. Divisions are working to make improvements in RN:HCA ratios. The Falls Prevention Specialist Nurse is supporting teams to focus on falls risk re-assessment, improving footwear, identifying those at risk of falling earlier in their episode of care and the Trust is commissioning an external review of the falls prevention and improvement plans.

Number of unstageable pressure ulcers acquired as an inpatient

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 included 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.

% PALS concerns closed in 5 days

This indicator has fallen for the last 2 months due to increased number and complexity of contacts, this has coincided with instability within the team. A proposal is being worked up for a change to the team to introduce a senior PALS advisor who will be able to deal with more complex responses and support the team

Friends & Family Test

The overall positive FFT score for the trust has fallen to 88.5%. ED has seen an improvement in August however its positive score remains lower than standard at 70.5%, there are also lower than expected scores in maternity and some surgical wards. The patient experience/PALs team will be working with divisions to better understand the data and assist teams to develop specific improvement plans. Action plans from the divisions will be presented to QDG in September.

Performance

During August, the Trust did not meet the national standards for 52 week waits, diagnostics, the 4 hour ED standard and 3 of the 9 cancer metrics(based on July data).

The Trust performance (type 1) for the 4 hour standard in August was 66.96% representing a 4.39% improvement on July's position.

The Trust did not meet the diagnostics standard in August which has deteriorated from 13.07% in July to 20.19%. The achievement of this standard remains compromised as a consequence of C-19, with the key contributor to this deterioration being Echo's with 75% of patients having breached 6 weeks.

The Trust did not meet the standard for 2 week wait cancer metrics with performance at 91.9% in July. The unvalidated position for August indicates a performance of 93.3%. The 62 day cancer wait standard was not achieved with an unvalidated position of 73.6% in July. Through validation this is likely to increase to around 75%. Both standards have been impacted by Covid self-isolation requirements and pathology challenges.

For elective care, the RTT performance in August was 74.2% (un-validated) which demonstrates some stability. The number of 52 week breaches for August is currently 1,598 (anticipated final position of ~1,580) which is the fifth consecutive month where reductions have been made. Patients continue to be treated in clinical order and 104 week risks. This represents approx. 2.6% of our current RTT waiting list which is one of the best positions within the South West.

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.

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						

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period August 2021

Presented at September 2021 Q&P and October 2021 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Contents	2
Executive Summary	3
Performance Against STP Trajectories	4
Demand and Activity	5
Trust Scorecard - Safe	6
Trust Scorecard - Effective	9
Trust Scorecard - Caring	11
Trust Scorecard - Responsive	12
Trust Scorecard - Well Led	15
Exception Reports - Safe	16
Exception Reports - Effective	23
Exception Reports - Caring	25
Exception Reports - Responsive	27
Exception Reports - Well Led	35
Benchmarking	36

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 August, 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 August was 66.85%. The system did not meet the delivery of 90% for the system in August, at 75.27%.

The Trust did not meet the diagnostics standard for August at 20.19%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did meet the standard for 2 week wait cancer at 93.3% but did not meet the standard for the 62 day cancer waits standard at 64.8% in August, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 73.33% (un-validated) in August, 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 1,622 in August. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. 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		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	166	140	152	166	333	286	262	362	316	262	253	440	354
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	36	21	42	95	440	336	219	382	237	85	117	475	294
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	83.15%	82.41%	80.09%	79.90%	77.03%	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.22%	85.61%	85.89%	86.04%	85.99%	86.19%	85.36%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%
	Actual	73.38%	71.84%	68.79%	69.75%	65.40%	68.58%	69.44%	69.97%	64.75%	61.43%	69.52%	62.57%	66.85%
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	60.07%	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	73.33%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	1233	1279	1285	1411	1599	2234	2640	3061	2657	2263	2016	1724	1622
% 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	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	90.80%	95.20%	96.00%	91.80%	93.60%	90.20%	97.10%	97.00%	94.80%	95.30%	92.80%	91.90%	93.30%
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	95.90%	93.30%	97.10%	85.20%	91.80%	71.80%	98.00%	99.00%	93.60%	96.50%	90.70%	96.60%	93.20%
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	97.20%	97.90%	100.00%	98.30%	97.50%	97.00%	99.20%	99.00%	96.60%	98.30%	98.50%	98.70%	95.90%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	98.90%	100.00%	100.00%	99.30%	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	99.40%	98.90%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	98.70%	99.00%	100.00%	97.50%	99.10%	100.00%	100.00%	98.50%	98.10%	97.70%	100.00%	98.20%	91.50%
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	86.00%	98.20%	100.00%	98.60%	100.00%	96.20%	97.20%	97.70%	90.00%	95.60%	95.80%	93.80%	87.80%
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	77.80%	100.00%	100.00%	96.90%	100.00%	93.10%	88.00%	89.70%	84.10%	90.60%	97.00%	96.00%	81.60%
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	92.30%	92.00%	86.40%	65.40%	80.60%	78.40%	93.30%	76.70%	90.80%	65.40%	70.60%	81.10%	60.00%
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	88.60%	82.20%	86.00%	81.90%	87.10%	86.40%	82.10%	84.80%	82.50%	76.50%	79.70%	74.50%	64.80%

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	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	% growth from previous year: Monthly (Aug)	% growth from previous year: YTD
GP Referrals	7,351	8,798	9,156	7,948	7,223	6,875	7,178	8,963	8,563	8,460	8,951	8,583	7,611	3.5%	42.0%
OP Attendances	39,210	50,027	52,473	52,939	47,526	45,549	46,059	57,840	50,379	51,114	54,797	51,806	46,730	19.2%	41.1%
New OP Attendances	12,573	16,232	17,490	17,253	14,412	13,617	13,532	17,944	15,988	16,305	17,147	16,068	14,225	13.1%	46.7%
FUP OP Attendances	26,637	33,795	34,983	35,686	33,114	31,932	32,527	39,896	34,391	34,809	37,650	35,738	32,505	22.0%	38.6%
Day cases	3,145	4,421	4,593	4,449	4,004	3,288	3,174	4,385	4,195	4,553	4,751	4,800	4,459	41.8%	79.1%
All electives	3,999	5,378	5,651	5,345	4,652	3,630	3,608	4,991	5,045	5,419	5,702	5,830	5,400	35.0%	76.0%
ED Attendances	11,636	10,904	10,279	9,475	9,309	8,289	8,021	10,687	11,063	11,930	11,975	12,296	12,006	3.2%	23.0%
Non Electives	3,896	4,116	4,175	3,791	3,759	3,569	3,381	4,108	4,019	4,395	4,643	4,542	4,367	12.1%	30.4%

Trust Scorecard - Safe (1)

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

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	21/22 Q1	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission	1,151	4	20	52	229	254	454	108	30	2	7	15	78	71	24	173	No target	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	207	0	1	3	60	86	41	13	3	0	3	12	13	15	15	43	No target	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	167	0	0	0	57	63	41	5	1	0	0	2	5	3	2	10	No target	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	162	1	0	0	58	70	29	3	1	0	1	1	3	7	2	12	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.9	0.0	0.0	1.4	.8	Zero	
Number of trust apportioned Clostridium difficile cases per month	75	0	4	8	4	4	4	11	8	3	14	11	10	15	28	53	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	6	1	1	2	1	2	5	3	3	7	7	5	9	17	31	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	6	3	7	2	3	2	6	5	0	7	4	5	6	11	22	<=5	
Clostridium difficile – infection rate per 100,000 bed days	22.7	0.0	15.7	29.2	15.8	15.2	19.2	21.8	30.9	13.5	60.2	42.6	34.9	51.1	39.2	41	<30.2	
Number of MSSA bacteraemia cases	18	1	0	1	1	4	1	2	3	1	2	2	2	5	5	13	<=8	
MSSA – infection rate per 100,000 bed days	6.4	4		3.6	3.9	15.2	3.8	5.9	11.6	4.5	8.6	7.7	7	17	7	10	<=12.7	
Number of ecoli cases	30	3	0	6	3	1	2	3	2	4	5	3	2	0	12	14	No target	
Number of pseudomona cases	6	0	0	0	0	2	0	1	1	1	2	0	0	1	3	4	No target	
Number of klebsiella cases	12	1	1	0	1	0	3	0	2	2	1	3	3	3	6	12	No target	
Number of bed days lost due to infection control outbreaks	9	0	0	5					0	0	6	161	15	60	167	242	<10	>30

Trust Scorecard - Safe (2)

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-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	1	1	1	1	0	1	1	Zero	
Number of falls per 1,000 bed days	6.5	7.3	7.5	6.9	7.7	8.5	8.6	7.5	6.6	6.1	6.2	6.2	7.1	7.5	6.2	6.7	<=6	
Number of falls resulting in harm (moderate/severe)	18	4	3	6	6	5	4	6	6	4	2	3	9	5	9	23	<=3	
Number of patient safety incidents – severe harm (major/death)	19	7	4	5	6	7	4	3	10	7	2	1	9	3	10	22	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	2	1	2	1	1	1	6	6	4	2	2	1	2	3	5	10	No target	
Medication error resulting in low harm	34	14	14	9	15	8	14	10	11	11	4	13	6	4	28	37	No target	
Number of category 2 pressure ulcers acquired as in-patient	79	24	13	23	28	30	27	19	29	16	22	17	24	27	55	106	<=30	
Number of category 3 pressure ulcers acquired as in-patient	2	3	4	5	3	1	0	1	1	1	0	1	0	3	2	5	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient	14	5	9	7	6	4	2	3	1	4	3	4	3	5	11	19	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	22	6	4	12	5	11	6	3	4	1	4	8	9	4	13	26	<=5	
RIDDOR																		
Number of RIDDOR	55	0	2	1	3	3	3	2	4	4	1	3	3	2	8	12	SPC	
Safeguarding																		
Number of DoLs applied for		38				45	32	46	29	54	73	57	55	59	184	298	No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	39	7	3	9	6	7	0	3	4	3	8	3	3	6	14	23	No target	
Total attendances for infants aged < 6 months, other serious injury				3	1	0	0	0	1	1	0	0	0		1	1	No target	
Total admissions aged 0-18 with DSH	71	10	10	7	11	3	6	9	15	13	26	15	13	11	54	78	No target	
Total ED attendances aged 0-18 with DSH	461	50	43	67	65	47	46	55	88	62	99	84	65	50	245	360	No target	
Total number of maternity social concerns forms completed								50	62	68	58	77	63	46	203	312	No target	

Trust Scorecard - Safe (3)

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-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%		74.00%			67.00%				70.00%							>=90%	<50%
Serious Incidents																		
Number of never events reported	2	0	1	0	3	0	0	2	0	0	2	0	0	1	2	3	Zero	
Number of serious incidents reported	13	5	4	3	4	2	2	5	4	4	3	2	4	4	9	17	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%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	91.2%	90.7%	87.0%	89.8%	94.6%	91.0%	90.4%	89.2%	92.2%	89.9%	89.8%	89.3%	87.0%	87.1%	89.7%	88.6%	>95%	

Trust Scorecard - Effective (1)

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	21/22 Q1	21/22	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	68.0%	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%	0.00%	0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		10.40%	9.70%	9.70%	10.80%	8.70%	9.50%	No target	
% C-section rate (planned and emergency)	29.44%	27.80%	31.13%	32.91%	28.09%	34.76%	28.12%	26.79%	31.67%	30.43%	28.88%	33.96%	29.04%	32.02%	31.13%	30.88%	<=27%	>=30%
% emergency C-section rate	15.56%	16.20%	15.14%	19.50%	15.73%	20.09%	15.65%	12.24%	17.71%	16.30%	17.72%	16.77%	15.58%	17.98%	16.93%	16.87%	No target	
% of women booked by 12 weeks gestation	92.8%	92.4%	95.0%	92.3%	95.4%	92.7%	94.2%	93.1%	93.6%	93.2%	92.6%	91.1%	92.1%	90.8%	92.3%	92.1%	>90%	
% of women that have an induced labour	31.42%	31.20%	32.41%	28.72%	32.58%	32.51%	33.91%	30.72%	30.63%	28.05%	27.92%	26.40%	25.90%	28.49%	27.45%	27.35%	<=30%	>33%
% stillbirths as percentage of all pregnancies	0.39%	0.00%	0.21%	0.83%	0.68%	0.22%	0.25%	0.23%	0.62%	0.00%	0.22%	0.42%	0.19%	0.00%	0.22%	0.16%	<0.52%	
% of women smoking at delivery	10.90%	13.80%	11.30%	12.58%	11.24%	11.06%	8.80%	9.24%	10.21%	9.42%	8.23%	9.56%	10.48%	8.19%	9.08%	9.18%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	57.1%	57.8%	51.7%	59.4%	56.2%	58.5%	60.2%	56.7%	54.0%	48.7%	49.0%	51.1%	48.4%	50.7%	50.2%		
% breastfeeding (initiation)	79.9%	79.7%	77.5%	76.6%	80.8%	80.4%	81.1%	83.1%	82.4%	81.0%	75.9%	78.4%	78.5%	79.8%	78.5%	78.8%	>=81%	
% Massive PPH >1.5 litres	4.4%	3.7%	5.8%	3.8%	4.3%	4.5%	3.9%	2.5%	5.2%	5.9%	5.0%	4.2%	5.2%	6.7%	5.0%	5.4%	<=4%	
Number of births less than 27 weeks	19	0	2	1	3	2	2	1	3	2	0	2	0	0	4	4		
Number of births less than 34 weeks	104	10	9	8	8	16	6	7	10	7	15	13	8	11	34	54		
Number of births less than 37 weeks	379	43	29	38	21	34	23	27	29	28	44	34	41	33	105	180		
Number of maternal deaths	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0		
Total births	5,570	497	472	482	443	445	408	437	483	463	468	486	526	544	1,415	2,487		
Percentage of babies <3rd centile born > 37+6 weeks	1.7%							1.8%	1.0%	2.3%	1.5%	1.7%	1.9%	0.9%	1.2%	1.6%		

Trust Scorecard - Effective (2)

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-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	1.1	1.1								NHS Digital	
Hospital standardised mortality ratio (HSMR)	107.9	105.1	104.7	103.9	105.2	108.2	107.9	104.9	103.9								Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	111.7	108.8	107.4	105.5	108.9	109.8	111.7	111.9	106.6								Dr Foster	
Number of inpatient deaths	1,425	143	147	142	182	246	277	159	129	145	155	146	182	155	446	783	No target	
Number of deaths of patients with a learning disability	19	3	4	1	1	1	2	1	0	2	4	0	4	2	6	12	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.98%	8.49%	7.37%	7.78%	7.91%	7.65%	8.96%	8.10%	7.89%	7.95%	7.86%	7.80%	8.25%		7.87%	7.97%	<8.25%	>8.75%
Research																		
Research accruals	4,152	350	629	461	578	382	177	110	220	555	207	328	114	150	1,090	1,354	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	53.2%	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%	89.7%	96.9%	81.3%	87.5%	90.1%	84.6%	88.4%	90.2%	83.1%	89.3%	91.8%	82.7%		88.1%	88.2%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	45.00%	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%	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	70.0%	71.9%	63.6%	66.1%	85.1%	74.6%	75.8%	61.5%	64.1%	84.4%	52.5%	66.3%	68.2%	60.7%	66.3%	65.6%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	69.20%	70.18%	62.12%	66.10%	82.98%	73.02%	75.76%	61.54%	64.06%	84.44%	52.54%	66.27%	68.18%	59.02%	66.31%	65.29%	>=65%	<55%

Trust Scorecard - Caring (1)

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	21/22 Q1	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	86.0%	88.7%	86.4%	85.7%	84.8%	89.7%	89.4%	89.6%	88.3%	90.2%	89.7%	87.0%	85.4%	89.4%	88.9%	>=90%	<86%
ED % positive	81.4%	77.2%	73.0%	75.4%	83.7%	77.6%	87.2%	83.9%	77.5%	76.3%	73.6%	74.8%	62.7%	70.5%	75.1%	74.0%	>=84%	<81%
Maternity % positive	92.9%	85.2%	93.9%	88.9%	88.4%	96.7%	98.6%	92.9%	92.6%	96.2%	93.0%	89.2%	92.9%	84.8%	92.5%	92.6%	>=97%	<94%
Outpatients % positive	94.0%	93.5%	92.8%	94.0%	94.1%	94.2%	94.7%	94.7%	94.5%	94.4%	93.6%	94.3%	93.1%	93.7%	94.1%	93.9%	>=94.5%	<93%
Total % positive	90.7%	90.0%	90.1%	91.7%	92.2%	91.9%	93.2%	92.9%	92.1%	91.5%	91.1%	91.2%	90.7%	88.5%	91.2%	91.1%	>=93%	<91%
Number of PALS concerns logged	2,394		273	312	227	163	137	204	262	256	275	191	241	238	722	1,201	No Target	
% of PALS concerns closed in 5 days	79%		73%	75%	81%	82%	86%	86%	83%	82%	85%	90%	85%	82%	85%	85%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	1	0	0	0	0	2	0	1	0	0	0	0	1	0	1	<=10	>=20

Trust Scorecard - Responsive (1)

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	21/22 Q1	21/22	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait	76.2%	78.0%	74.3%	74.3%	76.6%	78.4%	72.1%	76.6%	78.9%	79.5%	77.8%	77.0%	78.9%	78.7%	78.1%	78.3%	No target	
Cancer – 28 day FDS breast symptom two week wait	97.0%	98.0%	98.3%	97.0%	95.4%	93.8%	97.9%	96.8%	100.0%	98.6%	95.5%	95.2%	98.9%	100.0%	96.2%	97.4%	No target	
Cancer – 28 day FDS screening referral	71.3%	78.6%	66.7%	69.0%	62.9%	65.8%	52.6%	83.0%	86.5%	82.4%	85.7%	80.4%	77.8%	43.6%	82.6%	73.1%	No target	
Cancer – urgent referrals seen in under 2 weeks from GP	94.1%	90.8%	95.2%	96.0%	91.8%	93.6%	90.2%	97.1%	97.0%	94.8%	95.3%	92.8%	91.9%	93.3%	94.3%	93.6%	>=93%	<90%
2 week wait breast symptomatic referrals	91.6%	95.9%	93.3%	97.1%	85.2%	91.8%	71.8%	98.0%	99.0%	93.6%	96.5%	90.7%	96.6%	93.2%	93.3%	94.0%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	98.3%	97.2%	97.9%	100.0%	98.3%	97.5%	97.0%	99.2%	99.0%	96.6%	98.3%	98.5%	98.7%	95.9%	97.8%	97.7%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.7%	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	99.4%	98.9%	100.0%	99.7%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	97.1%	86.0%	98.2%	100.0%	98.6%	100.0%	96.2%	97.2%	97.7%	90.0%	95.6%	95.8%	93.8%	87.8%	93.4%	92.8%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.2%	98.7%	99.0%	100.0%	97.5%	99.1%	100.0%	100.0%	98.5%	98.1%	97.7%	100.0%	98.2%	91.5%	98.7%	97.6%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	85.0%	88.6%	82.2%	86.0%	81.9%	87.1%	86.4%	82.1%	84.8%	82.5%	76.5%	79.7%	74.5%	64.8%	79.7%	76.7%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	93.2%	77.8%	100.0%	100.0%	96.9%	100.0%	93.1%	88.0%	89.7%	84.1%	90.6%	97.0%	96.0%	81.6%	90.5%	89.2%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	82.7%	92.3%	92.0%	86.4%	65.4%	80.6%	78.4%	93.3%	76.7%	90.8%	65.4%	70.6%	81.1%	60.0%	80.0%	76.6%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	2	3	3	1	0	3	0	0	2	1	2	3	4	5	12	Zero	
Number of patients waiting over 104 days without a TCI date	269	15	8	8	9	13	14	14	12	14	10	11	9	12	35	56	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	25.49%	23.00%	17.50%	14.67%	14.04%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	11.39%	20.19%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	1,969	1,569	1,648	1,665	1,772	1,949	1,969	1,946	1,919	1,773	1,680	1,527	1,482	1,439	1,527	1,439	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	57.8%	57.5%	61.2%	60.6%	58.3%	52.3%	53.4%	59.3%	58.8%	61.2%	61.4%	62.3%	62.2%		61.7%	61.8%	>=88%	<75%

Trust Scorecard - Responsive (2)

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	21/22 Q1	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	69.78%	73.38%	71.84%	68.79%	69.75%	65.40%	68.58%	69.44%	69.97%	64.75%	61.43%	69.52%	62.57%	66.85%	65.55%	65.16%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	80.12%	83.15%	82.41%	80.09%	79.90%	77.03%	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	77.66%	76.06%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	99.87%	99.91%	99.95%	99.84%	99.94%	99.88%	99.92%	100.00%	99.62%	99.73%	99.68%	94.75%	84.95%	88.74%	97.69%	92.28%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	69.78%	73.38%	71.84%	68.79%	69.75%	65.40%	68.58%	69.44%	69.97%	64.75%	61.43%	63.34%	53.00%	57.55%	63.12%	60.09%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	168	1	0	0	13	37	95	21	1	0	0	1	11	2	1	14	Zero	
ED: % of time to initial assessment – under 15 minutes	61.7%	63.7%	61.3%	66.9%	66.5%	61.3%	64.5%	62.4%	48.8%	54.6%	62.0%	55.6%	39.6%	42.2%	57.5%	50.7%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	37.2%	31.4%	30.9%	38.1%	41.8%	40.8%	48.9%	44.2%	27.8%	26.5%	23.8%	21.6%	17.6%	21.8%	23.9%	22.2%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	5.00%	4.17%	3.67%	3.95%	4.59%	8.70%	8.14%	8.06%	9.82%	8.61%	6.66%	6.73%	11.91%	9.48%	7.31%	8.65%	<=2.96%	
% of ambulance handovers that are over 60 minutes	3.67%	0.90%	0.55%	1.09%	2.63%	11.50%	9.57%	6.74%	10.36%	6.45%	2.16%	3.11%	12.86%	7.88%	3.86%	6.43%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	86.67%	94.74%	95.83%	90.50%	78.30%	14.30%	76.50%	92.30%	92.00%	87.80%	87.50%	98.41%	100.00%	89.30%	97.91%	>=95%	
Urgent cancelled operations	66	2	10	7	4	14	4	3	3	0	1	13	12	10	14	36	No target	
Number of patients stable for discharge	112	73	109	108	105	134	118	136	110	113	114	124	161	160	117	134	<=70	
Number of stranded patients with a length of stay of greater than 7 days	370	319	361	371	362	403	369	385	386	363	339	422	375	428	375	385	<=380	
Average length of stay (spell)	5.17	4.66	4.78	4.86	4.77	5.55	6.22	5.55	5.23	4.68	4.79	5.15	4.98	4.84	4.88	4.89	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.65	5.15	5.34	5.44	5.43	6.06	6.41	5.92	5.56	5.18	5.25	5.7	5.58	5.39	5.38	5.42	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.59	2.32	2.47	2.59	2.09	2.71	4.15	2.61	2.88	2.31	2.6	2.64	2.39	2.31	2.52	2.45	<=3.4	>4.5
% day cases of all electives	84.44%	78.62%	82.19%	81.26%	83.22%	86.05%	90.55%	87.94%	87.84%	83.13%	84.00%	83.30%	82.32%	82.56%	83.49%	83.06%	>80%	<70%
Intra-session theatre utilisation rate	85.82%	88.26%	86.99%	84.65%	88.14%	80.62%	79.26%	85.29%	88.63%	90.08%	90.48%	88.15%	89.43%	89.52%	89.51%	89.49%	>85%	<70%

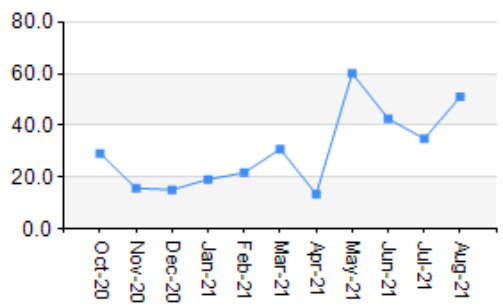
Trust Scorecard - Responsive (3)

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	21/22 Q1	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.04	1.99	1.94	1.88	1.95	2.14	2.14	2.23	2.09	2.06	2.01	2.04	2.09	2.16	2.04	2.07	<=1.9	
Did not attend (DNA) rates	6.19%	6.15%	6.48%	6.26%	6.24%	6.45%	6.46%	5.80%	5.69%	5.90%	6.02%	6.72%	7.05%	7.20%	6.23%	6.58%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.59%	60.07%	66.27%	69.36%	70.06%	69.48%	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	73.33%	72.38%	72.97%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,337	7,155	7,748	8,404	8,352	7,158	6,628	6,415	6,474	6,541	6,426	6,159	5,713	5,748	6,375	6,117	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,881	2,724	3,084	3,253	3,035	3,790	4,787	4,306	3,747	3,572	3,657	3,320	2,854	3,003	3,516	3,281	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,416	1,233	1,279	1,285	1,411	1,599	2,234	2,640	3,061	2,657	2,263	2,016	1,724	1,622	2,312	2,056	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)	127	57	77	85	111	158	243	304	459	608	667	745	806	647	673	695	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%								>=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%	

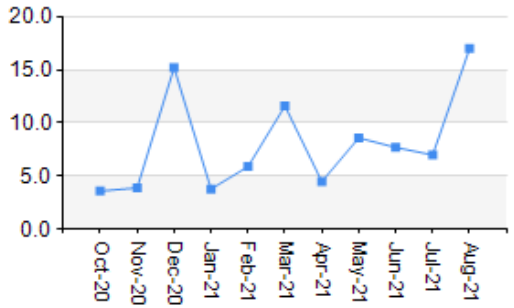
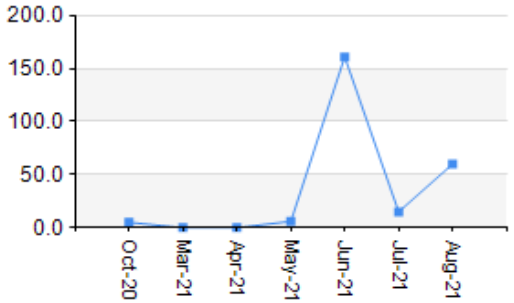
Trust Scorecard - Well Led (1)

	20/21	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	21/22 Q1	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	82.0%	84.0%	83.0%	83.0%	82.0%	80.0%	80.0%	83.0%	85.0%	85.0%	84.0%	80.0%	79.0%	84.0%		>=90%	<70%
Trust total % mandatory training compliance	90%	91%	94%	93%	93%	93%	93%	92%	90%	91%	90%	91%	90%	90%	91%		>=90%	<70%
Finance																		
Total PayBill Spend		33.9	34.7															
YTD Performance against Financial Recovery Plan		0	0															
Cost Improvement Year to Date Variance																		
NHSI Financial Risk Rating																		
Capital service																		
Liquidity																		
Agency – Performance Against NHSI Set Agency Ceiling																		
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	94.82%	102.19%	93.82%	96.30%	94.93%	90.64%	90.88%	95.00%	93.10%	98.29%	96.75%	91.64%	96.56%		95.39%	95.69%	>=75%	<70%
% registered nurse day	93.97%	101.91%	93.04%	95.49%	94.37%	91.04%	89.81%	93.14%	90.71%	96.38%	96.05%	90.72%	94.84%		94.28%	94.43%	>=90%	<80%
% unregistered care staff day	104.90%	117.68%	106.50%	101.36%	102.93%	93.42%	94.97%	95.53%	101.28%	106.08%	104.33%	95.67%	100.44%		101.82%	101.46%	>=90%	<80%
% registered nurse night	96.36%	102.70%	95.27%	97.77%	95.92%	89.93%	92.76%	98.22%	97.31%	101.83%	97.99%	93.27%	99.57%		97.38%	97.96%	>=90%	<80%
% unregistered care staff night	113.19%	131.81%	114.61%	113.36%	112.05%	97.48%	99.23%	113.17%	108.91%	111.13%	113.00%	103.77%	109.58%		109.20%	109.30%	>=90%	<80%
Care hours per patient day RN	5.6	5.7	5.2	5.1	5.6	5.2	6.1	6.2	5.8	5.2	5.5	5.2	5.4		5.3	5.3	>=5	
Care hours per patient day HCA	3.6	4.2	3.5	3.3	3.6	3.4	3.6	3.9	3.7	3.7	3.5	3.4	3.5		3.5	3.5	>=3	
Care hours per patient day total	9.2	9.9	8.6	8.5	9.2	8.6	9.7	10.1	9.5	8.9	9	8.6	8.9		8.8	8.8	>=8	
Vacancy and WTE																		
% total vacancy rate		7.10%	5.26%	5.74%	6.03%	5.99%	5.57%	4.36%	4.75%	4.30%	7.12%		7.00%	7.50%			<=11.5%	>13%
% vacancy rate for doctors		3.27%	1.54%	1.07%	0.37%	1.43%	1.77%	1.83%	0.73%	1.38%	4.15%		9.40%	7.80%			<=5%	>5.5%
% vacancy rate for registered nurses		8.90%	10.01%	7.76%	9.06%	8.70%	8.80%	5.08%	7.92%	7.24%	6.60%		8.50%	9.40%			<=5%	>5.5%
Staff in post FTE		6463.25	6548.39	6557.43	6551.18	6546.28	6560.89	6666.58	6653.99	6678.31	6672.09	6672.85	6676.43	6657.34			No target	
Vacancy FTE		494.04	365.97	399.63	420.14	417.44	409.32	286.96	330.61	298.88	510		505.63	537.29			No target	
Starters FTE		62.46	151.56	73.19	46.87	52.85	50.64	48.84	67.2	86.69	50.85	56.53	36.05	36.53			No target	
Leavers FTE		106.66	66.41	76.11	68.76	40.52	50.03	34.82	45.79	36	57.02	62.03	52.16	78.84			No target	
Workforce Expenditure and Efficiency																		
% turnover		10.3%	10.3%	9.6%	10.1%	9.5%	9.5%	9.5%	9.2%	9.2%	9.5%	10.0%	10.2%	10.7%			<=12.6%	>15%
% turnover rate for nursing		10.34%	10.10%	9.41%	10.23%	9.61%	9.83%	9.83%	9.86%	8.88%	8.96%	9.18%	9.80%	9.77%			<=12.6%	>15%
% sickness rate		3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.7%	3.7%	3.6%	3.6%	3.8%			<=4.05%	>4.5%

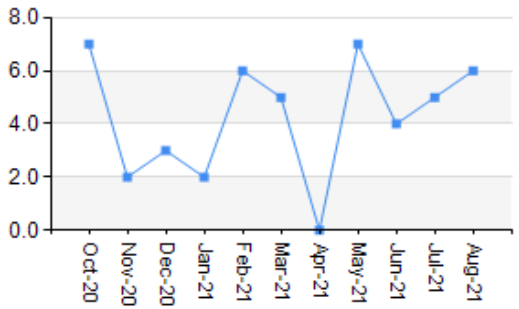
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Clostridium difficile – infection rate per 100,000 bed days **Standard: <30.2**		9 health care associated (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. 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. 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.	**Associate Chief Nurse, Director of Infection Prevention & Control**

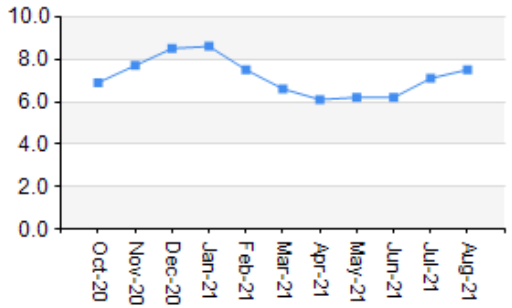
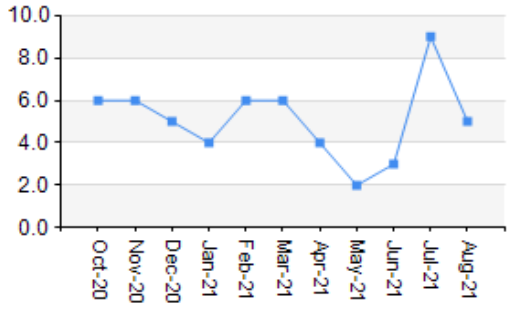
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
MSSA – infection rate per 100,000 bed days **Standard: <=12.7**		There have been 5 MSSA cases during August. This is slightly above the baseline rate and has not been investigated in detail as the IPC Team have only been able to focus on COVID-19 and C. difficile. This approach will be reviewed during September.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of bed days lost due to infection control outbreaks **Standard: <10**		A number of bays have been closed following identification of patients with COVID-19 on repeat testing. There was a confirmed outbreak of COVID-19 on Knightsbridge ward affecting 4 patients that resulted in bed closures for a two week period.	**Associate Chief Nurse, Director of Infection Prevention & Control**

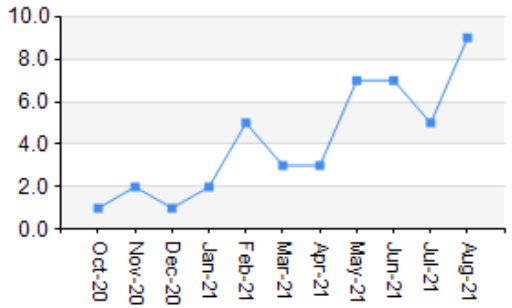
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of community-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		9 health care associated (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. 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. 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.	**Associate Chief Nurse, Director of Infection Prevention & Control**

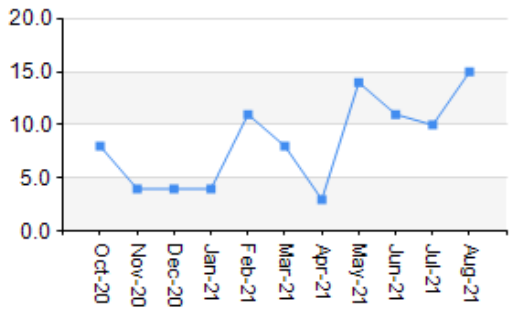
Exception Reports - Safe (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls per 1,000 bed days **Standard: <=6**		We have recovered from a spike in the number of in-patient falls, reaching 8.6 per 1000 bed days in January 2021, performance in the past 2 months is comparable to the rate seen in Winter and is perhaps reflective of the operational pressures the hospitals face, this is evident in 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 falls resulting in harm (moderate/severe) **Standard: <=3**		We have recovered from a spike in the number of in-patient falls, reaching 8.6 per 1000 bed days in January 2021, performance in the past 2 months is comparable to the rate seen in Winter and is perhaps reflective of the operational pressures the hospitals face, this is evident in 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**

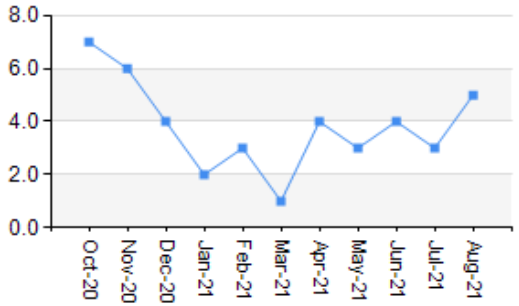
Exception Reports - Safe (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		9 health care associated (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. 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. 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.	**Associate Chief Nurse, Director of Infection Prevention & Control**

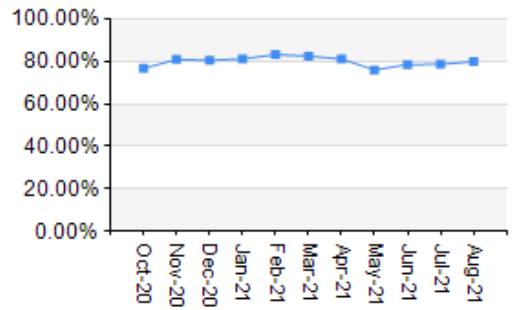
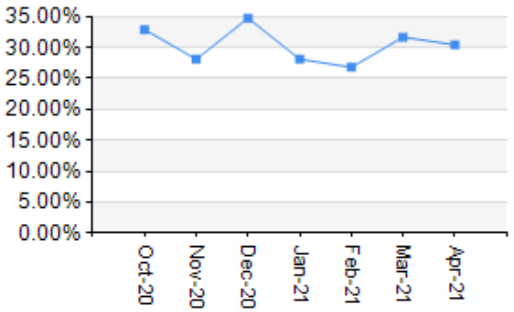
Exception Reports - Safe (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of trust apportioned Clostridium difficile cases per month **Standard: 2020/21: 75**		9 health care associated (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. 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. 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	**Associate Chief Nurse, Director of Infection Prevention & Control**

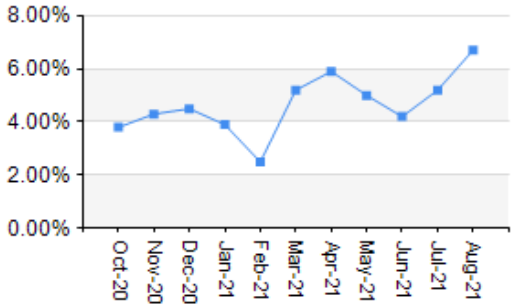
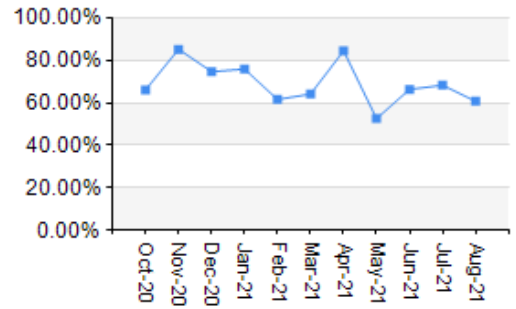
Exception Reports - Safe (7)

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**

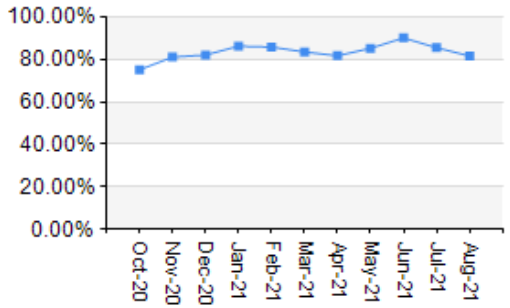
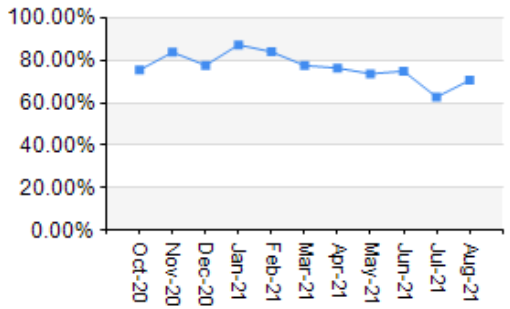
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		Some of this decision is a personal choice element. Antenatal classes where feeding is discussed is still not face to face yet due to COVID and so this is potentially a factor. Staff training has continued but has been virtual due to COVID and this may also have had an impact, as it is not straightforward.	**Divisional Director of Quality and Nursing and Chief Midwife**
% C-section rate (planned and emergency) **Standard: <=27%**		July and August has been a time of high activity and it is possible that these are linked to our having to delay inductions. These inductions are in the process of being reviewed and may provide us with some insight. Also mothers are being offered elective LCSC as a change to our management of rupture of membranes, i.e. immediate management rather than expectant management. August is always an interesting month as the new registrars embed, so there may be an element of that impacting the emergency caesareans.	**Divisional Director of Quality and Nursing and Chief Midwife**

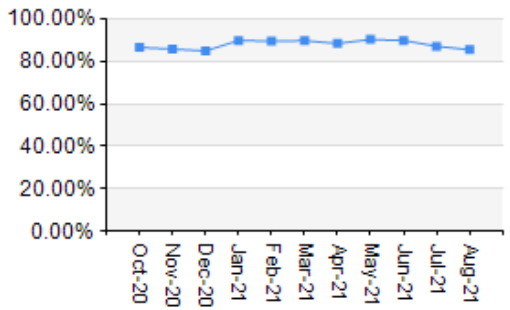
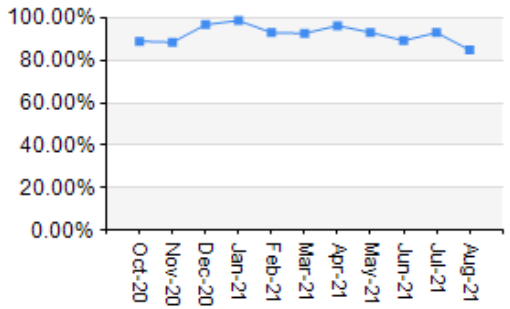
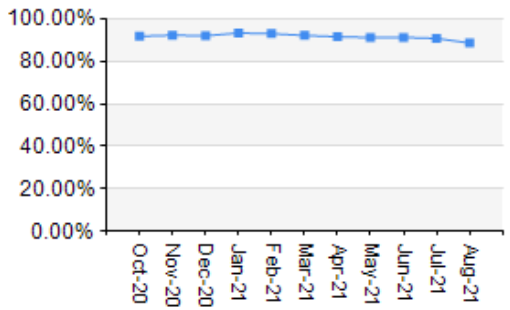
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% Massive PPH >1.5 litres **Standard: <=4%**		Continues to rise and is an area of key focus. We are working with Bristol to benchmark and share interventions to improve outcomes and work is being progressed as a MDT QI project, involving midwives, obstetricians and anaesthetists. As part of this work there is a monthly forum to discuss the massive PPH's and a staff survey to elicit any barriers to implementing the prevention and management of PPH.	**Divisional Director of Quality and Nursing and Chief Midwife**
% 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.	**Director of Operations - Surgery**

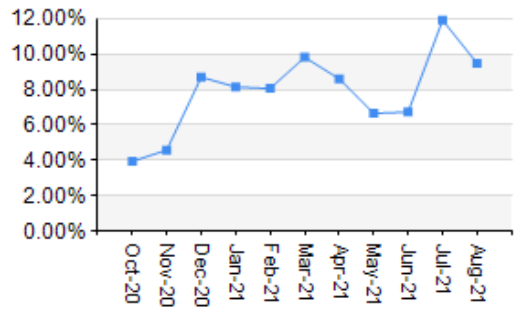
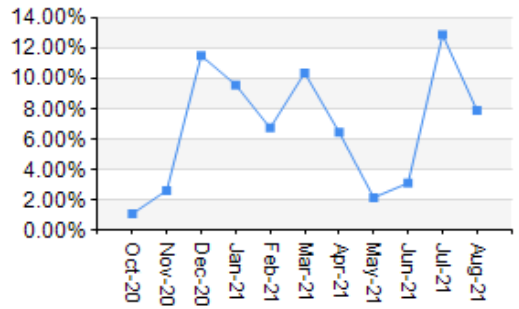
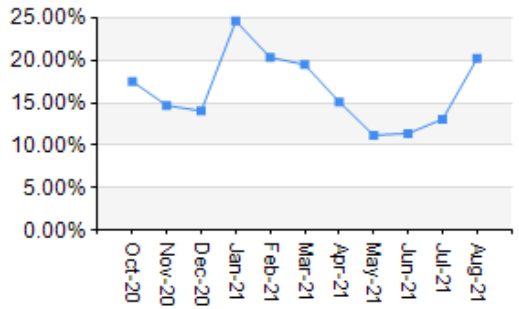
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		Due to increase in volume of concerns and sickness/annual leave in the team, the current % is 81.5%. We have put forward proposals for introducing a senior pals advisor role to hold some of the complex cases and provide support for the team in managing and closing concerns, which is going through VCP process.	**Head of Quality**
ED % positive **Standard: >=84%**		This month we have seen an increase in responses from July, and also an increase in positive score to 70.5%. The team are currently recruiting a FTC patient experience lead to support work in this area on the patient experience improvement plan, and recruiting more volunteers in the department.	**Head of Quality**

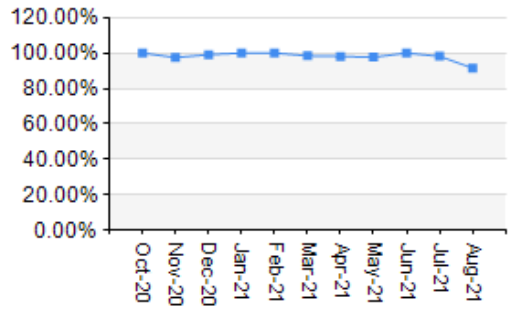
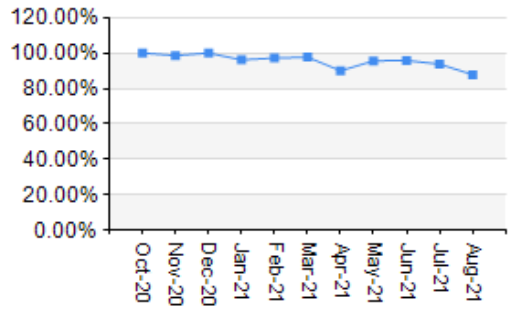
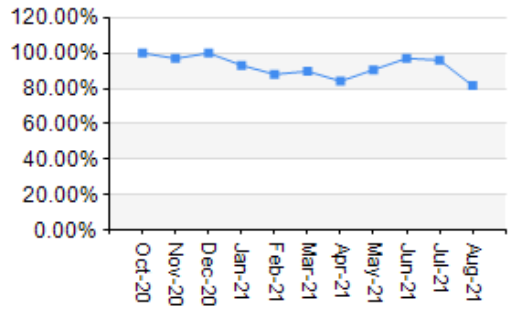
Exception Reports - Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Inpatients % positive **Standard: >=90%**		The inpatient positive score has decreased this month to 85.4%, with some surgical wards highlighted as particular areas of concern. The team are working with DDQNs to review where this data is being monitored in divisions and actions that are in place, to see if any additional support from the central team can be offered to further understand the responses and put plans in place for improvement.	**Head of Quality**
Maternity % positive **Standard: >=97%**		Maternity FFT is at 88.4%, with an increase in responses this month. The maternity ward has shown a decrease in positive score over the last few months, and the team are working with the divisional lead to identify if there are known issues and what plans are in place to support the team with thei improvement plans.	**Head of Quality**
Total % positive **Standard: >=93%**		The overall positive FFT score for the Trust has decreased to 88.5%. This is partially due to an increase in the number of responses received for ED services, where the overall positive score is 70.5%.	**Head of Quality**

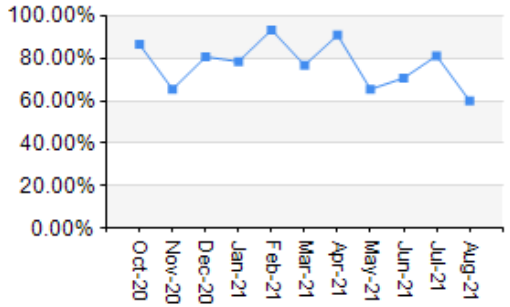
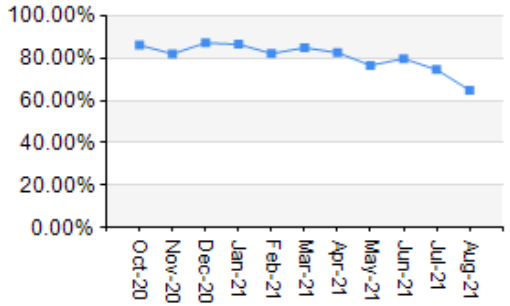
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		Ambulance arrivals have increased in August, by 1.08% compared to July. Despite the challenges this has brought, August saw a fall in ambulance waiting times in both 'over 30' and 'over 60 minutes' delays.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		Ambulance arrivals have increased in August, by 1.08% compared to July. Despite the challenges this has brought, August saw a fall in ambulance waiting times in both 'over 30' and 'over 60 minutes' delays.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Performance has dipped significantly in month moving from 13% last month to 20% this month. As referenced previously, this deterioration is associated primarily with Echo waiting times. The number of patients waiting >6 weeks has increased to 1,461, compared to 1,017 last month. 75% of the Echo patients are now breaching 6 weeks.	**Deputy Chief Operating Officer**

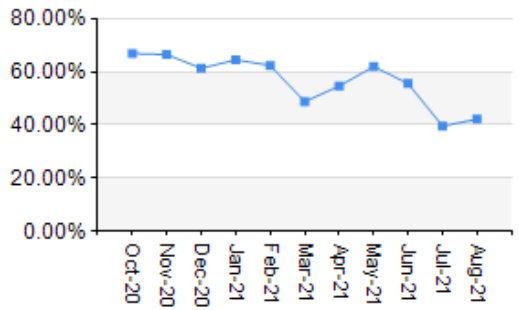
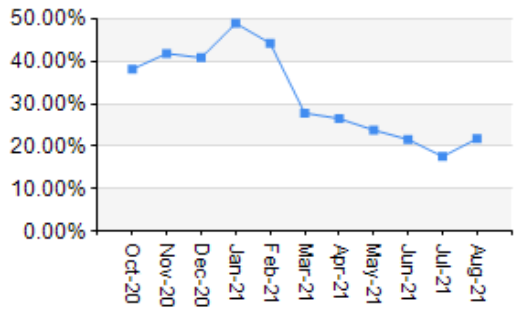
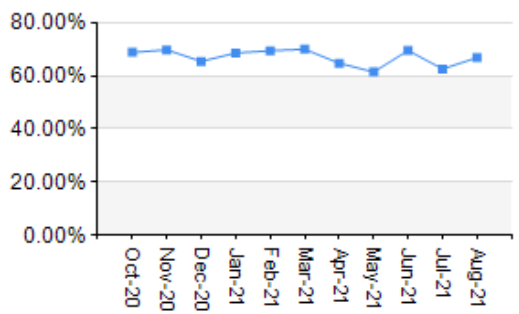
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy) **Standard: >=94%**		31 day subs radiotherapy performance (unvalidated) = 98.2% target = 94% National performance = 97.4%	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer – 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		31 day subs surgery performance (unvalidated) = 93.8% target = 94% National performance = 87.2%	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (screenings) **Standard: >=90%**		62 day screening performance (unvalidated)= 90.2% target = 90% National performance = 75.9%	**Director of Planned Care and Deputy Chief Operating Officer**

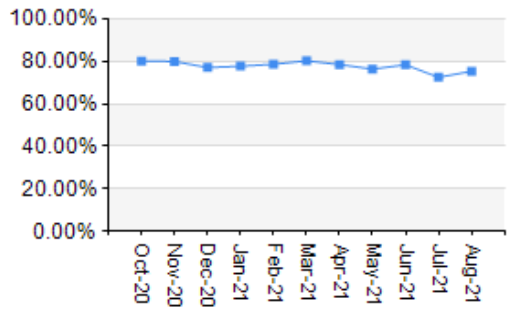
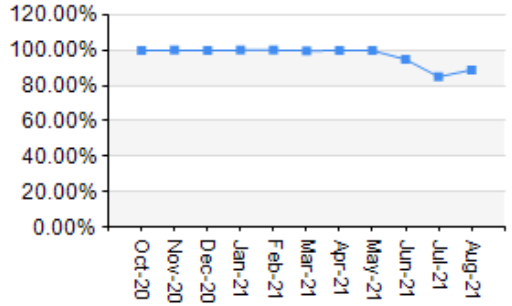
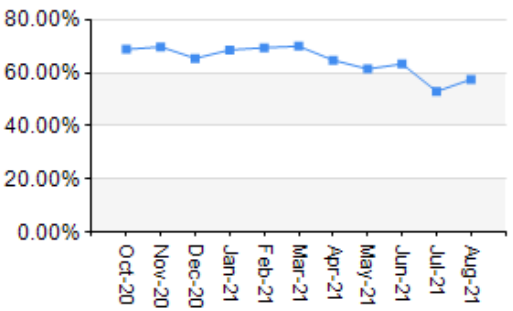
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated)= 77.50% target = n/a National performance = 81.7% 3.5 breaches	**Director of Planned Care and Deputy Chief Operating Officer**
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) = 73.6% target = 85% National performance = 72.1% "196 treatments 49 breaches LGI 11.5 Gynae 9 Uro 9 Key actions: - Lower GI pathway review with implementation of RDS pathway "	**Director of Planned Care and Deputy Chief Operating Officer**

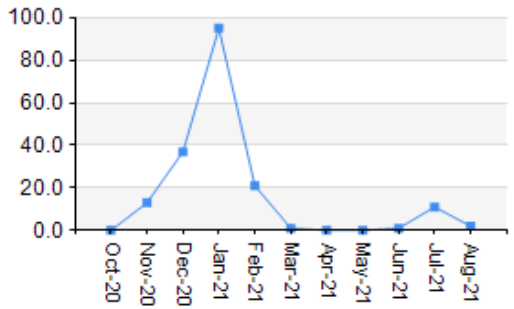
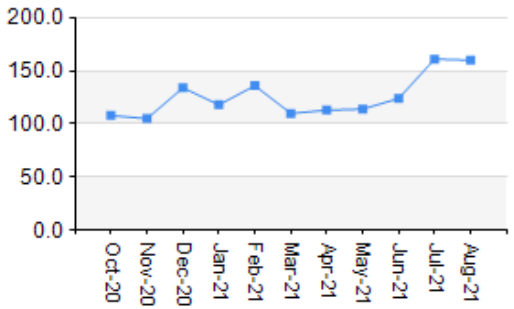
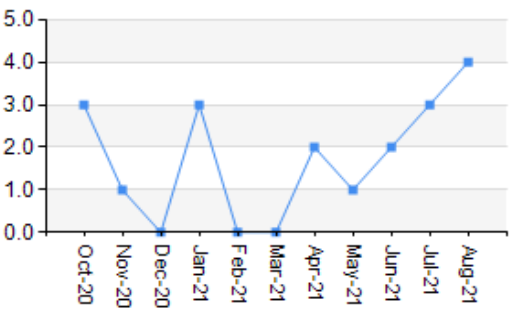
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Average triage wait in minutes has improved for both ambulance arrivals and walk ins, despite the large increase of walk in patients. However, this still remains over the 15 minute target. An improved staffing model to support triage demand is being worked on as well as 24/7 roll out of the pit stop model.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		The start of August saw the annual rotation of all training doctors. ED received a near full deanery rotation and the start of 5.2 WTE additional ED SHO's. This has resulted in a dramatic change to the Emergency Department rotas, weekend staffing continues to be challenging, but slight improvements have also been reflected here. The increase in doctor staffing lead to a trust wide fall in average wait to see a doctor by over 34 minutes however this still remains over the 60 minute target.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		The Emergency Departments 4 hour performance metric has improved across both sites, operational support has been in place focussing solely on improving performance and as always a focus on improving flow is present. Performance was 66.96% compared to 62.57% in July.	**Director of Unscheduled Care and Deputy Chief Operating Officer**

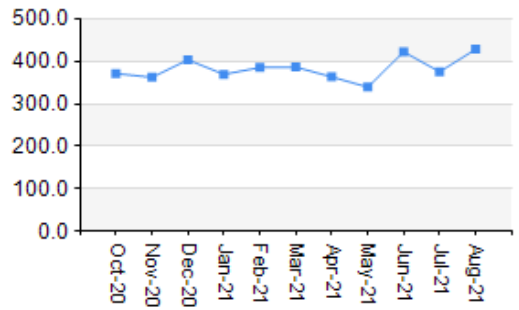
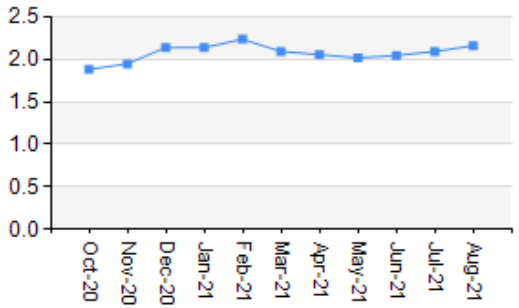
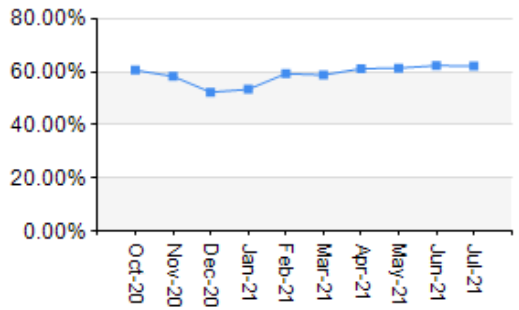
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		The Emergency Departments 4 hour performance metric has improved across both sites, operational support has been in place focussing solely on improving performance and as always a focus on improving flow is present.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours CGH **Standard: >=95%**		The Emergency Departments 4 hour performance at CGH was 88.77% which improved from July which was 84.95%	**Director of Unscheduled Care and Deputy Chief Operating Officer**
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		The Emergency Departments 4 hour performance at GRH was 57.7% which improved from July which was 53%	**Director of Unscheduled Care and Deputy Chief Operating Officer**

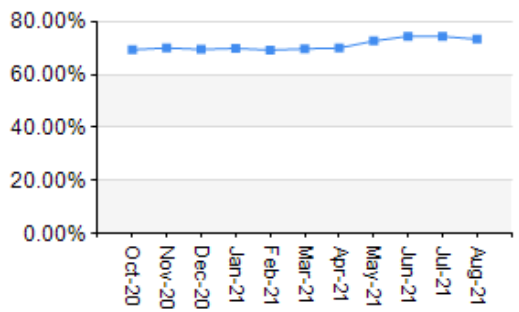
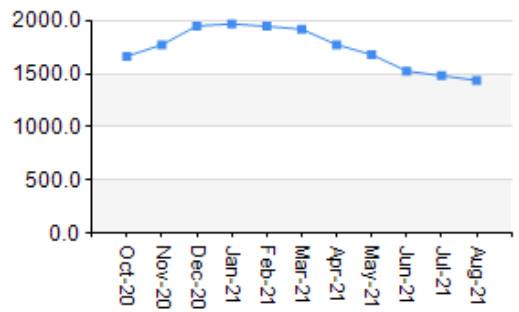
Exception Reports - Responsive (6)

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**		There were no 12 hour trolley waits in August.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		Further narrative will be provided by verbal updates.	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		5	**Director of Planned Care and Deputy Chief Operating Officer**

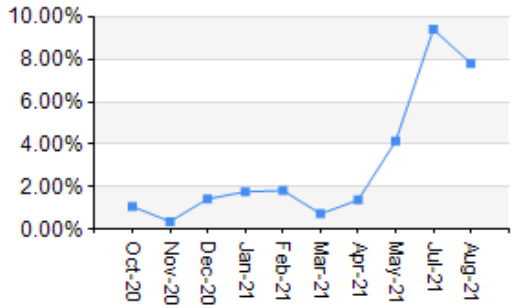
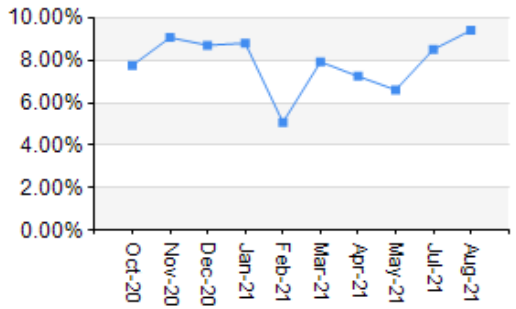
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		Further narrative will be provided by verbal updates.	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		The ratio generally remains relatively consistent, albeit having dropped slightly in month to 2.16 (from 2.09 last month), and just over the target of <=1.9.	**Director of Unscheduled Care and Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Further narrative will be provided by verbal updates.	**Medical Director**

Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. Performance remains relatively stable with 73.3% being an unvalidated snapshot. The month end position for August is likely to be confirmed as 74.1% which remains around the national average for RTT. 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**		Further narrative will be provided by verbal updates.	**Medical Director**

Exception Reports - Well Led (1)

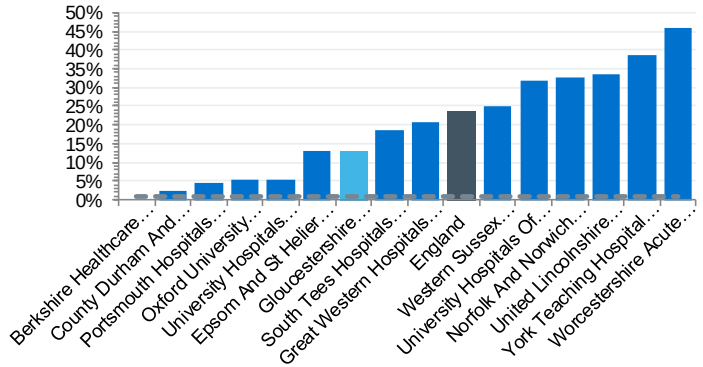
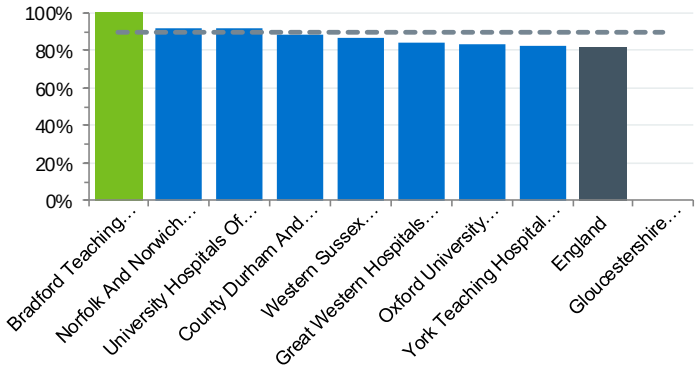
Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors **Standard: <=5%**		August rotation has seen increased intake of Junior Drs from the Deanery which has resulted in increased fill rate compared to previous years. Identified posts are looking to alternative cover options where appropriate including Physicians Associates. All current recruitment activity is underway for Consultants where VCP approval has been received.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses **Standard: <=5%**		International Recruitment activity has been increased further as a result of additional funding. This will bring the planned number of internationally recruited nurses to 130 by the end of the financial year. This year's intake of newly qualified nurses will be starting in post during September with further recruitment events scheduled for October to target newly qualified this year and students entering into their 3rd year of training and looking to qualify summer 2022.	**Director of Human Resources and Operational Development**

Benchmarking (1)

Gloucestershire Hospitals NHS Foundation Trust

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

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

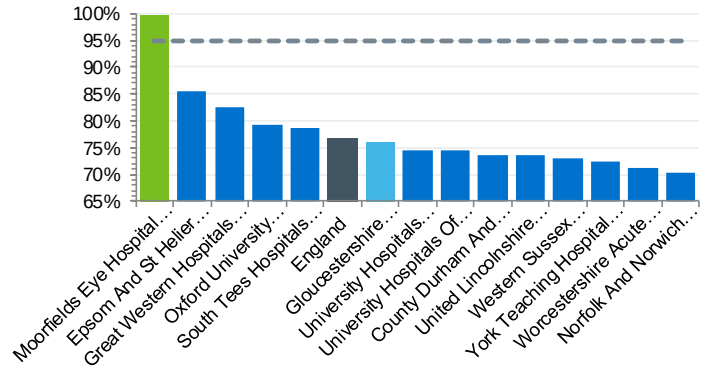
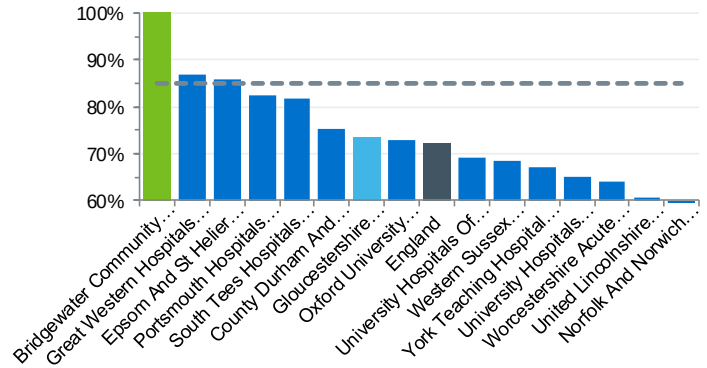
Metric	Period	Peer Group	Rank	Quartile
Diagnostics	July-21		63 / 158	2nd
Dementia	February-20		82 / 82	4th

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

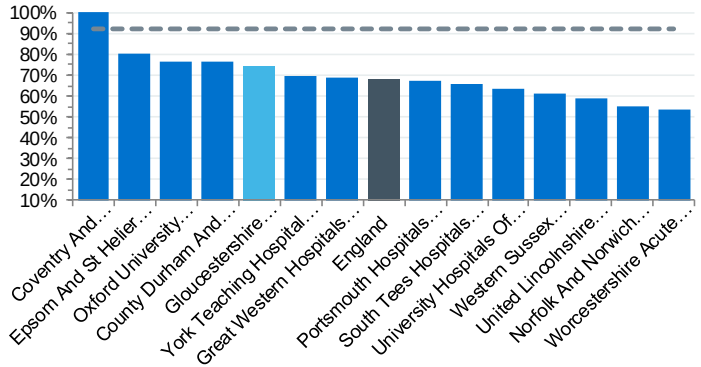
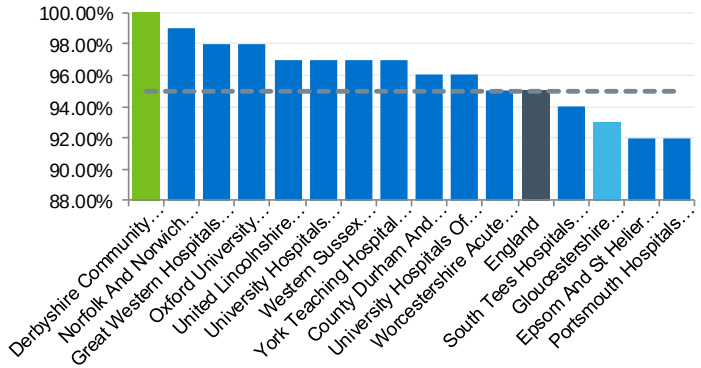
Metric	Period	Peer Group	Rank	Quartile
ED 4 Hour (Type 1 & Type 3)	August-21		69 / 113	3rd
Cancer 62 Days GP Referrals	July-21		65 / 133	2nd

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

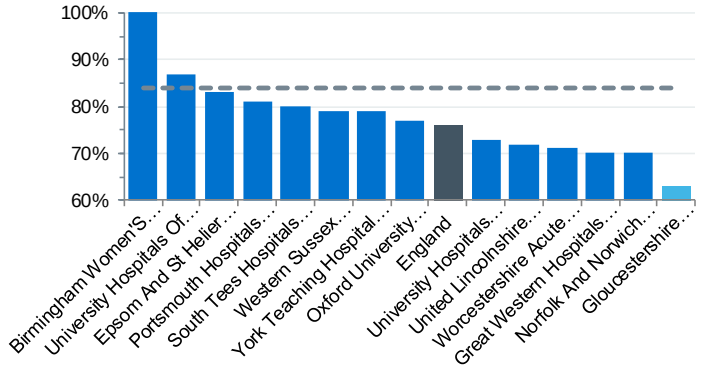
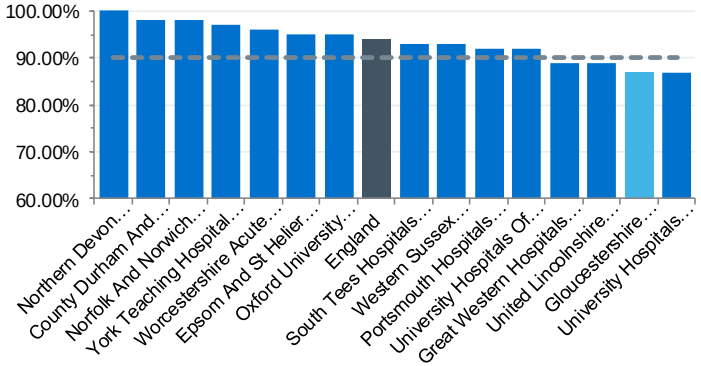
Metric	Period	Peer Group	Rank	Quartile
RTT	July-21		70 / 154	2nd
VTE (published quarterly)	December-19		116 / 149	4th

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

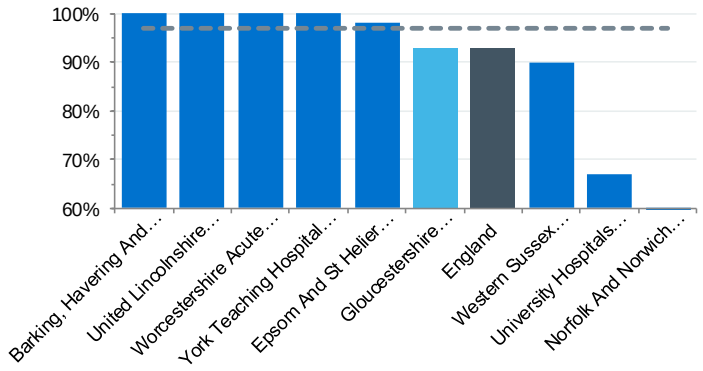
Metric	Period	Peer Group	Rank	Quartile
FFT - ED	July-21		112 / 120	4th
FFT - Inpatient	July-21		125 / 135	4th

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	July-21		60 / 95	3rd

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period August 2021

Presented at September 2021 Q&P and October 2021 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Contents	2
Guidance	3
Executive Summary	4
Access	5
Quality	31
Financial	35
People & OD Risk Rating	36

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 August, 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 August was 66.85%. The system did not meet the delivery of 90% for the system in August, at 75.27%.

The Trust did not meet the diagnostics standard for August at 20.19%. We have, as with many services prioritised same day diagnostics and support for patients to be prioritised post clinical review. The achievement of this standard has been majorly impacted by C-19, specifically endoscopy tests. MR and CT have recovered their waiting time position.

The Trust did meet the standard for 2 week wait cancer at 93.3% but did not meet the standard for the 62 day cancer waits standard at 64.8% in August, this is as yet un-validated performance at the time of the report.

For elective care, the RTT performance is 73.33% (un-validated) in August, 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 1,622 in August. This is as yet un-validated performance at the time of the report.

Directors Operational Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team. 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

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

Variation

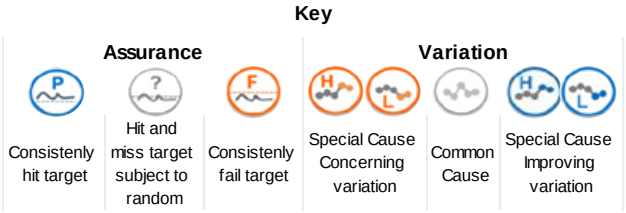
- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Cancer	Cancer – 28 day FDS two week wait	No target	Aug-21	78.7%	
Cancer	Cancer – 28 day FDS breast symptom two week wait	No target	Aug-21	100.0%	
Cancer	Cancer – 28 day FDS screening referral	No target	Aug-21	43.6%	
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Aug-21	93.3%	
Cancer	2 week wait breast symptomatic referrals	>=93%	Aug-21	93.2%	
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Aug-21	95.9%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Aug-21	98.9%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Aug-21	87.8%	
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Aug-21	91.5%	
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Aug-21	64.8%	
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Aug-21	81.6%	
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Aug-21	60.0%	
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Aug-21	4	
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Aug-21	12	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Aug-21	20.19%	
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Aug-21	1,439	
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Jul-21	62.20%	
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Aug-21	66.85%	
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Aug-21	75.27%	
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Aug-21	88.74%	
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Aug-21	57.55%	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Aug-21	2	
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Aug-21	42.2%	
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Aug-21	21.8%	
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Aug-21	9.48%	
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Aug-21	7.88%	
Maternity	% of women booked by 12 weeks gestation	>90%	Aug-21	90.8%	
Operational Efficiency	Number of patients stable for discharge	<=70	Aug-21	160	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Aug-21	428	
Operational Efficiency	Average length of stay (spell)	<=5.06	Aug-21	4.84	
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Aug-21	5.3883	
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Aug-21	2.3	
Operational Efficiency	% day cases of all electives	>80%	Aug-21	82.6%	
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Aug-21	89.5%	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Aug-21	100.0%	
Operational Efficiency	Urgent cancelled operations	No target	Aug-21	10	
Outpatient	Outpatient new to follow up ratio's	<=1.9	Aug-21	2.1585	
Outpatient	Did not attend (DNA) rates	<=7.6%	Aug-21	7.2%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Jul-21	8.3%	
Research	Research accruals	No target	Aug-21	150	

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

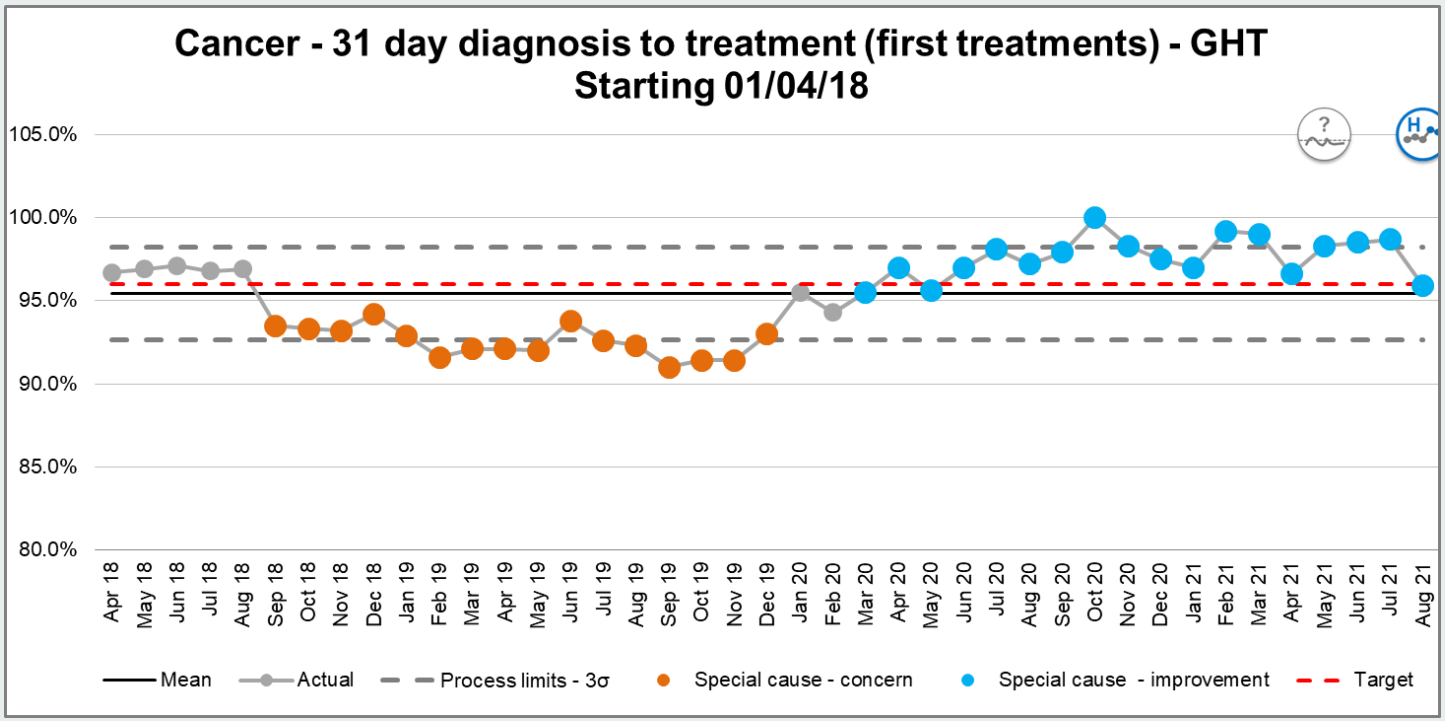


This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%	F	Aug-21	73.33%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Aug-21	5,748	H
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Aug-21	3,003	H
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero	F	Aug-21	1,622	H
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Aug-21	647	H
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%	?	May-21	48.9%	H
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%	?	Jul-21	82.7%	
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%	
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%	?	Aug-21	60.70%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%	?	Aug-21	59.0%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

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

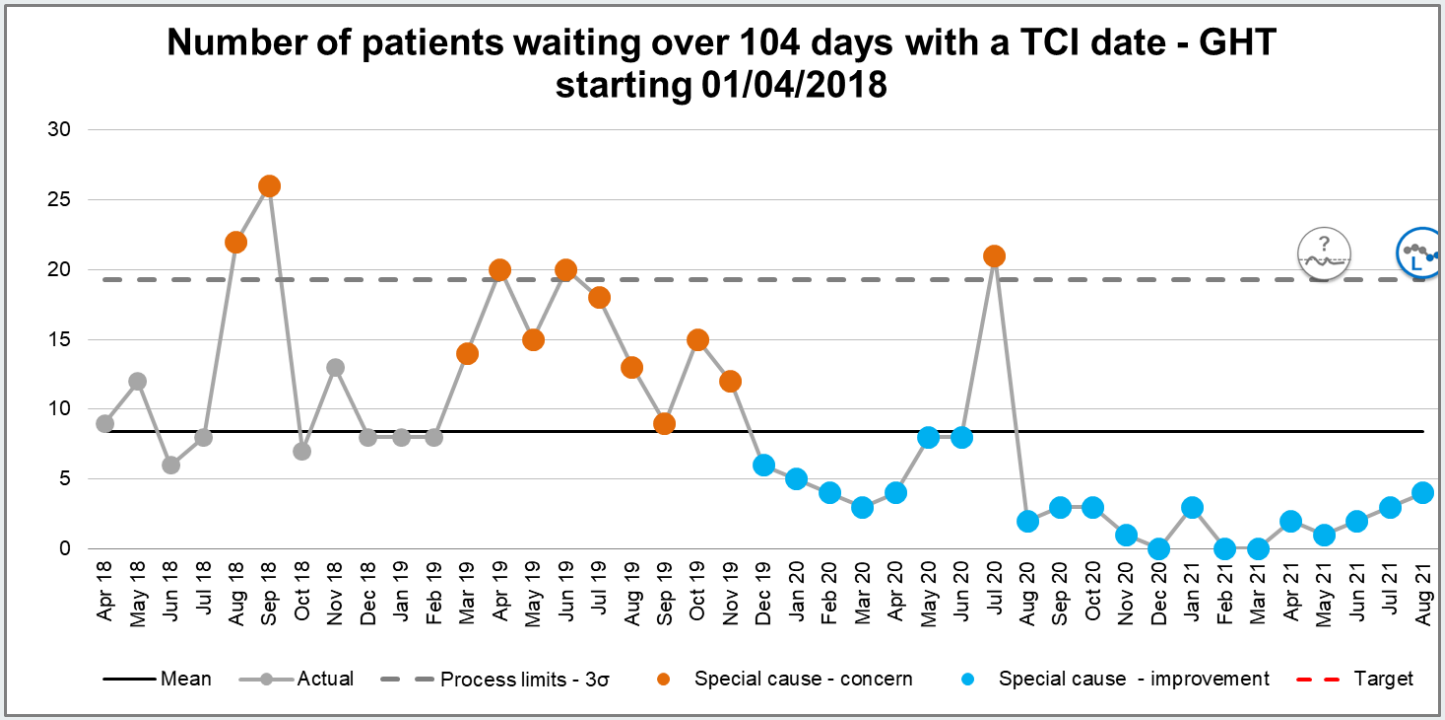
- Director of Planned Care and Deputy Chief Operating Officer

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

5

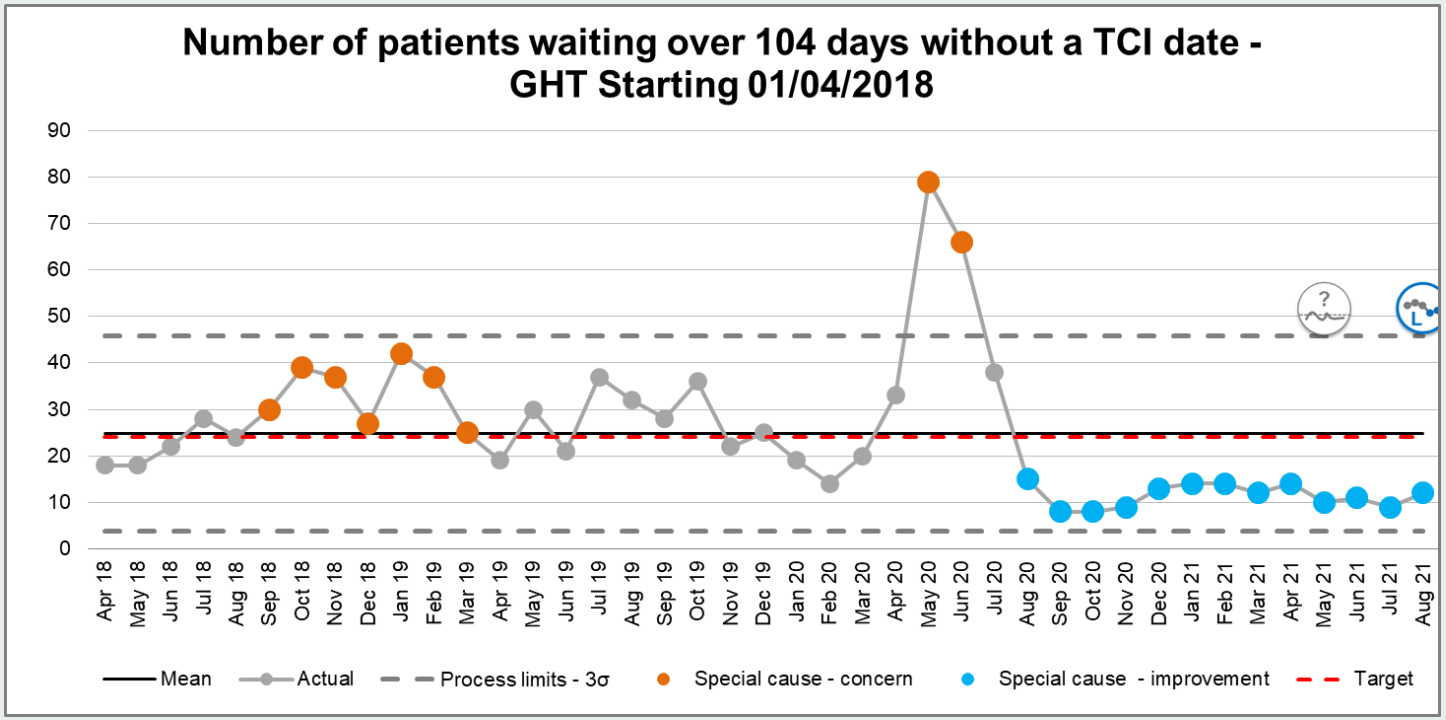
- Director of Planned Care and Deputy Chief Operating Officer

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 this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

18

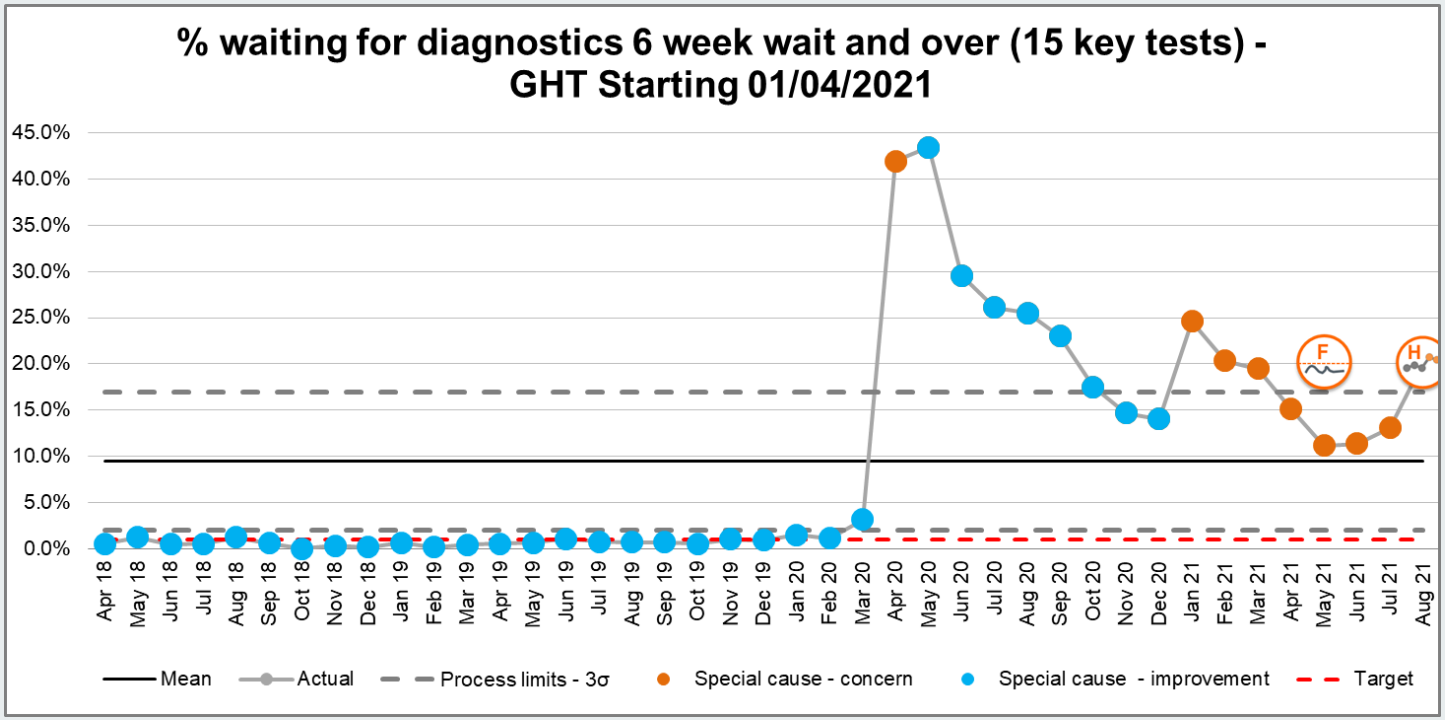
- Director of Planned Care and Deputy Chief Operating Officer

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 above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance has dipped significantly in month moving from 13% last month to 20% this month. As referenced previously, this deterioration is associated primarily with Echo waiting times. The number of patients waiting >6 weeks has increased to 1,461, compared to 1,017 last month. 75% of the Echo patients are now breaching 6 weeks.

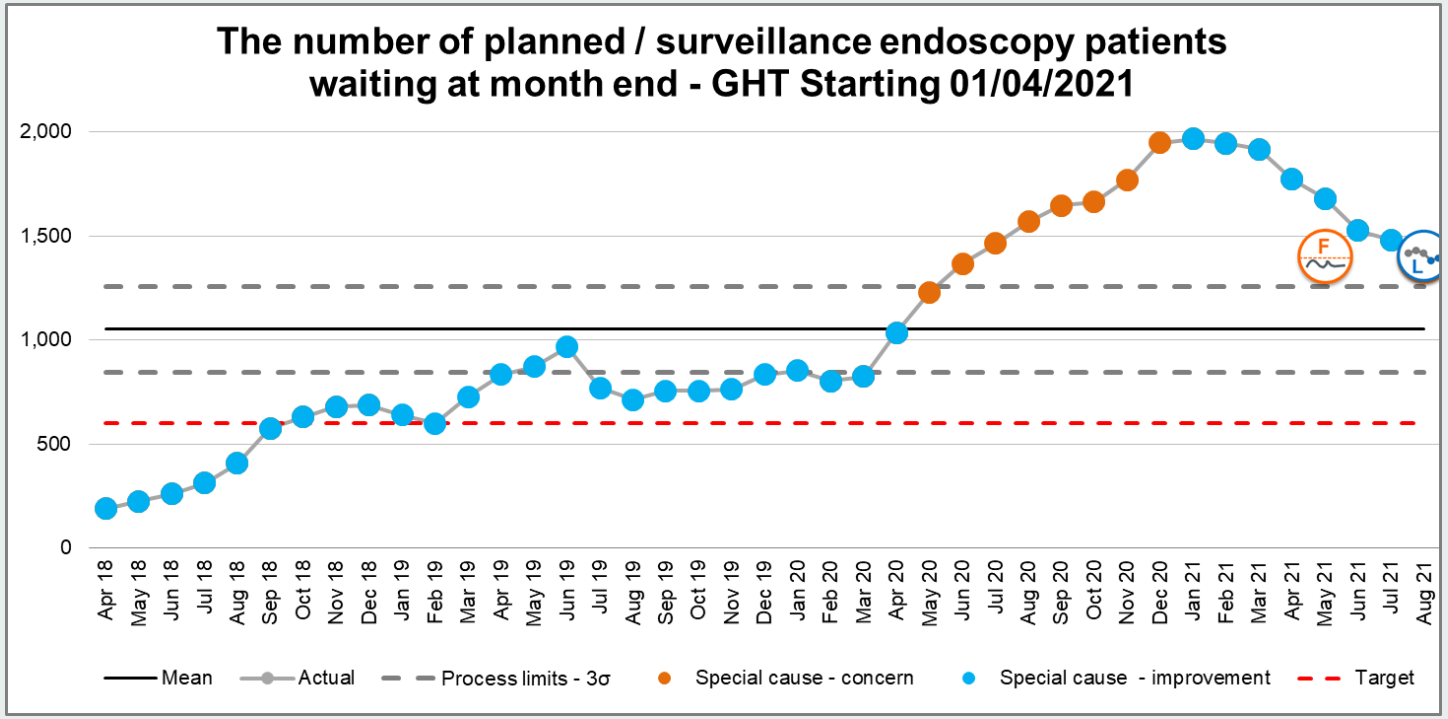
- Director of Unscheduled Care and Deputy Chief Operating Officer

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 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 sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Further narrative will be provided by verbal updates.

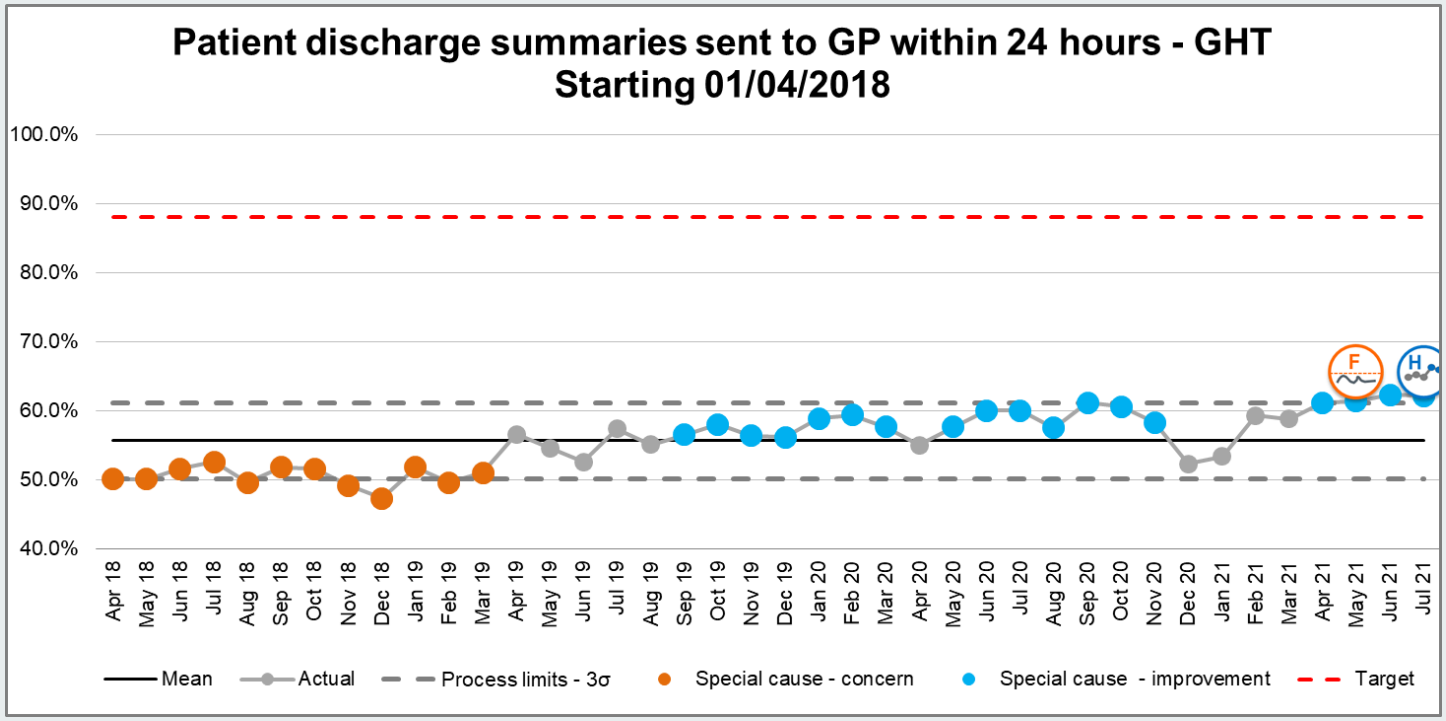
- Medical Director

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 15 data points which are above the line. There are 21 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.
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 this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Further narrative will be provided by verbal updates.

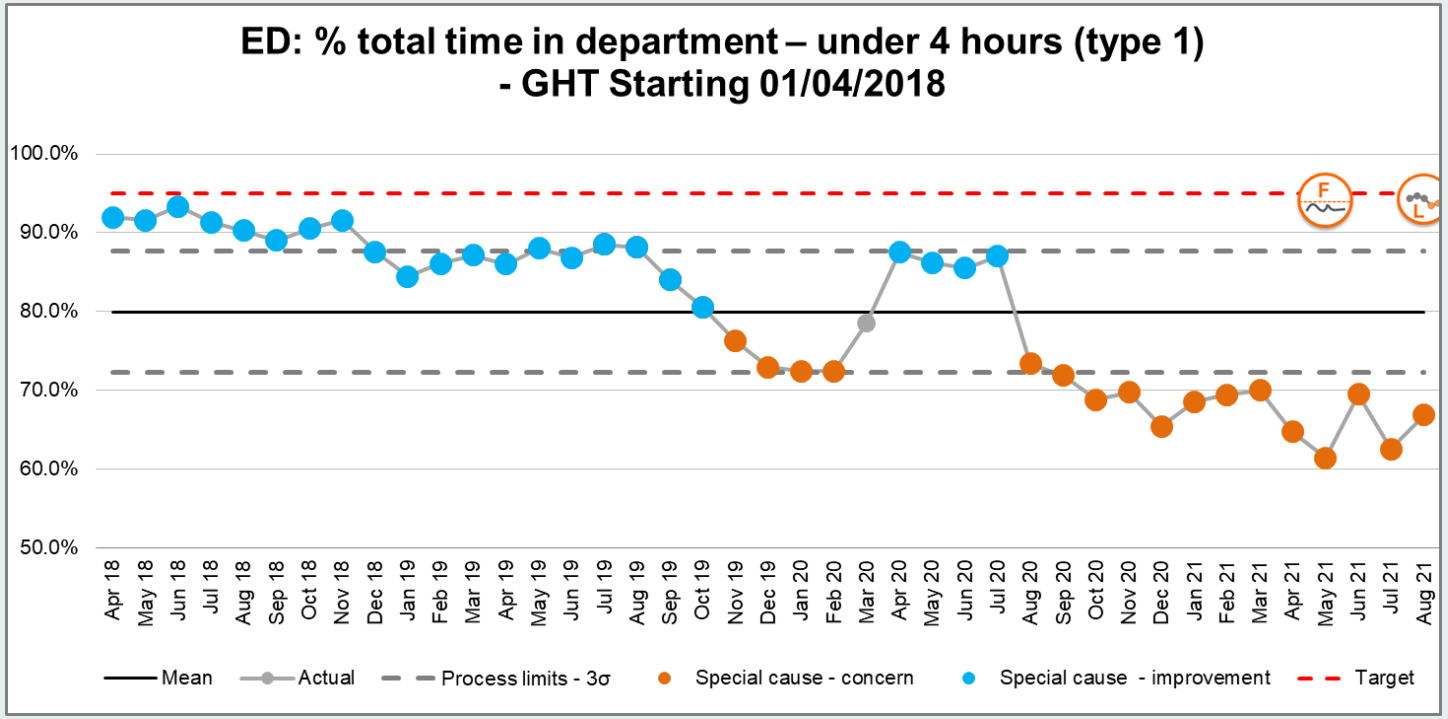
- Medical Director

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 5 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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

The Emergency Departments 4 hour performance metric has improved across both sites, operational support has been in place focussing solely on improving performance and as always a focus on improving flow is present. Performance was 66.96% compared to 62.57% in July.

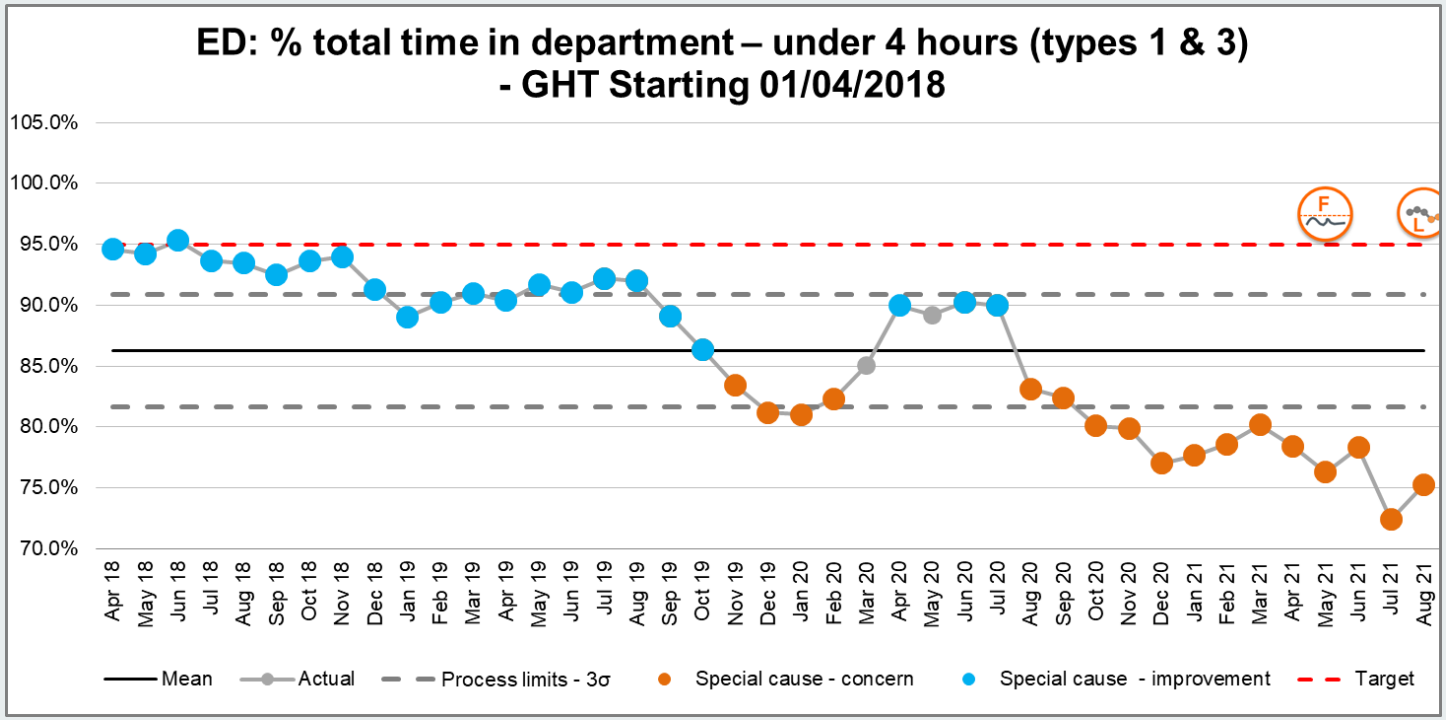
- Director of Unscheduled Care and Deputy Chief Operating Officer

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.
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

The Emergency Departments 4 hour performance metric has improved across both sites, operational support has been in place focussing solely on improving performance and as always a focus on improving flow is present.

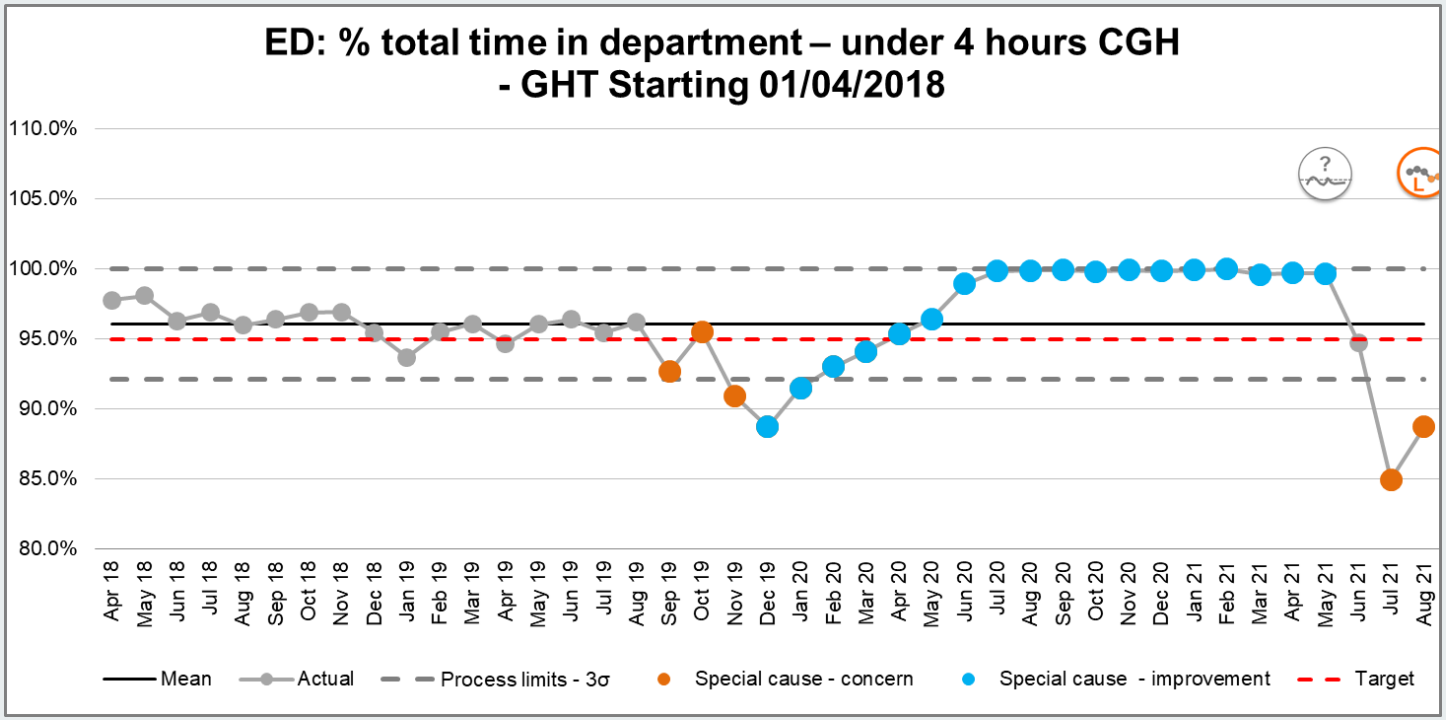
- Director of Unscheduled Care and Deputy Chief Operating Officer

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 14 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
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

The Emergency Departments 4 hour performance at CGH was 88.77% which improved from July which was 84.95%

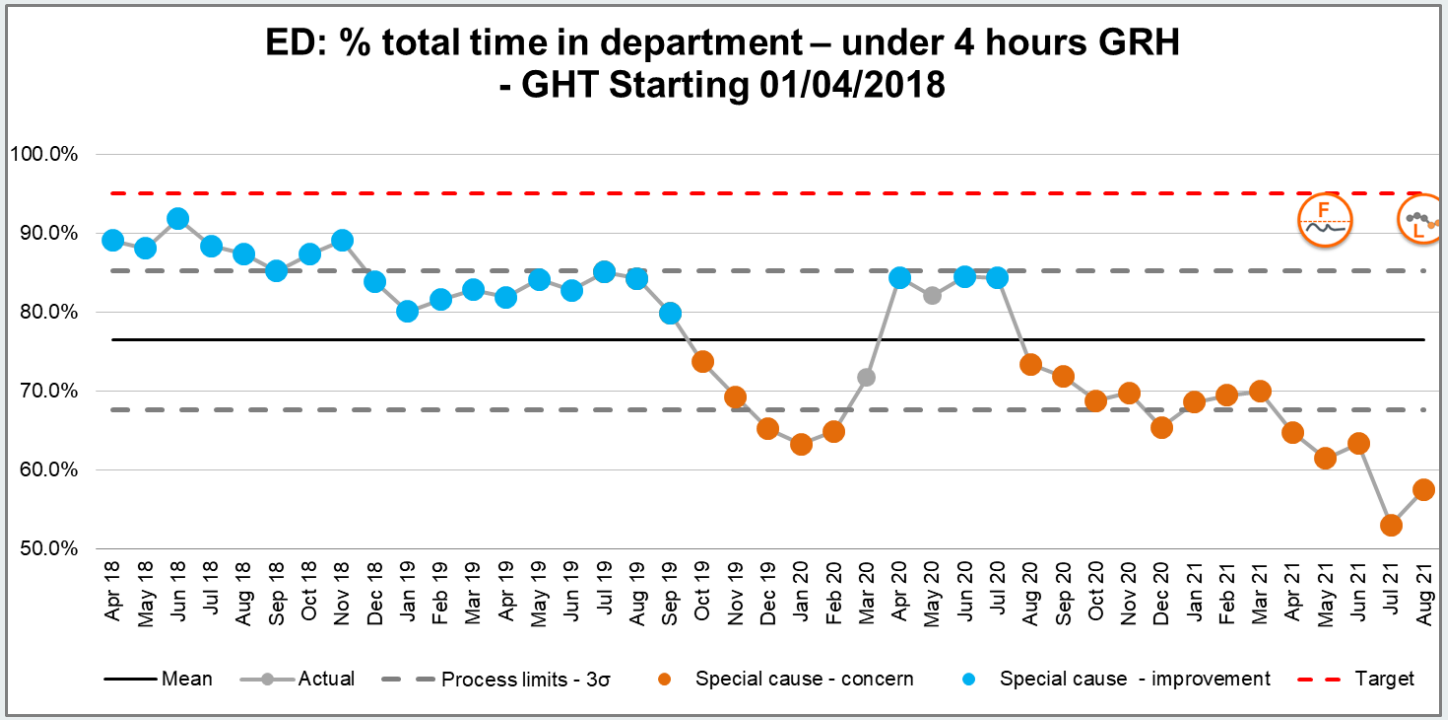
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Emergency Departments 4 hour performance at GRH was 57.7% which improved from July which was 53%

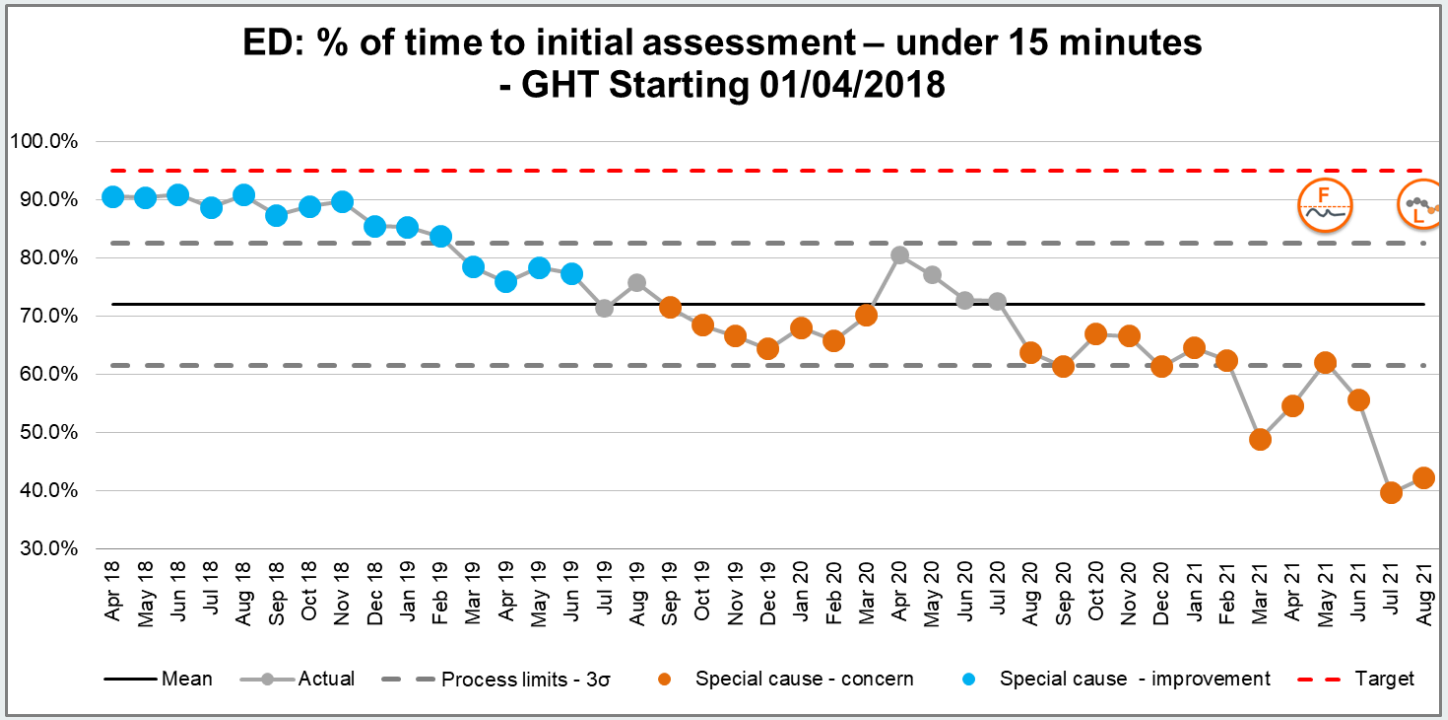
- Director of Unscheduled Care and Deputy Chief Operating Officer

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Average triage wait in minutes has improved for both ambulance arrivals and walk ins, despite the large increase of walk in patients. However, this still remains over the 15 minute target. An improved staffing model to support triage demand is being worked on as well as 24/7 roll out of the pit stop model.

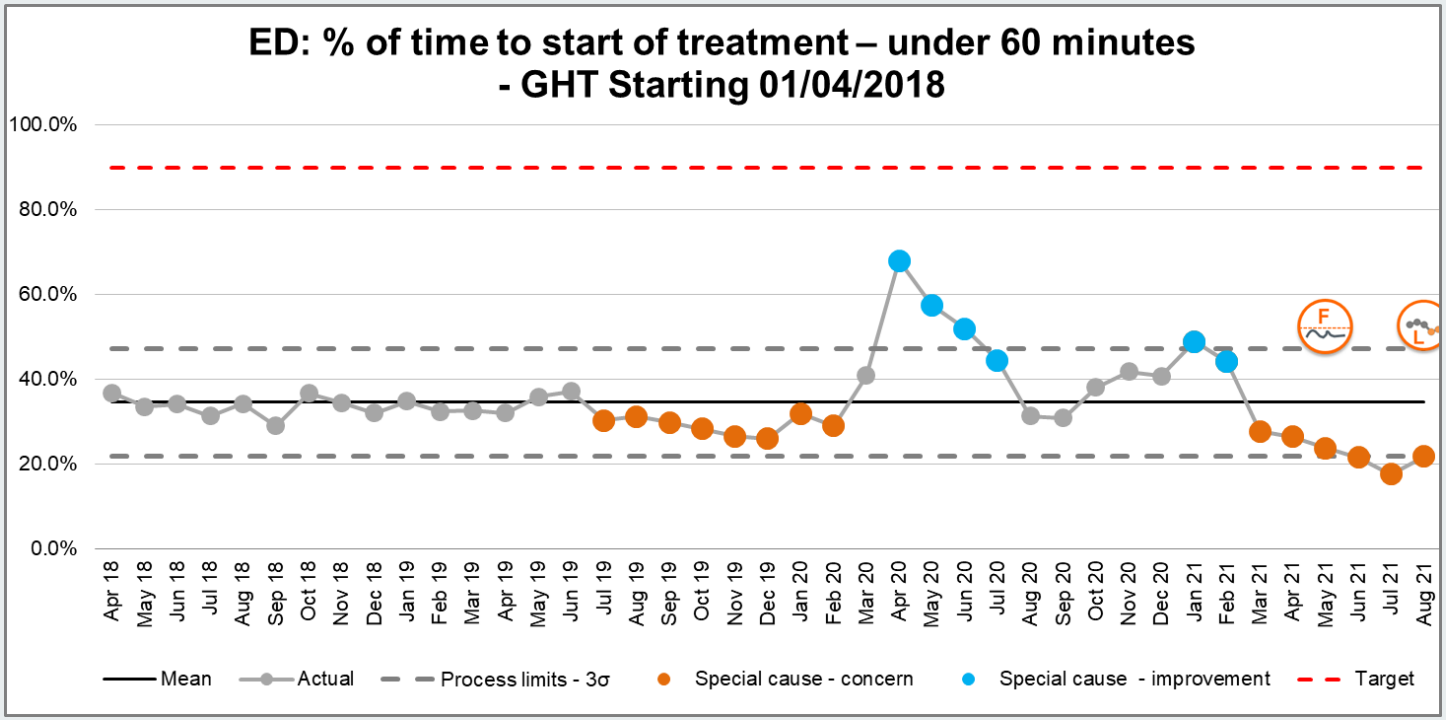
- Director of Unscheduled Care and Deputy Chief Operating Officer

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The start of August saw the annual rotation of all training doctors. ED received a near full deanery rotation and the start of 5.2 WTE additional ED SHO's. This has resulted in a dramatic change to the Emergency Department rotas, weekend staffing continues to be challenging, but slight improvements have also been reflected here. The increase in doctor staffing lead to a trust wide fall in average wait to see a doctor by over 34 minutes however this still remains over the 60 minute target.

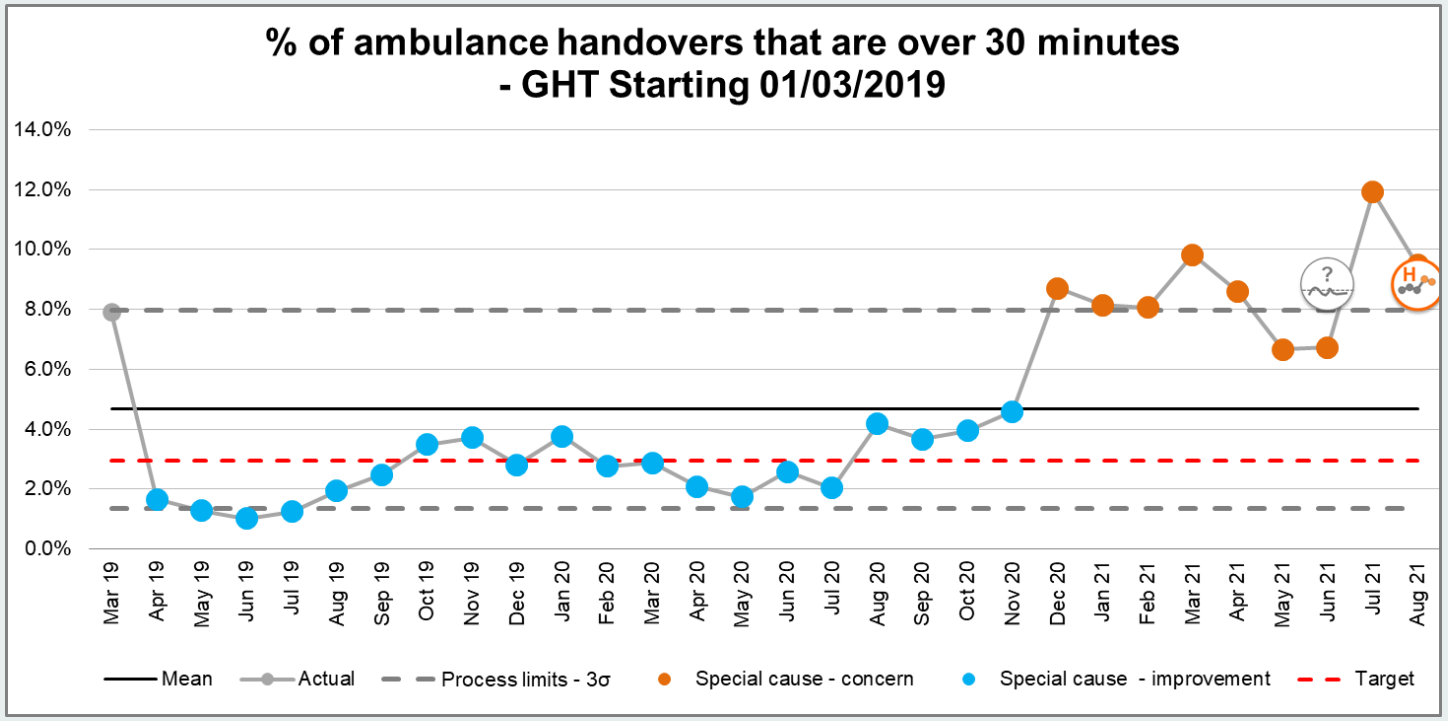
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 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 below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Ambulance arrivals have increased in August, by 1.08% compared to July. Despite the challenges this has brought, August saw a fall in ambulance waiting times in both 'over 30' and 'over 60 minutes' delays.

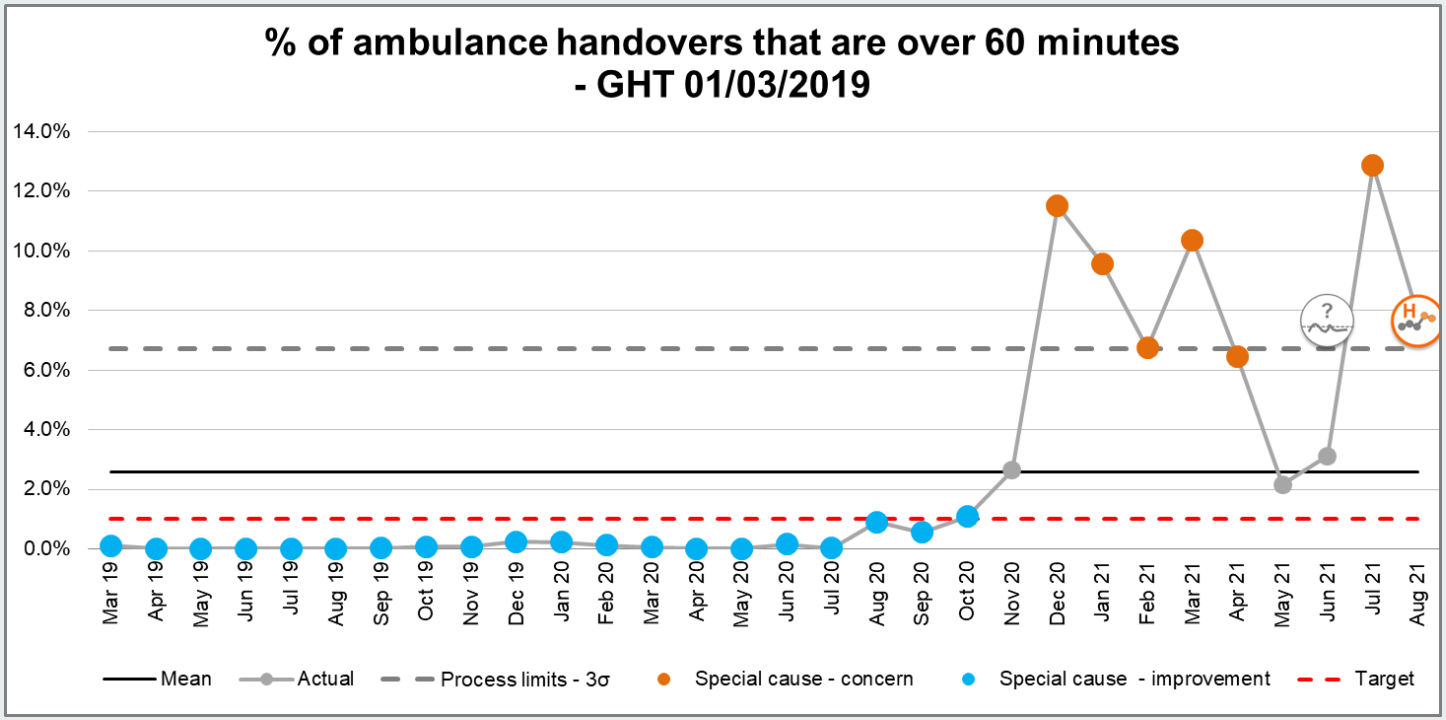
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Ambulance arrivals have increased in August, by 1.08% compared to July. Despite the challenges this has brought, August saw a fall in ambulance waiting times in both ‘over 30’ and ‘over 60 minutes’ delays.

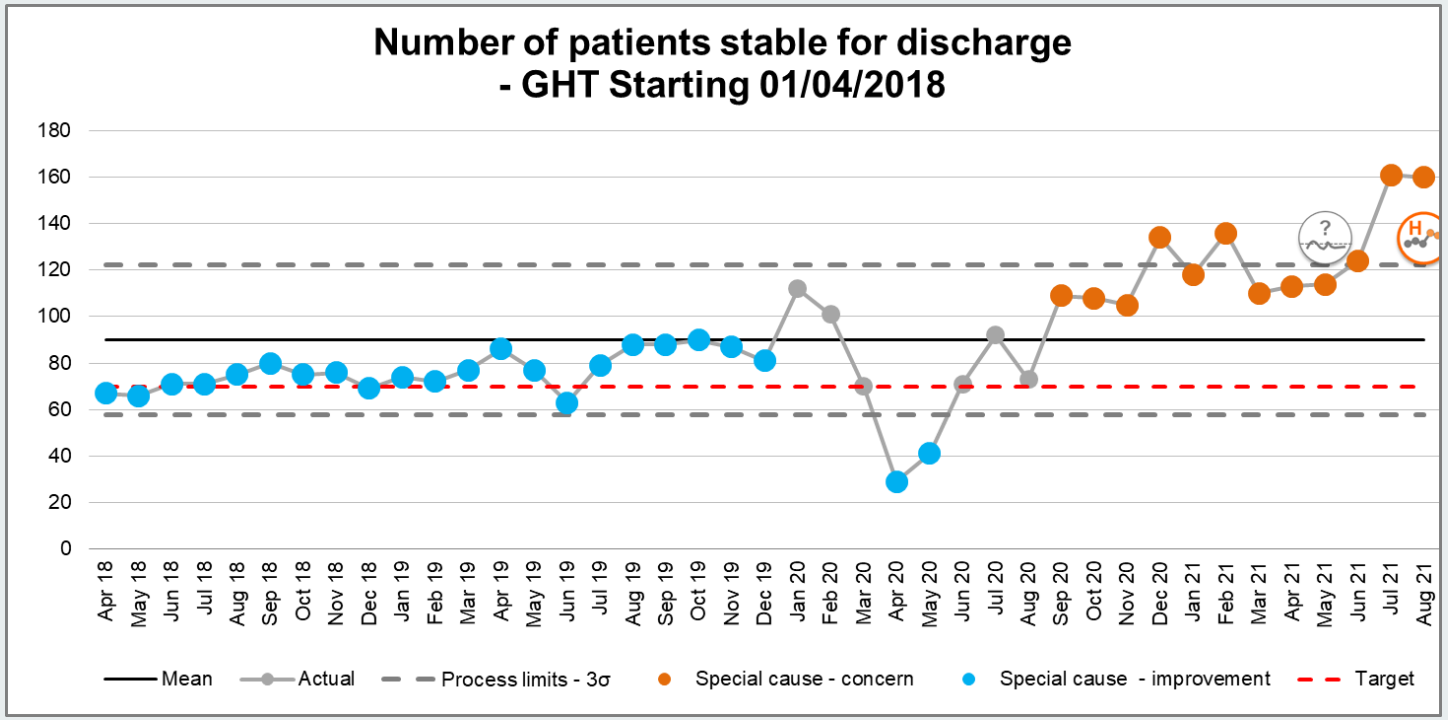
- Director of Unscheduled Care and Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points 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

Further narrative will be provided by verbal updates.

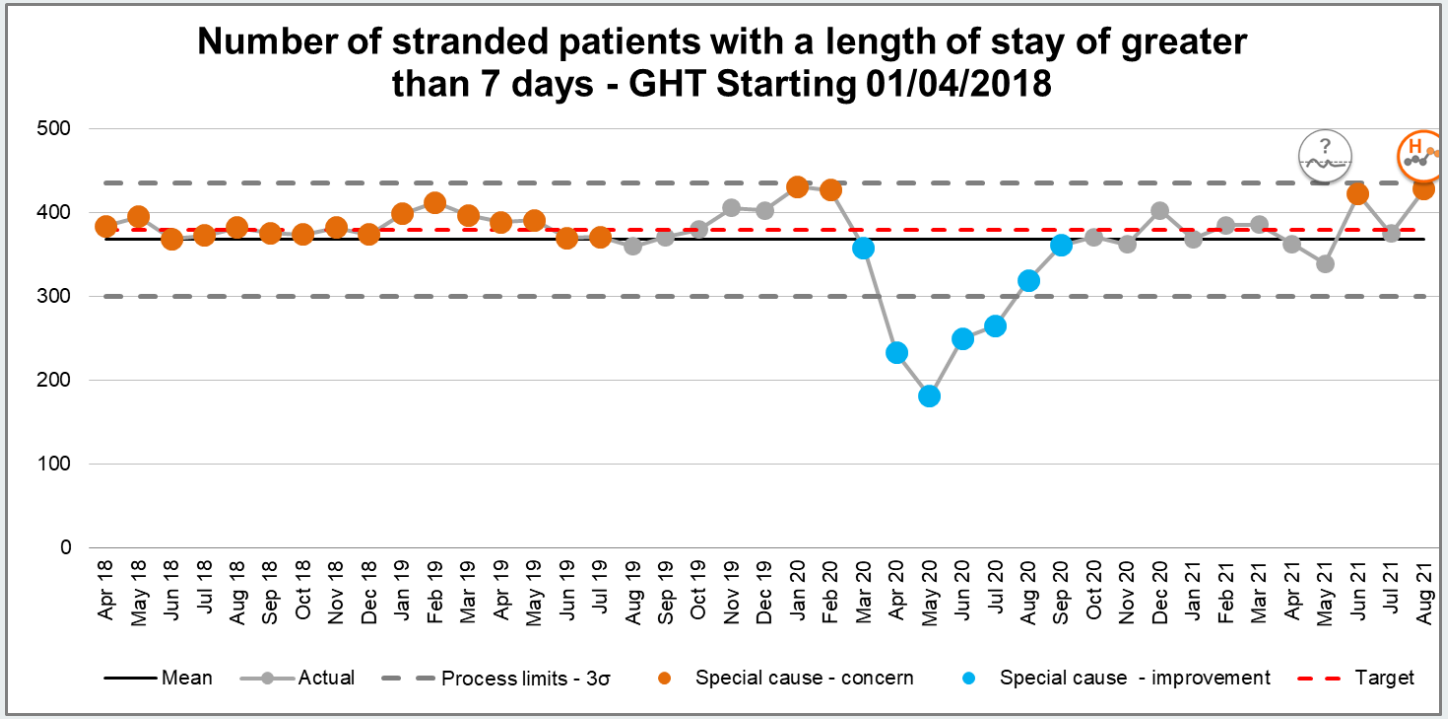
- Head of Therapy & OCT

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Further narrative will be provided by verbal updates.

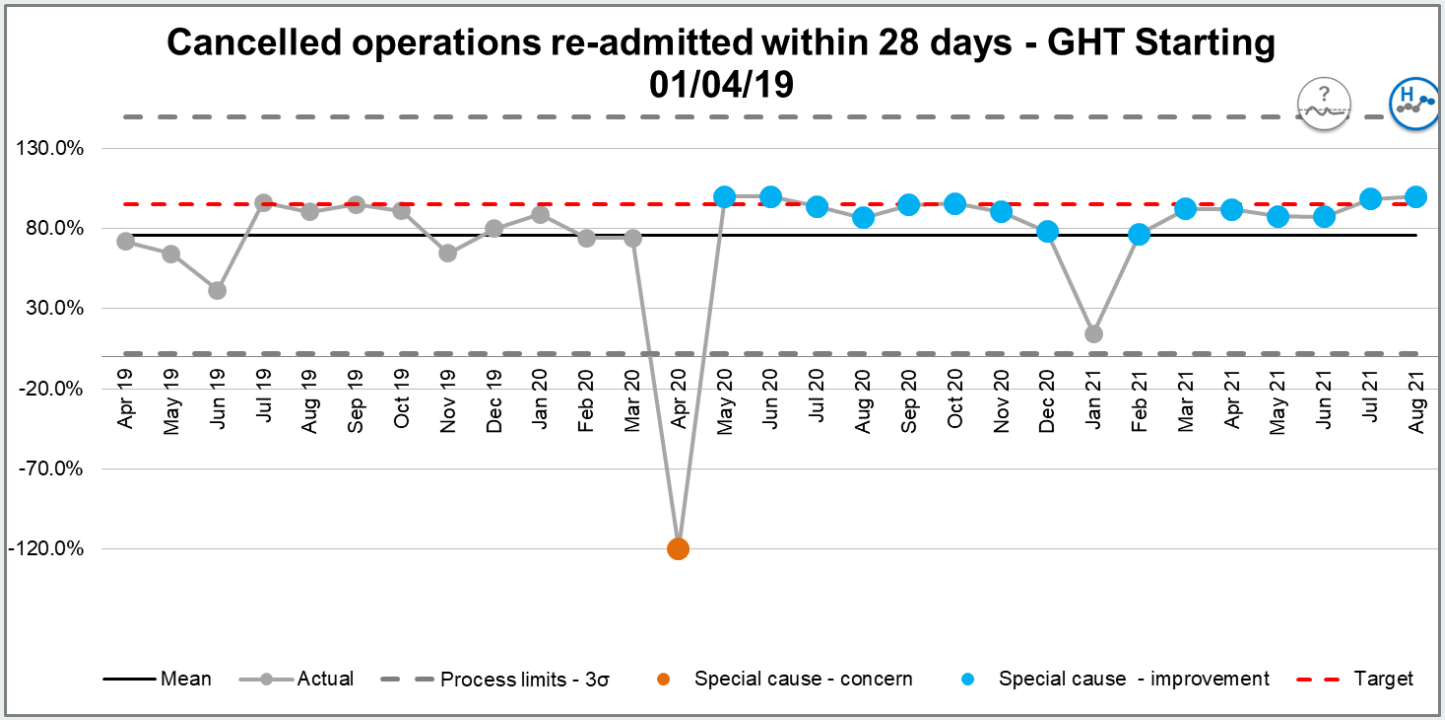
- Director of Planned Care and Deputy Chief Operating Officer

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In July there were a total of 8 patients that were cancelled on the day that could not be rescheduled within 28 days. This is an improvement on previous months .

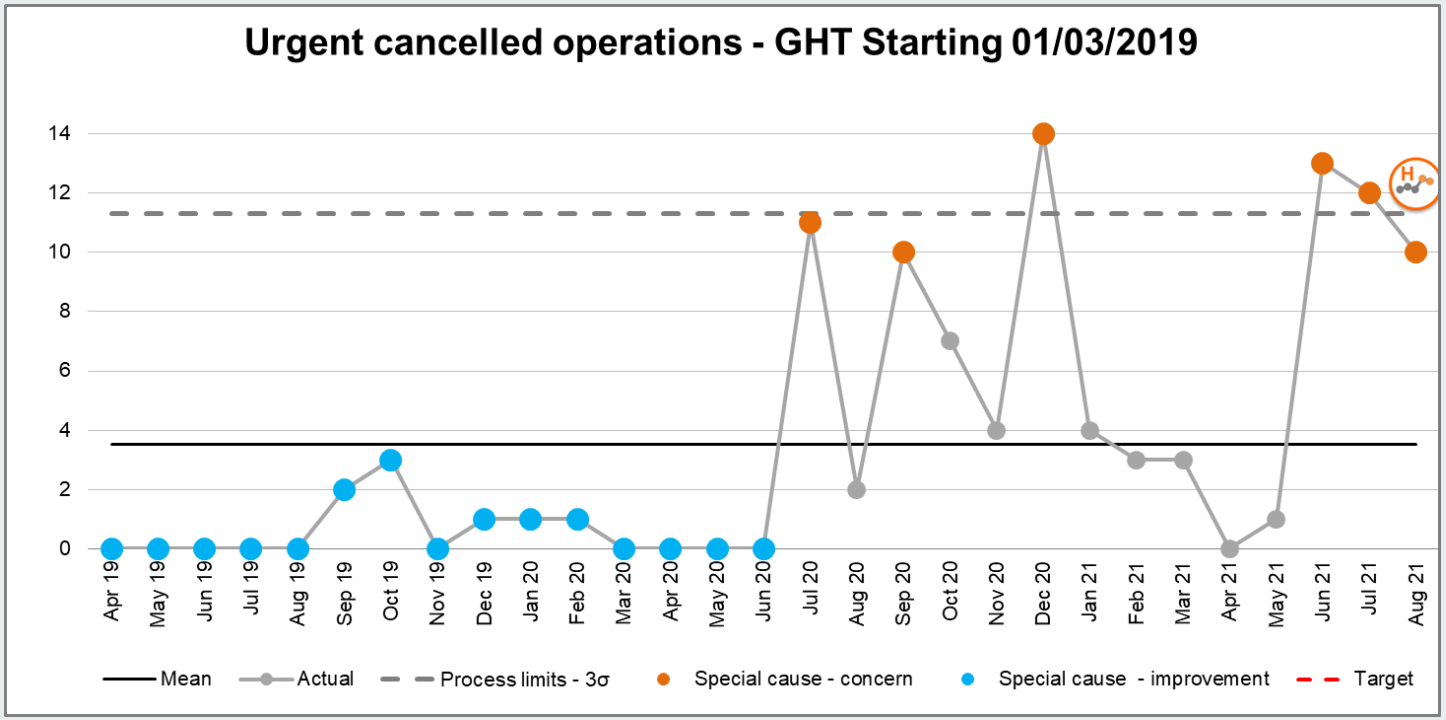
- Deputy Chief Operating Officer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Further narrative will be provided by verbal updates.

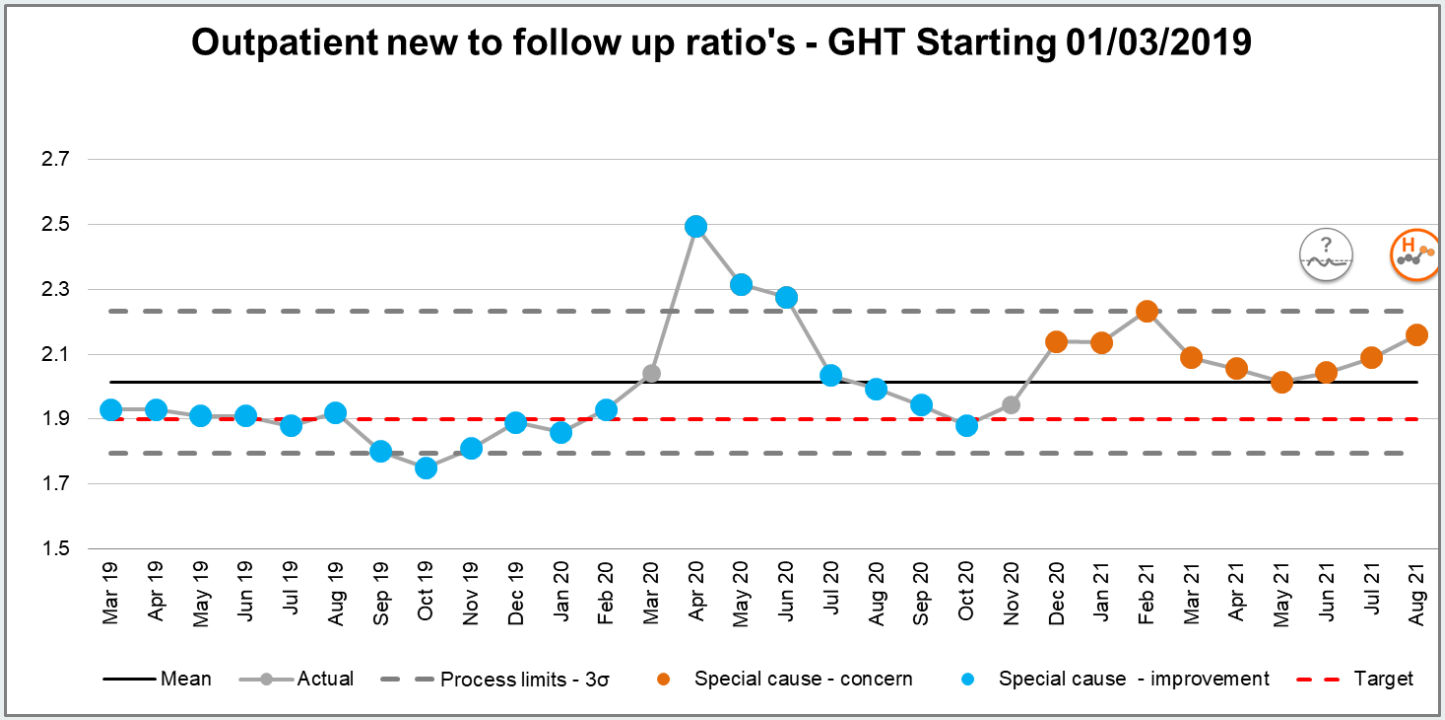
- Director of Operations - Surgery

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The ratio generally remains relatively consistent, albeit having dropped slightly in month to 2.16 (from 2.09 last month), and just over the target of <=1.9.

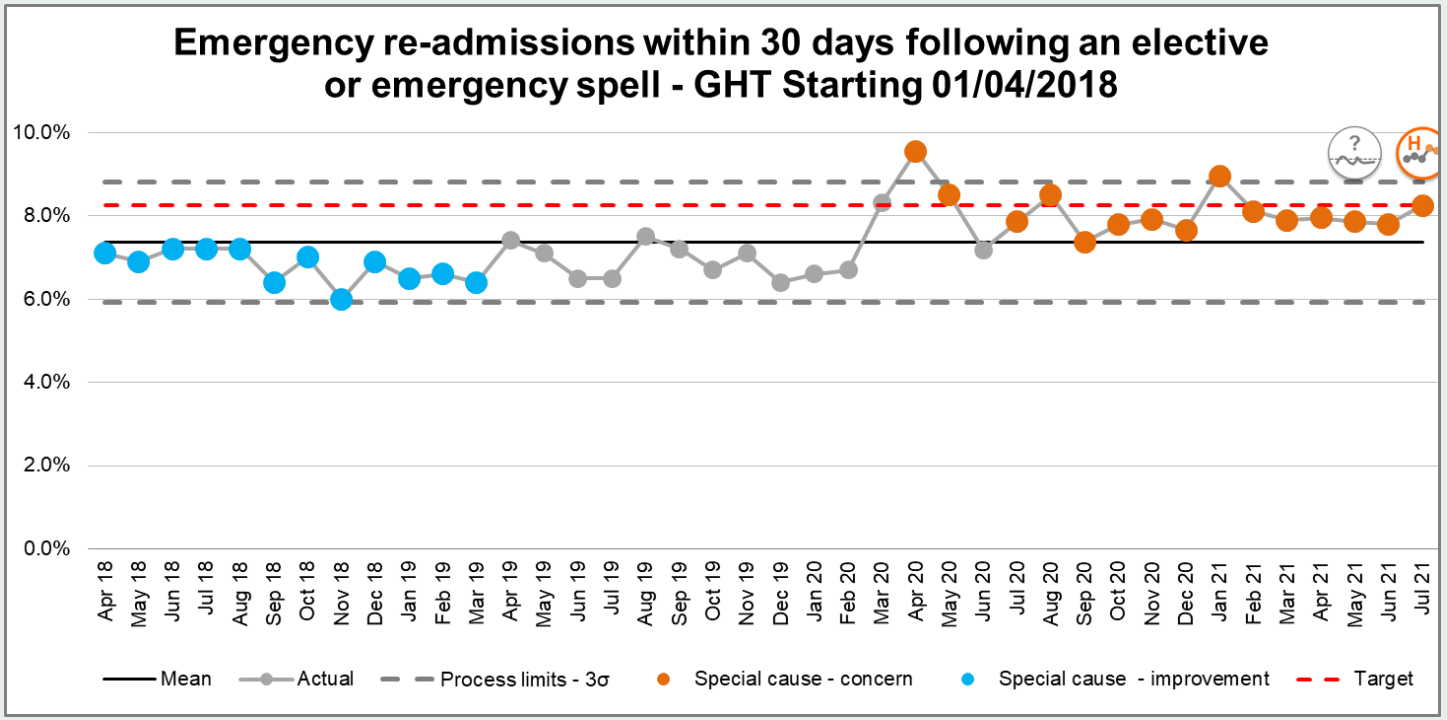
- Director of Unscheduled Care and Deputy Chief Operating Officer

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 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 sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Further narrative will be provided by verbal updates.

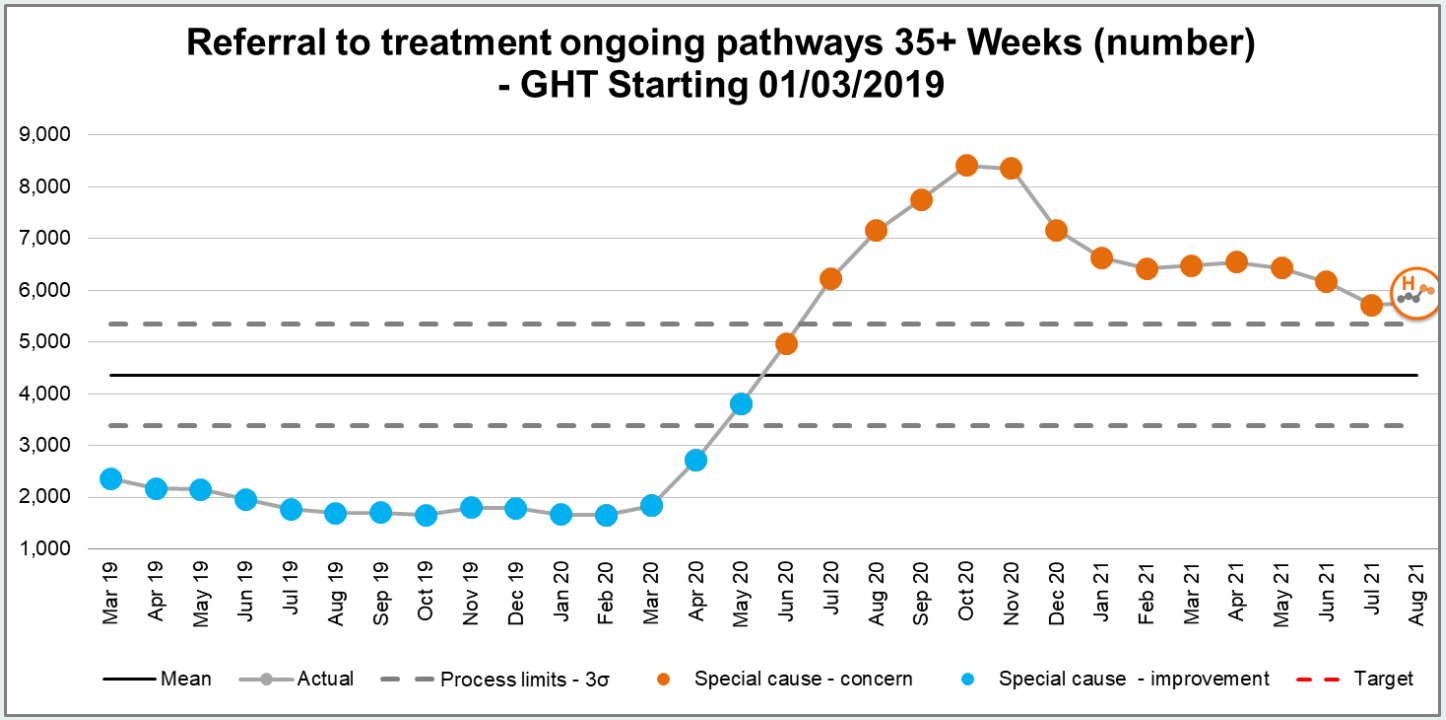
- Deputy Medical Director

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The cohort of patients over 35+ weeks has decreased for the past 3-4 months. However, this month there has been a minimal increase of 35 patients, with now 5,748 patients waiting over 35 weeks for treatment.

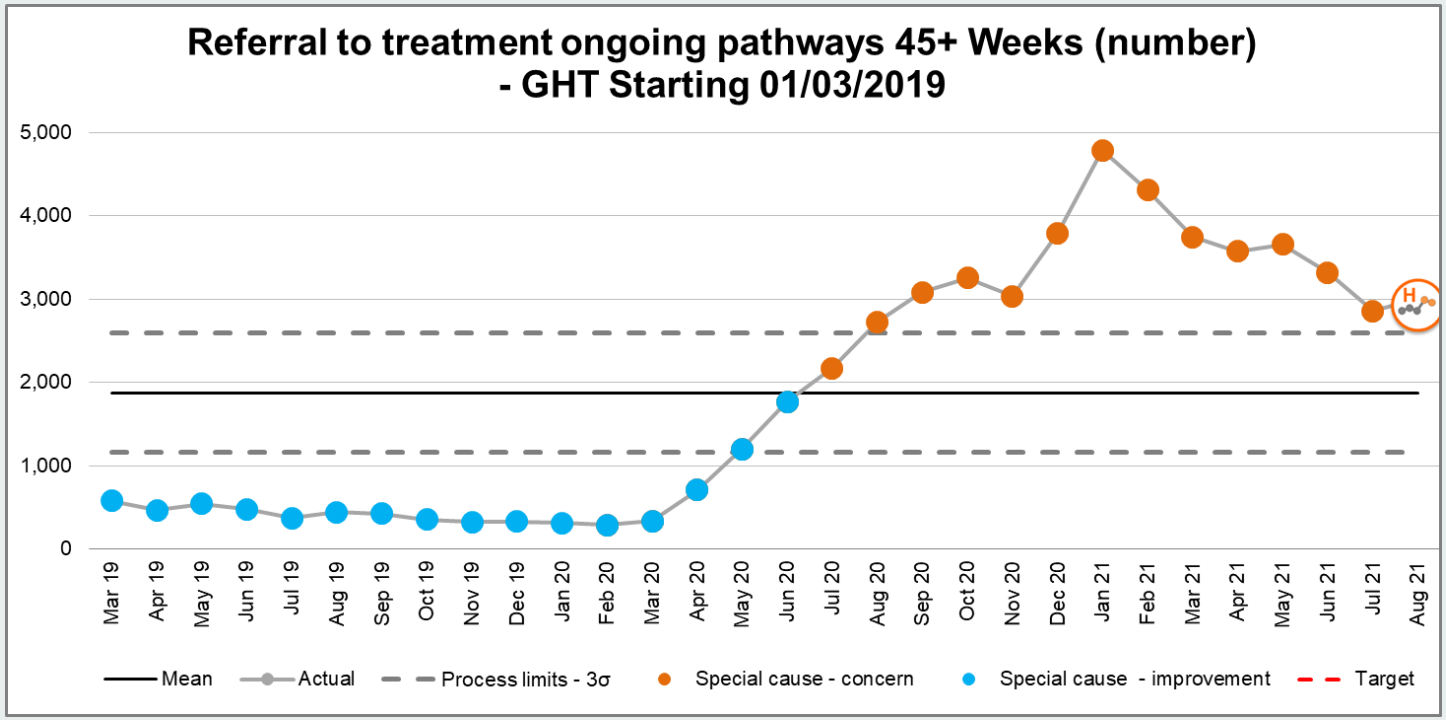
- Deputy Chief Operating Officer

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 14 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 sigificant 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 this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Similar to those >35 weeks cohort, in month there has been a minimal increased with 149 patients. The total now being 3,003.

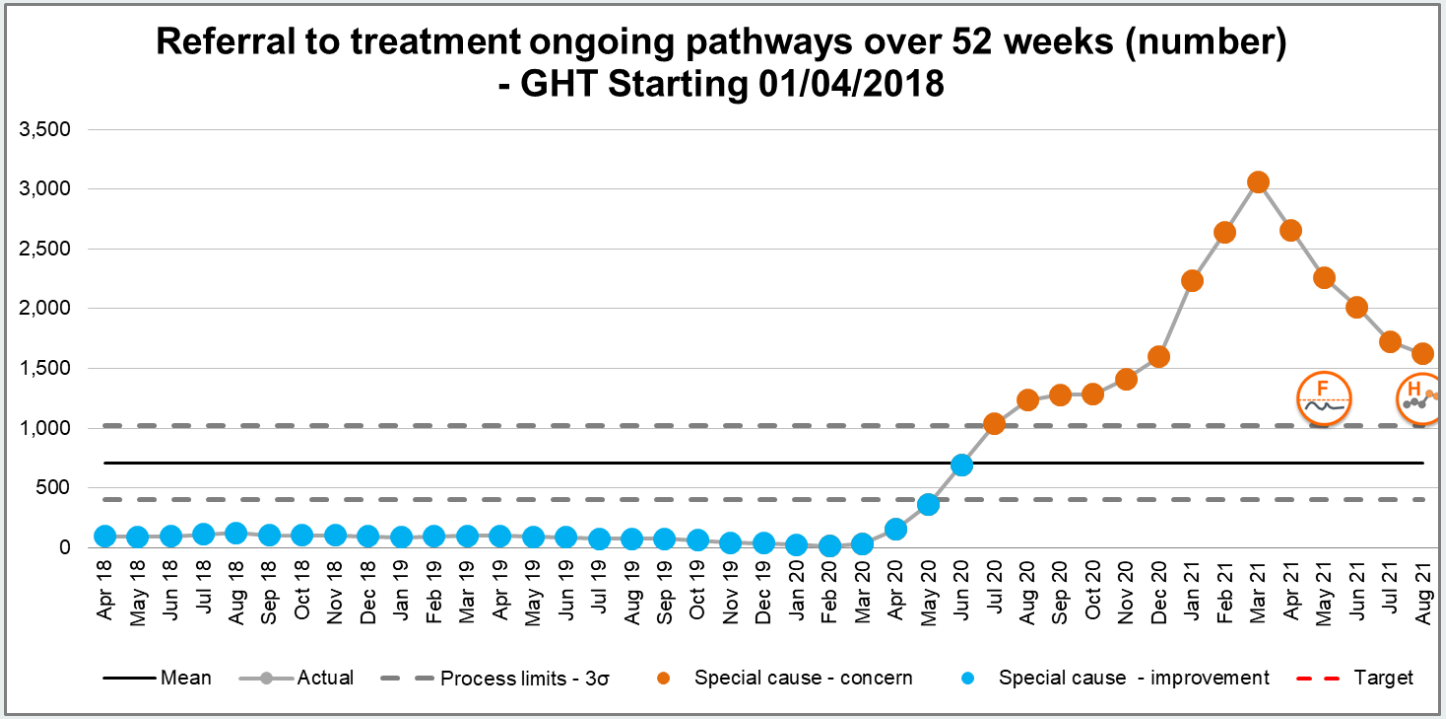
- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 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 sigificant 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 this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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 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 sigificant 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 this is a warning that the process may be changing

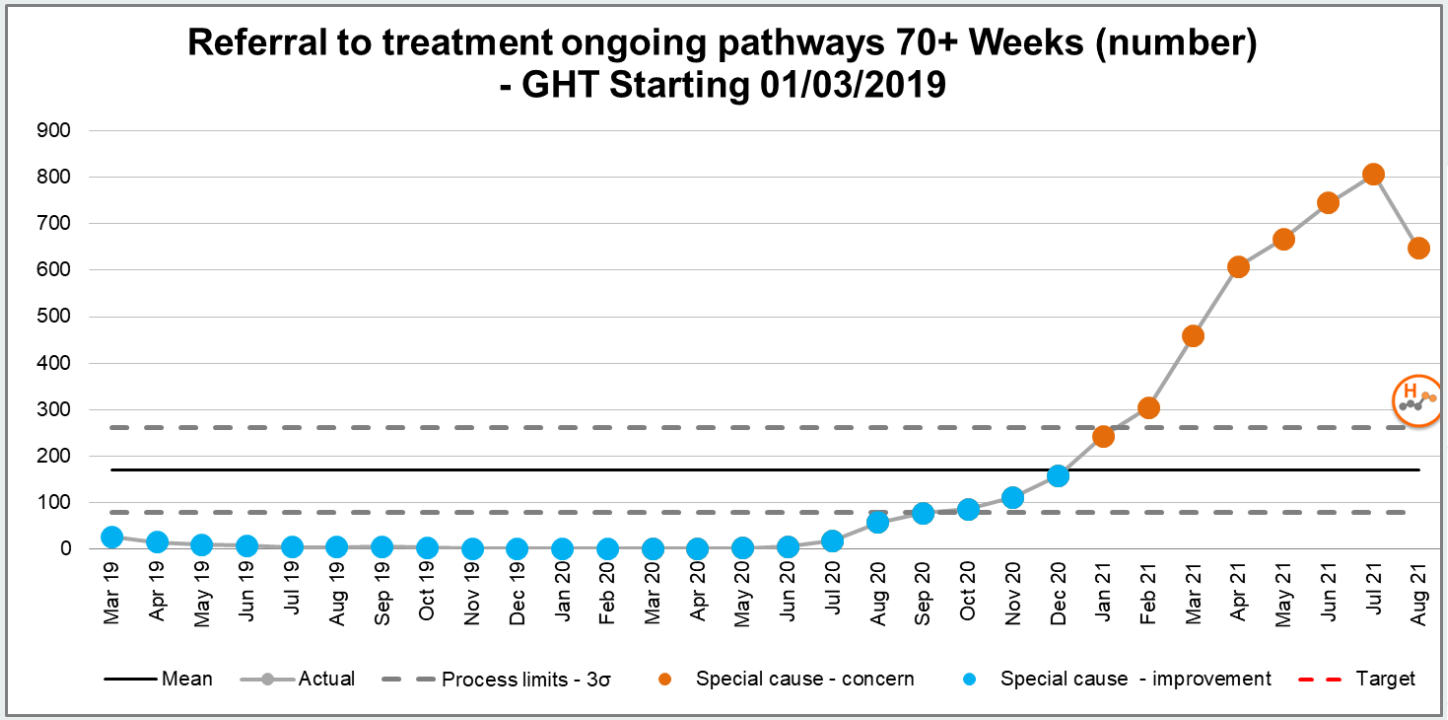
Commentary

See Planned Care Exception report for full details. For the fifth consecutive month a reduction has been made with this cohort of patients and continues to steadily reduce. The anticipated final/validated month-end position is anticipated to be around 1,614. This is compared to the peak being 3,061 at the end of March 2021. Please note that given the focus on clinical priority, this does often result in slight increases in those waiting greater than 70, 78 and 104 weeks (as P4 or P3 patients).

- Deputy Chief Operating Officer

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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 a reduction of 159 patients waiting more than 70 weeks bringing the total to its lowest point in the past 3 months. 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 7 data points which are above the line. There are 19 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.
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 this is a warning that the process may be changing

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Mar-21	70%	
Friends & Family Test	Inpatients % positive	>=90%	Aug-21	85.4%	
Friends & Family Test	ED % positive	>=84%	Aug-21	70.5%	
Friends & Family Test	Maternity % positive	>=97%	Aug-21	84.8%	
Friends & Family Test	Outpatients % positive	>=94.5%	Aug-21	93.7%	
Friends & Family Test	Total % positive	>=93%	Aug-21	88.5%	
PALS	Number of PALS concerns logged	No Target	Aug-21	238	
PALS	% of PALS concerns closed in 5 days	>=95%	Aug-21	82%	
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Aug-21	0	
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Aug-21	0	
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Aug-21	15	
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Aug-21	6	
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Aug-21	9	
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Aug-21	51.1	
Infection Control	Number of MSSA bacteraemia cases	<=8	Aug-21	5	
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Aug-21	17	
Infection Control	Number of ecoli cases	No target	Aug-21	0	
Infection Control	Number of pseudomona cases	No target	Aug-21	1	
Infection Control	Number of klebsiella cases	No target	Aug-21	3	
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Aug-21	60	
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	No target	Aug-21	71	

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	Aug-21	15	
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	No target	Aug-21	3	
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	No target	Aug-21	7	
Maternity	% C-section rate (planned and emergency)	<=27%	Aug-21	0	
Maternity	% emergency C-section rate	No target	Aug-21	18.0%	
Maternity	% of women smoking at delivery	<=14.5%	Aug-21	0	
Maternity	% of women that have an induced labour	<=30%	Aug-21	28.5%	
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Aug-21	0.00%	
Maternity	% of women on a Continuity of Carer pathway	No target	Aug-21	10.80%	
Maternity	% breastfeeding (initiation)	>=81%	Aug-21	79.8%	
Maternity	% Massive PPH >1.5 litres	<=4%	Aug-21	6.7%	
Maternity	Number of births less than 27 weeks	NULL	Aug-21	0	
Maternity	Number of births less than 34 weeks	NULL	Aug-21	11	
Maternity	Number of births less than 37 weeks	NULL	Aug-21	33	
Maternity	Number of maternal deaths	NULL	Aug-21	0	
Maternity	Total births	NULL	Aug-21	544	
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Aug-21	0.92%	
Maternity	% breastfeeding (discharge to CMW)	NULL	Aug-21	48.4%	
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Mar-21	1.0	
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Mar-21	103.9	
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Mar-21	106.6	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

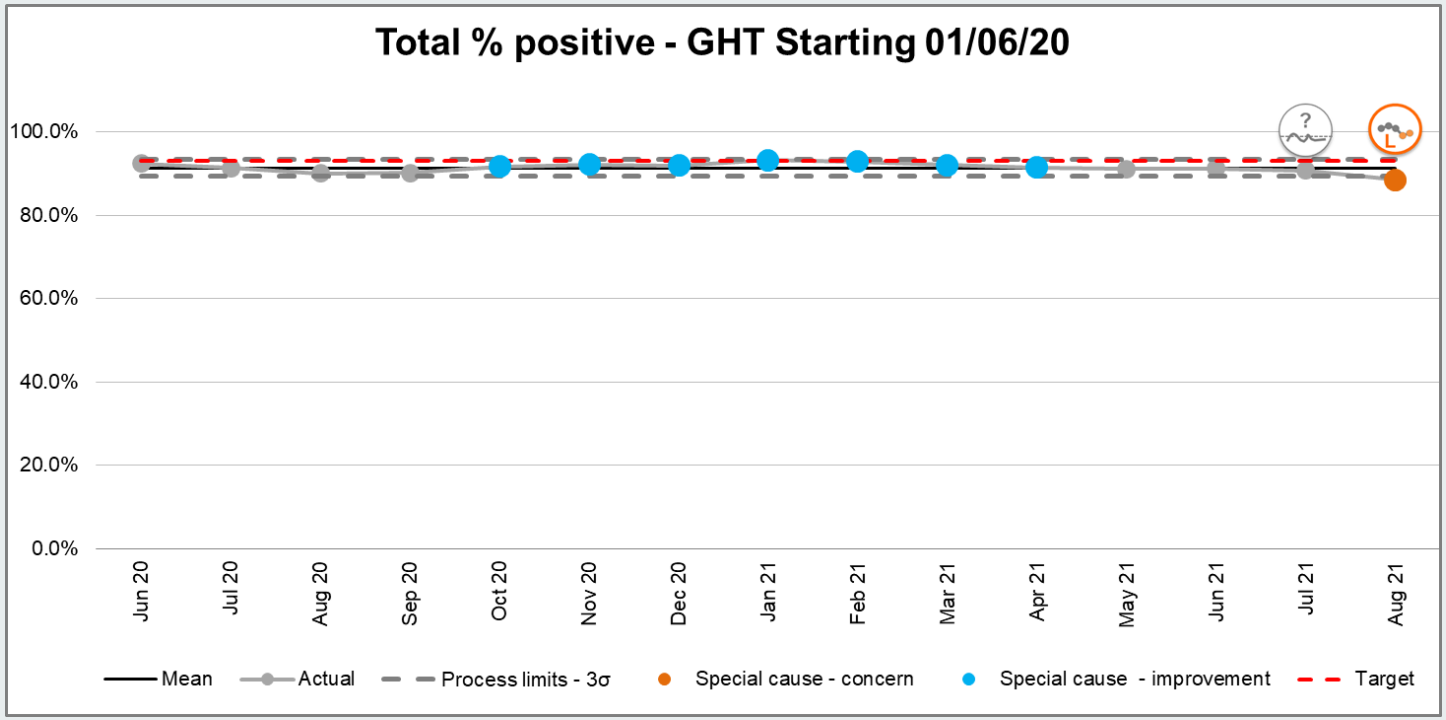
- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target		Aug-21	155	
Mortality	Number of deaths of patients with a learning disability	No target		Aug-21	2	
MSA	Number of breaches of mixed sex accommodation	<=10		Aug-21	1	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero		Aug-21	0	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6		Aug-21	7.5	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3		Aug-21	5	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target		Aug-21	3	
Patient Safety Incidents	Medication error resulting in severe harm	No target		Aug-21	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target		Aug-21	3	
Patient Safety Incidents	Medication error resulting in low harm	No target		Aug-21	4	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30		Aug-21	27	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5		Aug-21	3	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero		Aug-21	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3		Aug-21	5	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5		Aug-21	4	
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		Aug-21	2	
Safety Thermometer	Safety thermometer – % of new harms	>96%		Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero		Aug-21	1	
Serious Incidents	Number of serious incidents reported	No target		Aug-21	4	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%		Jul-21	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%		Aug-21	100%	

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%		Aug-21	87.1%	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target		Nov-19	95%	
Safeguarding	Number of DoLs applied for	No target		Aug-21	59	
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target		Aug-21	6	
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target		Jul-21	0	
Safeguarding	Total admissions aged 0-18 with DSH	No target		Aug-21	11	
Safeguarding	Total ED attendances aged 0-18 with DSH	No target		Aug-21	50	
Safeguarding	Total number of maternity social concerns forms completed	No target		Aug-21	46	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The overall positive FFT score for the Trust has decreased to 88.5%. This is partially due to an increase in the number of responses received for ED services, where the overall positive score is 70.5%.

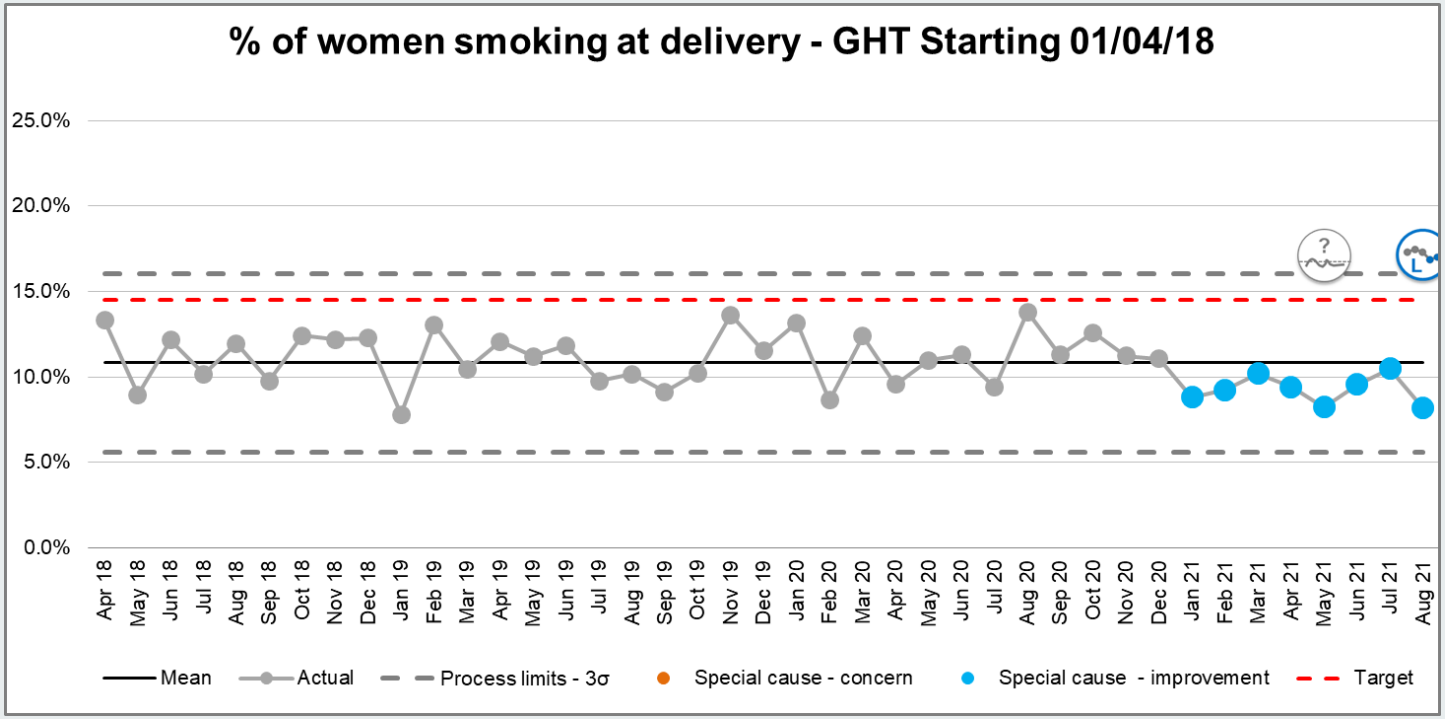
- Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Further narrative will be provided by verbal updates.

- Divisional Director of Quality and Nursing and Chief Midwife

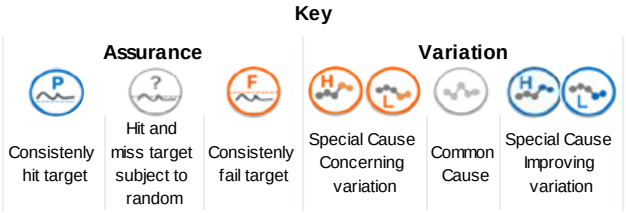
Data Observations

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

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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



MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	
Finance	NHSI Financial Risk Rating		Sep-20	
Finance	Capital service		Sep-20	
Finance	Liquidity		Sep-20	
Finance	Agency – Performance Against NHSI Set Agency Ceiling		Sep-20	

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

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

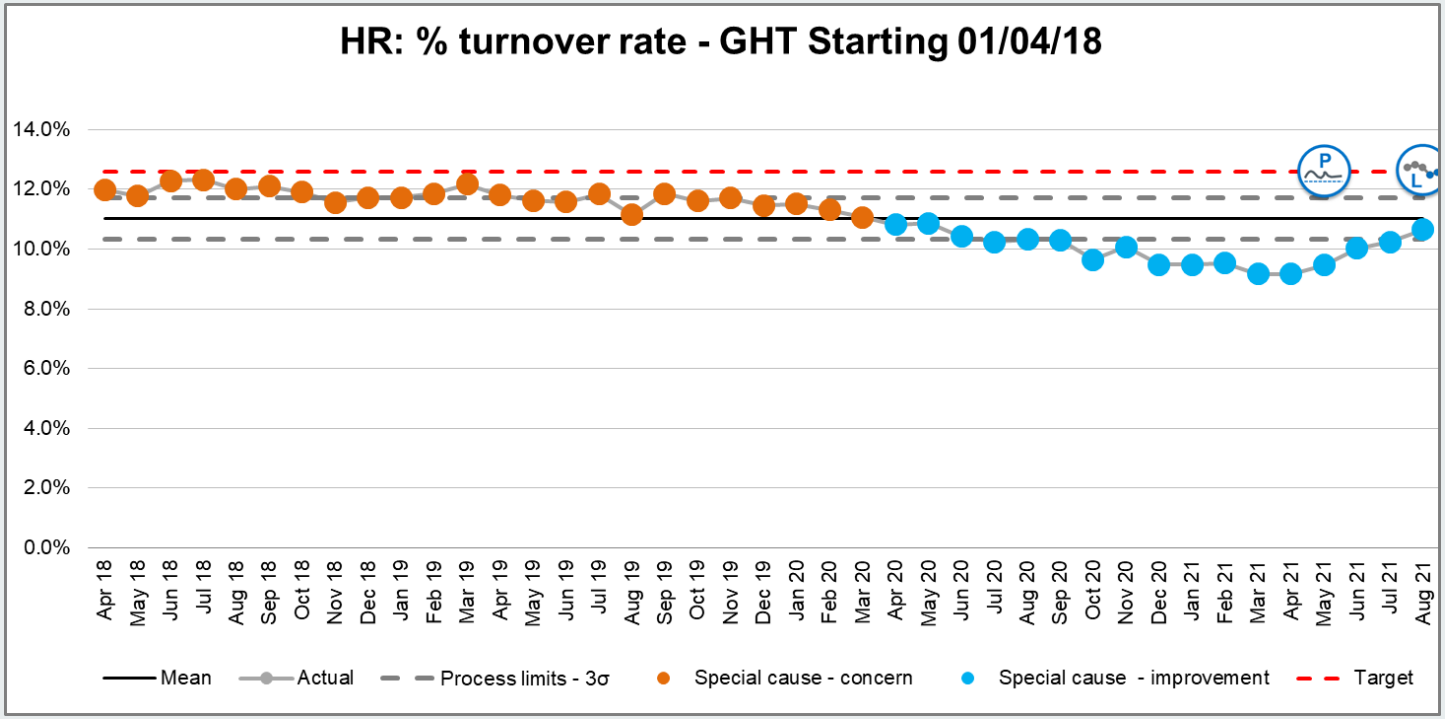
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	Aug-21	79.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Aug-21	90%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	P	Jul-21	96.6%	
Safe Nurse Staffing	% registered nurse day	>=90%		Jul-21	94.8%	
Safe Nurse Staffing	% unregistered care staff day	>=90%	P	Jul-21	100.4%	
Safe Nurse Staffing	% registered nurse night	>=90%		Jul-21	99.6%	
Safe Nurse Staffing	% unregistered care staff night	>=90%	P	Jul-21	109.6%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Jul-21	5.4	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Jul-21	3.5	H
Safe nurse staffing	Care hours per patient day total	>=8		Jul-21	8.9	
Vacancy and WTE	Staff in post FTE	No target		Aug-21	6657.3	
Vacancy and WTE	Vacancy FTE	No target		Aug-21	537.29	
Vacancy and WTE	Starters FTE	No target		Aug-21	36.53	
Vacancy and WTE	Leavers FTE	No target		Aug-21	78.84	
Vacancy and WTE	% total vacancy rate	<=11.5%	P	Aug-21	7.50%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Aug-21	7.80%	H
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	F	Aug-21	9.40%	
Workforce Expenditure	% turnover	<=12.6%	P	Aug-21	10.7%	L
Workforce Expenditure	% turnover rate for nursing	<=12.6%	P	Aug-21	9.8%	L
Workforce Expenditure	% sickness rate	<=4.05%	P	Aug-21	3.8%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Trust rolling annual turnover rate has consistently decreased since 2019 , however has shown a slight increase to 10.7% placing the Trust in the 2nd quartile when benchmarked to the Model Hospital Recommended Peer Group (as at April 21). (Average in Peer Group was 12%)

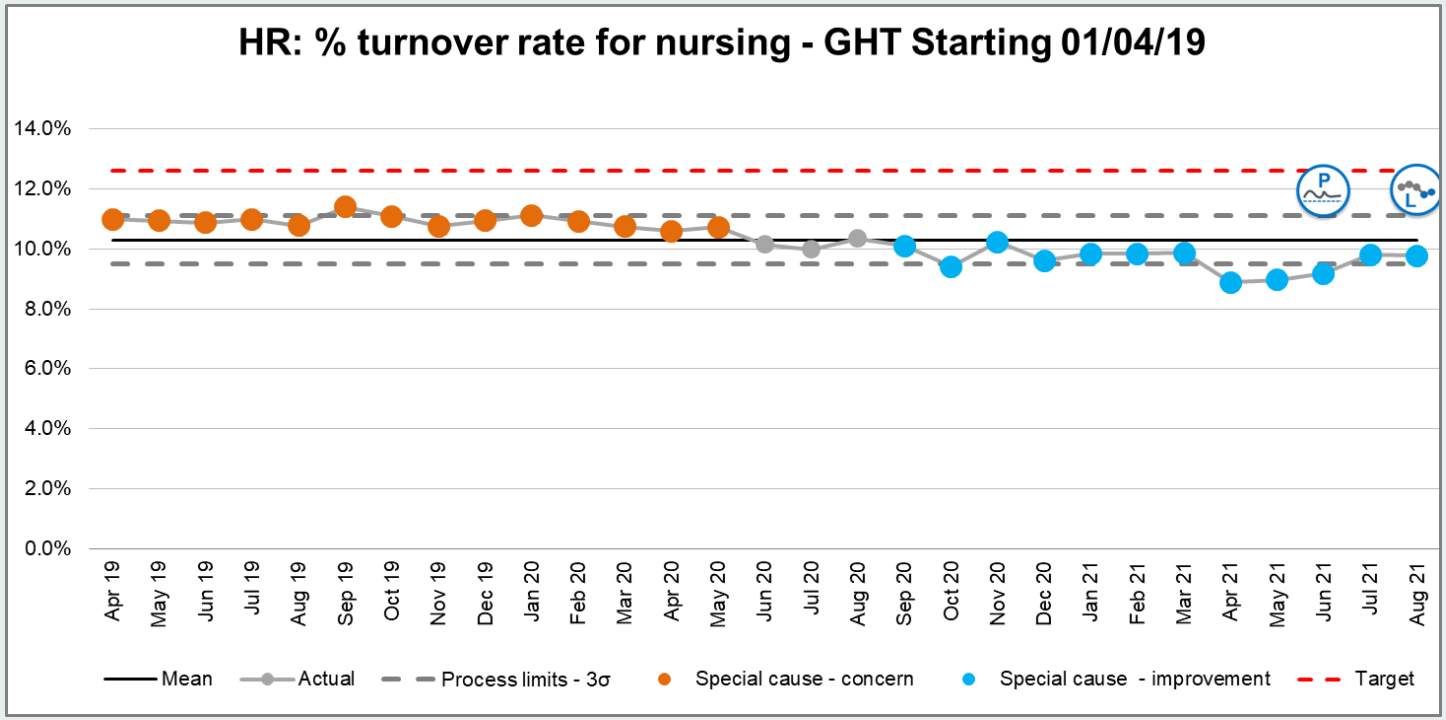
- **Director of Human Resources and Operational Development**

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 15 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 sigificant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Registered Nurse Retention figures remain consistently higher than 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 2 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 sigificant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Exception Report

KLOE	MetricID	Metric Name	Exception Notes	Owner
Effective	544	% of women smoking at delivery		Divisional Director of Quality and Nursing and Chief Midwife
Effective	136	Emergency re-admissions within 30 days following an elective or emergency spell		Deputy Medical Director
Responsive	186	Number of patients stable for discharge		Head of Therapy & OCT
Responsive	288	Number of stranded patients with a length of stay of greater than 7 days Standard: <=380		Deputy Chief Operating Officer
Responsive	301	Patient discharge summaries sent to GP within 24 hours Standard: >=88%		Medical Director
Responsive	184	The number of planned / surveillance endoscopy patients waiting at month end Standard: <=600		Medical Director

Responsive	**552**	**Urgent cancelled operations** **Standard: No target**		**Director of Operations - Surgery**

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – October

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

This report describes the business conducted at the Quality and Performance Committee held on 22nd September 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 update including latest FFT themes and trends, refreshed focus on improvement in EPR compliance and detail of key quality metrics.	With CQC 'must dos' action plan following recent visit to the Emergency Department, was the action regarding increase of senior decision makers at night going in the right direction? Can the use of the EPR and releasing time to care be quantified?	This recommendation still outstanding as work in progress. Assurance provided that 1, 2 and 5 year plans being worked on. Confirmation that all other actions completed. How to describe the impact will be reviewed, noting not a linear process.	Detailed update on non-achieved KPIs to October meeting. Revised reporting on EPR will come through QDG exception reporting to Committee.
	Cancer Delivery group report on latest validated performance of cancer standards.	Is there an impact of the group not having met since June? Further update on the risk with TCLE issues in pathology requested.	Assurance given that daily and weekly meetings and reviews taking place, noting formal meetings will also resume. Progress described as being made and a process for clinical prioritisation in place which means any	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		Noting previous achievement of 9/9 standards, does the forward plan and trajectory for recovery include all specialties? Do we know the future demand and what GPs are seeing in terms of cancer presentations?	sample of concern could be escalated through the system. Confirmation that trajectories in place and will be shared with committee. Confirmed that people have presented who may have held back during early covid period, broadly speaking, demand in most specialties returning to pre covid levels.	
	Planned care report highlighted latest performance and detailed work being undertaken on those waiting over 104 weeks.	Has there been progress with Consultant engagement with the referral assessment service and will it give the impact required? Is there confidence with the speed of the communications plan for patients, the set up of the customer service hub model and use of digital systems? What is the position with independent sector support?	Progress described although not suitable for all specialties with impact being dependent in part for alternative management for patients in the system. Service hub being recruited to within next 6 weeks and existing staff being utilised. Work underway regarding letter and text opportunities. Discussions ongoing regarding local progress.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Emergency Care update reporting sustained severe operational pressures at both Trust sites and system level. Running at high occupancy levels, which limits ability for flow. No 12hour waits reported.	With use of escalation areas, what leant from previous covid waves?	Escalation process planning and trigger points refined and specific use of non-bedded clinical areas, considering staffing levels and dignity. Despite this, remains very challenging operationally.	
	Maternity Delivery Group briefing on various work streams including the Maternity Incentive Scheme, Perinatal Quality and Safety Report, update on leadership recruitment and service pressures. Letter from the Healthcare Safety Investigation Branch (HSIB) noted detailing contentment with Trust approach.	Concern was raised on missing surgical site infection (SSI) rates for caesarean sections within the report noting a long-standing issue and Trust PPH rate against nationally reported rates. When will Committee see any outcomes of the listening events?	Reassured that (SSI) was a timing issue and that significant plan in place to address, results of which should come to Committee through usual reporting. Reporting of progress with PPH improvements will come through regular reporting. Need to understand themes following the events and verbal update will come to next meeting.	
Draft Winter Plan	Emerging plan presented at early stage with assumptions, challenges and plans with various scenarios outlined.	Several questions on plans in place, confidence of mitigations, modelling and learning from covid regarding colleague well-being. Also the need for a credible plan with success criteria.	Commended for seeing the developing plan at such an early stage and positive system support noted.	Review at next Sub-committees, including Quality and Performance and onward to Board.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Clinical Improvement, Audit and GSQIA Annual Report	20/21 Annual Report received including oversight, function, plans and training.	Clarity asked on how Quality Improvement ideas became supported projects.	Commended a good report outlining processes and progress during the year of a well-established function. Noted to be an important part of Trust and system ambitions and achievements.	
Safeguarding Children and Adult Annual Report	20/21 Annual Report received outlining increased capacity within the team, upcoming Liberty Protections Safeguards (LPS) legislation, areas of improvement focus and future plans. Update on system working to become one integrated team noted.	Questions on ability to recruit in time for LPS implementation, improvement of the transition of 16-18 year olds, progress of Single records and support for colleagues in challenging areas.	Commended a well-written report and progress from previous year. Council of Governors to receive the report as key area of interest.	
Safer Staffing- Strategic Nursing Workforce Review	Safe Nursing Care Tool reviewed, including x 3 times daily census undertaken. Divisional positions noted. Progress against previous recommendations outlined, further recommendations described and in year investment noted. Recruitment a challenge but domestic and international programmes in play. Retention a key area of focus.	Regarding recruitment, are there people out there to recruit?	Report commended. Reassurance that people are available, retention also crucial. Use of new/ different roles described.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Clinical Harm Policy implementation update	Update report, noting process previously paused on national advice although some clinical divisions had continued to use. All specialties have been asked to describe and undertake their own approach.	Balance between focussing on harm reviews and delivering clinically accepted, is the balance correct now?	Specialty teams to decide balance, generally felt to be working well although not fully embedded throughout.	Update in three months' time.
Serious Incident Report including Never Events update	Report into current position with never events, open and closed serious incidents, HSIB cases, complaints handling including PHSO. As requested by Committee, detailed report received into never events themes Regular and proactive communications with the CQC in place.	Questions regarding 72 hour reports and closed action plans. Ongoing delays to complaints handling noted previously, are planned improvements on track?	Some progress but remains an ongoing challenge. 11point plan for improvement noted and importance of attention on human factors reiterated. Committee will receive exceptions reports on delivery of the plan through the Quality Delivery group report.	
Risk Register	Review of current, new, closed and emerging risks and mitigations. New Patient Safety Forum being developed to support delivery on the patient safety strategy.	Is there a timescale on the resolution of the national blood bottle shortage? When would all patients/ families countywide receive a personal letter regarding nosocomial infections?	Updated that the situation is dynamic and not currently creating a significant clinical challenge in the Trust. Multiple factors to be considered and confidence before sending individual letters, awareness of timeliness. Trust approach to	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Communications from the Care Quality Commission CQC) on the wheelchair incident indicate no further action to be taken and investigation closed.		communications with the CQC commended.	

Alison Moon
Chair of Quality and Performance Committee
24th September 2021

Gloucestershire Hospitals
NHS Foundation Trust

Trust Board – 14 October 2021

Report Title
Digital Programme Report
Sponsor and Author(s)
Author: Jon Stone, Head of EPR Nicola Davies, Digital Engagement & Change Sponsor: Mark Hutchinson, Executive Chief Digital & Information Officer
Executive Summary

Purpose

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

Key Issues to Note

- Support for Pathology following the implementation of their new lab system (TCLE) is continuing.
- Floorwalking support for EPR in ED at GRH stepped down after 4 weeks following a successful go-live.
- Sepsis 6 toolkit will launch on Sunrise EPR on 22nd September.
- A new clinical document management system - which will integrate into Sunrise EPR – is being launch in Winter 2021/22.
- Upgrade of Sunrise EPR to version 20 is on schedule.
- Quarterly benefits update shows income improvements in ED following launch of EPR and cost savings already being made following implementation of Docman (electronic letters to outpatients).
- Nursing documentation financial benefits have now been validated by finance teams.

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 Committee 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 and Patient Impact							
Progression of the Digital agenda will improve the safety and reliability of care in the most efficient and effective manner.							
Resource Implications							
Finance				Information Management & Technology			**X**
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	**X**

Gloucestershire Hospitals
NHS Foundation Trust

FINANCE & DIGITAL COMMITTEE

SEPTEMBER 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 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	22 Sept 2021	
EMM (Electronic Medicines Management)	Oct 2021	
Upgrade of Sunrise EPR	17 Nov 2021	
Clinical Data Storage Platform (Onbase)	Dec 2021	
Order Communications (theatres & outpatients expansion)	TBC	
Electronic Prescribing & Medicines Administration (known as ePMA)	March 2022	

2.2 TCLE Update

Digital teams continue to provide support to pathology and operational workstreams working to reduce the outstanding issues following the new lab system go live. A Task & Finish Group was also established to focus on issues surfacing in histology in particular – this is being led by operational teams working direct with pathology.

A new Project Manager has been assigned to manage the delivery of the remaining digital/EPR elements of the TCLE programme. The new PM has recently worked on the Welsh national programme, so is acquainted with Lab Management systems in general and TCLE in particular. This work will focus on the delivery of the TrakCare upgrade, a key dependency for the successful migration of Blood Transfusion functionality, as well as the delivery of Blood Transfusion itself. Detailed planning work is in train, working closely with pathology who will drive this change. This will report through EPR Programme Delivery Group.

2.3 Sepsis Documentation

A new go live date of 22nd September has been planned for the launch of the Sunrise EPR Sepsis Documentation. This was agreed with the project team and through PDG after taking into consideration a number of factors including operational pressures and lack of availability of clinical teams to support and complete training.

To support the training, engagement sessions are planned with all clinical teams and the EPR and ACRT teams are attending huddles, team meetings and all ward areas throughout September to promote awareness and training.

2.4 eMM (Electronic Medicines Management)

eMM is an enabler for ePMA and will enhance pharmacies ability to interface with their current stock control system. It will go live with a ward-by-ward phased approach starting on 7th September. This will affect pharmacy staff but other clinical staff working out in the Trust should notice no change to their processes.

Full system testing has concluded and training is currently underway for all relevant members of the pharmacy team.

2.5 Upgrade of Sunrise EPR

The upgrade of Sunrise EPR is progressing to plan and the first stage of testing (of three) will soon conclude. This has been an extensive test of all of the current functionality held within the system. No issues have been found so far in upgrading the EPR development environment to this new version.

This upgrade will ensure a smoother experience for users in some areas of system functionality and enable some key avenues of development to the team which will be utilised during the ePMA deployment.

2.6 Clinical Data Storage Platform (Onbase)

The implementation of a new clinical data storage platform (Onbase) is a major step towards ensuring that Sunrise EPR is the single source of clinical information in our hospitals. The platform will enable clinicians to access information from a range of other systems, without leaving Sunrise, reducing the time it takes to search for information, reducing the number of systems open at once and providing much more patient information when it's needed. The implementation is happening in a phased approach.

The solution provider, Onbase, are currently developing the base build of this system, ready to hand over to GHT for further refinement and testing in October. While this work progresses, teams have worked to define which ancillary systems will be prioritised for inclusion in the data storage platform at go live, and which will be prioritised soon after that. The chosen systems will have their clinical information surfaced directly through Sunrise EPR before any other systems.

The list is currently outlined below and has been reviewed and approved by the EPR Clinical Documentation Workstream and the EPR Programme Delivery Group.

The first systems for integration have been prioritised because they can be most easily integrated and templates are in place, they are:

- Import of document viewer from Sunrise EPR
- New Infoflex letters
- TCLE result attachments
- eTrauma
- Medilogik
- Medisoft

Other systems to be scoped further as a priority are below. These systems need more work on integration and detailed scoping before progressing:

- eRS
- eHNA (MacMillan)
- EDDI

- MedICUs
- AuditBase
- MobiMed
- Vital Data (Renal)

2.7 Order Communications (Theatres & Outpatients Expansion)

The re-planning of order comms (requests and results) in Theatres (histology) and outpatients is now underway however it should be noted that there are a number of dependencies on issues currently being addressed as part of the TCLE project go live. There may also be a need to complete the TCLE and TrakCare upgrade prior to a full release of all of this functionality.

2.8 Electronic Prescribing & Medicines Administration (ePMA)

The ePMA project is progressing to plan and will soon enter a first stage of testing, ahead of schedule, which will look to build and test a “prototype” of the system with a handful of drugs. This will draw out and help to address any large issues with the build as early as possible. The prototype will be based on the GHT drugs catalogue which has been complied and reviewed by both EPR and Pharmacy teams.

Work is continuing with all other areas of the project but particularly to design early versions of the forms users will use to order medication and a digitised version of a patient’s drug chart. All of these elements are planned to be showcased to clinical teams on 17th September in a large engagement session to raise awareness with Trust staff and to ask for support in testing and critiquing what has been developed to date.

2.9 EPR Programme RAG Status Updates

Highlight reports detail the status of live EPR projects. This update is correct as reported to DCDG in September.

2.10 Activity Planned for Next Period

- Sepsis documentation will launch in Sunrise EPR for adult inpatient areas.
- The TCLE and revised Order Comms Phase 5 (Results Viewing in SCM) post go-live incident and issue management will continue.
- Work will complete to relocate paediatric ED attendances back to main ED and ensure they can utilise EPR to document care for these patients.
- Testing of the SCM upgrade will complete in the development environment and a second phase of testing in the test environment will commence.
- Development of an EPMA “prototype” built will complete and a testing plan will be available to allow clinicians to start planning their involvement.
- Large engagement session with clinicians will take place to introduce the ePMA rollout.
- Roll out of eMM will commence across the Trust, ward by ward.

3. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). Since the last report, no project has been completed and closed and no project has gone into closure.

Since the last report one project has been completed and closed and no project has gone into closure.

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

- A number of projects remain on awaiting necessary resource to become available, the delivery of dependent projects and appropriate governance requirements to be met.
- The DOCMAN10 - Transfers of Care project closure documentation is still pending approval from stakeholders and ownership of several items needs agreeing before the project formally closes, but all delivery work has now completed. 59,000 letters have now been delivered through the system since June.
- The Quayside House New GP Surgery project has been completed and closed.
- A new eTrauma project has been initiated to ensure that the product being used to replace the Virtual Trauma Board previously used to manage Orthopaedic Trauma referrals conforms to governance requirements.

The majority of 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.

In order to support the go-live of TCLE and EPR in ED projects, a massive collective push has been required of the Digital team and most project managers have been needed to aside their normal duties for some time to support go-live activities. Go live support to ED is due to be stood down in early August, at which time colleagues will resume their normal roles.

4. Countywide IT Service (CITS) Monthly Report

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

Key issues to note:

- An increase in calls (and complexity of calls) to the service desk during July reflects two major system go-lives, impacting GHFT and the CCG. These were labs (TCLE) and Gloucester ED (EPR).

- Calls included new accounts set up and guidance (Sunrise EPR results viewing) and changes to the way GPs view results in ICE/SystmOne. Increased smartcard calls relate to the ED go-live and setting up of tap & go.

- 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.

- CITS also supports many hospital moves at short notice, putting increased pressure on deployment and network resources.

5. Cyber Security

This section highlights cybersecurity activity for July 2021 and details the controls in place to protect Gloucestershire Healthcare Community's information assets.

Key issues to note:

- A Patching for PrintNightmare (CC-3894) continues across ICS and is reported separately.
- New KACE server operational: 3rd party patching for browsers, Adobe products and remote meeting platforms.
- July patching saw 80 updates deployed within 12 days (NHSD target is 14 days), which includes PrintNightmare patches; however, rollout has yet to reach 100% across ICS.

-Ends-

Authors: Jon Stone, Head of EPR
Nicola Davies, Digital Engagement & Change Lead
Presenter: Mark Hutchinson, Executive Chief Digital & Information Officer

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 14 October 2021

Report Title
Financial Performance Report **Month Ended 31st August 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 5 to the Board.

Key issues to note

The Trust is reporting a year-to-date (YTD) surplus of £141k, which is £145k ahead of a planned £4k deficit position. Our ongoing RMN pressures have been funded through the system Elective Recovery Funding (ERF) for the rest of this year but will remain an issue to resolve on an ongoing basis through contract discussions.

System Position for H1

The Gloucestershire System has submitted a plan with a small surplus of £11k for H1 (April to September 2021). The Trust contributes to this by planning for a £6k surplus in H1.

Month 5 overview

Month 5 reports a £5k surplus in month, compared to a plan of breakeven, so is £5k better than plan in month. For the YTD we report £141k surplus, which is £145k better than plan.

Activity delivered 100% of the YTD19/20 activity levels, and 96% of the August 2019 levels. The Trust is earning Elective Recovery Fund (ERF) income as a result of this activity delivery. In our M5 YTD position we include £5.0m of ERF income, which is £2.5m more than plan and reflects additional cost of recovery activity above that which we had planned for, as well as reimbursement for the costs of registered mental health nurses above our baseline costs in 19/20.

As a system we have reviewed the information from NHSE in relation to ERF earned in July. The data provided does not currently include the impact of un-coded spells, and as such shows that the Trust did not generate an ERF payment for July. This position being discussed with NHSE as the inclusion of uncoded spells (at an estimated value) would generate an ERF payment, albeit below the plan value. There is no risk to the financial position of the Trust as the funding provided by system for costs incurred is below the total actual ERF earned to date – there is, however, a risk towards the ability to fund future schemes if this position remains unchanged.

Conclusions

The Trust is reporting a year to date surplus of £141k, £145k better than the planned £4k deficit 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)

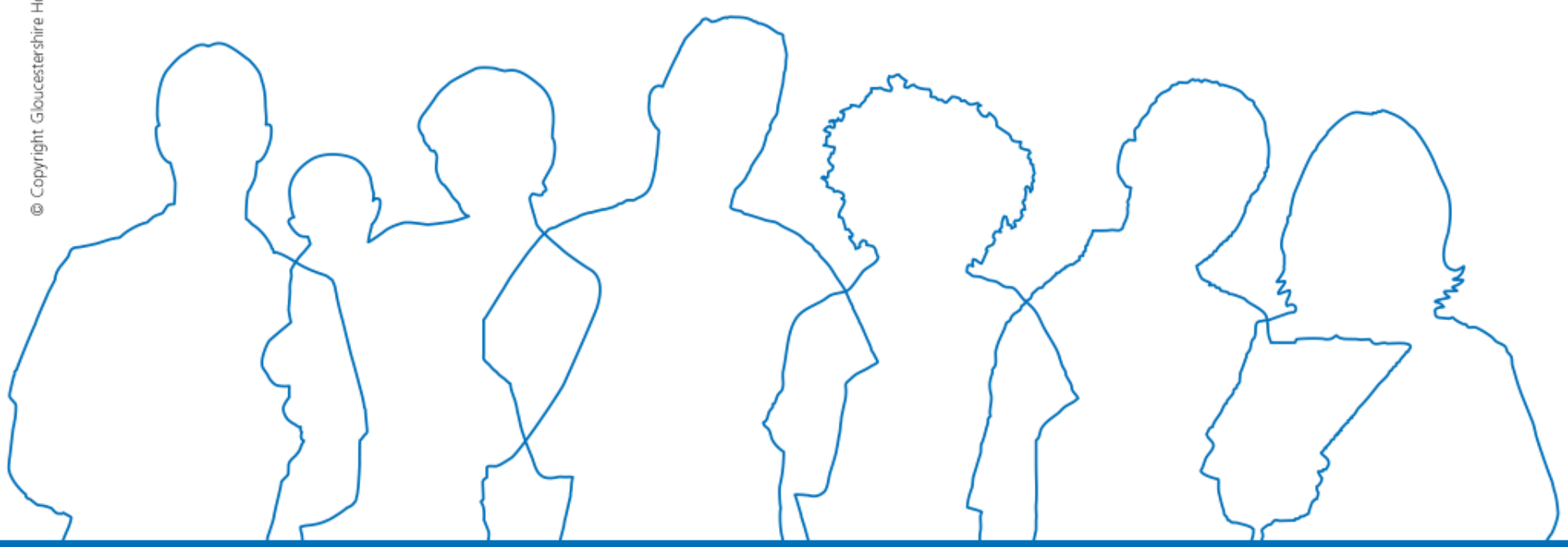
Audit & Assurance Committee	Finance & Digital Committee	Estates & Facilities Committee	People & OD Committee	Quality & Performance Committee	Remuneration Committee	Trust Leadership Team	Other (specify)
	30/09/2021						DOAG 16/09/2021

Outcome of discussion when presented to previous Committees/TLT

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 31st August 2021



Director of Finance Summary

System Position for H1

The Gloucestershire System has submitted a plan with a small surplus of £11k for H1 (April to September 2021). The Trust contributes to this by planning for a £6k surplus in H1.

Month 5 overview

Month 5 reports a £5k surplus in month, compared to a plan of breakeven, so is £5k better than plan in month. For the YTD we report £141k surplus, which is £145k better than plan.

Activity delivered 100% of the YTD19/20 activity levels, and 96% of the August 2019 levels. The Trust is earning system Elective Recovery Fund (ERF) income as a result of this activity delivery. In our M5 YTD position we include £5.0m of ERF income, which is £2.5m more than plan and reflects additional cost of recovery activity above that which we had planned for, as well as reimbursement for the costs of registered mental health nurses above our baseline costs in 19/20.

As a system we have reviewed the information from NHSE in relation to ERF earned in July. The data provided does not currently include the impact of un-coded spells, and as such shows that the Trust did not generate an ERF payment for July. This position being discussed with NHSE as the inclusion of uncoded spells (at an estimated value) would generate an ERF payment, albeit below the plan value. There is no risk to the financial position of the Trust as the funding provided by system for costs incurred is below the total actual ERF earned to date – there is, however, a risk towards the ability to fund future schemes if this position remains unchanged.

H1 / H2 and 2022/23 Planning update

The Trust is preparing for H2 planning through working through forecasts and the underlying run rate. Divisions have been asked to confirm assumptions around recovery activity, Winter, any service changes, and financial sustainability schemes, in order that we will know our expected cost base and can be ready to negotiate our share of the system allocation, once it is confirmed. National planning is expected to be complete by mid-November 2021 (already well into H2), with 2022/23 planning to commence shortly after this.

Month 5 headlines

Gloucestershire Hospitals NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £141k surplus		Overall YTD financial performance is £141k surplus. This is £145k better than plan. With only a £5k surplus in month, there is minimal change month on month. We have been allocated ICS Elective Recovery Funding to offset the costs of providing additional waiting list initiative activity and to cover the costs of our Registered Mental Health Nurses on agency rates.
Income is better than plan at £274.0m YTD.		YTD £11.1m better than plan, predominantly due to £2.0m Salix grant funding (removed in the final reported position), £4.1m high cost drugs above plan, £2.5m Elective Recovery Fund (ERF) above plan, £1.5m Covid (outside envelope) funding, and £1.0m variable cost model devices (new NHSE funding flows M3 onwards).
Pay costs are more than plan at £164.5m YTD.		YTD £1.5m adverse to plan. Broadly, RMN costs account for £1.0m of this, with Covid outside envelope not included in the plan at £0.8m ytd, less £0.3m underspends.
Non-Pay expenditure is more than plan at £103.9m.		YTD this is £7.4m worse than plan. The main drivers of this are the £4.1m high cost drugs above plan, £0.7m Covid outside envelope costs excluded from the plan, £1.0m variable cost model devices (new NHSE funding flows M3 onwards), £0.9m car parking costs now grossed up, £0.5m prudent accruals for the CNST rebate, which we budget to receive but won't be confirmed until October / November 2021, and the £0.2m unexpected costs for Catheter Laboratory hire that was expected to be capitalised.
Financial Sustainability schemes are ahead of 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 5 the H1 forecast identifies £3.6m. For the YTD, delivery is at £3.1m, £1.1m ahead of plan.
The cash balance is £77.6m.		

Month by Month Trend

Gloucestershire Hospitals NHS Foundation Trust

When looking at the run rate it is worth noting that Month 12 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 4 to Month 5 is stable at £3k difference and a £5k surplus in month. Pay reduced predominantly because there was a capital to revenue transfer in Month 4 that was not repeated, and the new junior medical rotation meant that locum spend was lower in month. In non pay we included some prudence accruals for expected increases in contractual costs, and for income that is uncertain.

6 months' Run Rate Actuals	2020/21 M12	21/22 M01	M02	M03	M04	M05	Month 4 to Month 5 change
Pay	(55,297)	(32,036)	(32,033)	(32,748)	(32,936)	(32,524)	412
Non Pay	(28,939)	(19,117)	(19,401)	(20,761)	(20,979)	(21,607)	(628)
Covid Costs (in envelope)	(1,504)	(682)	(671)	(481)	(462)	(452)	10
Covid Costs (outside envelope)	(531)	(458)	(349)	(261)	(234)	(164)	70
Non-operating Costs	148	(639)	(844)	(745)	(715)	(810)	(95)
Remove impact of Salix Grant				(1,966)			0
Remove impact of Donated Asset Depreciation / impairments	(1,158)	37	59	48	48	48	0
Total Cost	(87,281)	(52,895)	(53,239)	(56,914)	(55,278)	(55,509)	(231)
Run Rate Funding / Billable Income	86,794	51,924	52,352	55,467	53,788	54,009	221
Est Elective Recovery Fund Income		500	500	1,371	1,258	1,341	83
Covid Income (outside envelope)	530	458	349	261	234	164	(70)
Total Reported Surplus / (Deficit)	**43**	**(13)**	**(38)**	**185**	**2**	**5**	**3**

M5 Group Position versus Plan

Gloucestershire Hospitals NHS Foundation Trust

The financial position as at the end of August 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 August the Group's consolidated position shows a £141k surplus. This is £145k better than plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 5 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	237,940	243,644	5,705				237,940	243,644	5,705
PP, Overseas and RTA Income	1,743	1,546	(197)				1,743	1,546	(197)
Other Income from Patient Activities	2,615	3,101	486				2,615	3,101	486
Elective Recovery Fund	2,500	4,970	2,470				2,500	4,970	2,470
Operating Income	16,578	18,893	2,316	25,260	26,069	809	18,120	20,716	2,596
Total Income	**261,376**	**272,155**	**10,779**	**25,260**	**26,069**	**809**	**262,918**	**273,978**	**11,060**
Pay	(153,801)	(155,912)	(2,111)	(9,085)	(8,774)	311	(163,032)	(164,506)	(1,474)
Non-Pay	(105,070)	(111,557)	(6,487)	(15,201)	(16,067)	(866)	(96,407)	(103,850)	(7,443)
Total Expenditure	**(258,871)**	**(267,469)**	**(8,598)**	**(24,287)**	**(24,842)**	**(555)**	**(259,439)**	**(268,356)**	**(8,917)**
EBITDA	**2,505**	**4,686**	**2,181**	**974**	**1,227**	**254**	**3,479**	**5,622**	**2,143**
EBITDA %age	**1.0%**	**1.7%**	**0.8%**	**3.9%**	**4.7%**	**0.9%**	**1.3%**	**2.1%**	**0.7%**
Non-Operating Costs	(2,741)	(2,814)	(74)	(978)	(1,227)	(249)	(3,717)	(3,753)	(36)
Surplus / (Deficit)	**(235)**	**1,872**	**2,107**	**(4)**	**(0)**	**4**	**(239)**	**1,868**	**2,107**
Fixed Asset Impairments									
Surplus / (Deficit) after Impairments	**(235)**	**1,872**	**2,107**	**(4)**	**(0)**	**4**	**(239)**	**1,868**	**2,107**
Excluding Donated Assets & Salix grant	235	(1,727)	(1,962)				235	(1,727)	(1,962)
Control Total Surplus / (Deficit)	**(0)**	**145**	**145**	**(4)**	**(0)**	**4**	**(4)**	**141**	**145**

* Trust position excludes £15.5m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £23.7m 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 ongoing discussions.

M5 Detailed Income & Expenditure (Group)

Gloucestershire Hospitals NHS Foundation Trust

Consolidated Group Summary						
Month 5 Financial Position	M05 Plan £000s	M05 Actuals £000s	M05 Variance £000s	M05 Cumulative Plan £000s	M05 Cumulative Actuals £000s	M05 Cumulative Variance £000s
SLA & Commissioning Income	47,587	49,718	2,131	237,940	243,644	5,705
PP, Overseas and RTA Income	351	290	(62)	1,743	1,546	(197)
Other Income from Patient Activities	523	289	(235)	2,615	3,101	486
Elective Recovery Fund	500	1,341	841	2,500	4,970	2,470
Operating Income	3,624	3,877	253	18,120	20,716	2,596
Total Income	**52,585**	**55,514**	**2,929**	**262,918**	**273,978**	**11,060**
Pay						
Substantive	(29,324)	(29,070)	254	(146,620)	(144,985)	1,635
Bank	(1,540)	(1,661)	(121)	(7,602)	(9,667)	(2,065)
Agency	(1,410)	(1,840)	(430)	(7,049)	(7,614)	(565)
Locum	(332)	(241)	91	(1,761)	(2,240)	(479)
Total Pay	**(32,606)**	**(32,812)**	**(206)**	**(163,032)**	**(164,506)**	**(1,474)**
Non Pay						
Drugs	(6,487)	(7,003)	(516)	(32,436)	(35,643)	(3,208)
Clinical Supplies	(4,454)	(4,280)	174	(22,270)	(20,122)	2,148
Other Non-Pay	(8,339)	(10,651)	(2,312)	(41,701)	(48,084)	(6,383)
Total Non Pay	**(19,280)**	**(21,934)**	**(2,654)**	**(96,407)**	**(103,850)**	**(7,443)**
Total Expenditure	**(51,886)**	**(54,746)**	**(2,860)**	**(259,439)**	**(268,356)**	**(8,917)**
EBITDA	**699**	**768**	**70**	**3,479**	**5,622**	**2,143**
EBITDA %age	**0**	**0**	**(0)**	**0**	**0**	**(0)**
Non-Operating Costs	(746)	(810)	(64)	(3,717)	(3,753)	(36)
Surplus / (Deficit)	**(47)**	**(43)**	**4**	**(239)**	**1,868**	**2,107**
Fixed Asset Impairments	0	0	0	0	0	0
Surplus / (Deficit) after Impairments	**(47)**	**(43)**	**4**	**(239)**	**1,868**	**2,107**
Excluding Donated Assets	47	48	1	235	(1,727)	(1,962)
Control Total Surplus / (Deficit)	**0**	**5**	**5**	**(4)**	**141**	**145**

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), as well as Registered Mental Health Nurses required for enhanced care to patients.

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

Forecast as at M05

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 £6k for H1, with the Integrated Care System intending to achieve an overall surplus of £11k.

As at Month 5 we still expect to achieve our plan of £6k surplus. The forecast has been updated to include an agreed £3.6m expected cost and offsetting ERF income from the system for elective recovery in Month 6. Due to ongoing uncertainty around the level of ERF the system will earn in H1, and the potential that this may need to be repaid once validations have been complete, this income does not benefit our H1 position.

Forecast Position H1 (£000)	Actuals M01	Actuals M02	Actuals M03	Actuals M04	Actuals M05	Forecast M06	H1 Total Forecast
Pay	(32,036)	(32,033)	(32,748)	(32,936)	(32,524)	(32,936)	**(195,213)**
Non Pay	(19,117)	(19,401)	(20,761)	(20,979)	(21,607)	(24,714)	**(126,579)**
Covid Costs excl RAG (in envelope)	(682)	(671)	(481)	(462)	(452)	(462)	**(3,210)**
Covid Costs (outside envelope)	(458)	(349)	(261)	(234)	(164)	(234)	**(1,700)**
Non-operating Costs	(639)	(844)	(745)	(715)	(810)	(715)	**(4,468)**
Remove impact of Salix Grant	0	0	(1,966)	0	0	0	**(1,966)**
Remove impact of Donated Asset Depreciation	37	59	48	48	48	48	**287**
Total Cost	(52,895)	(53,239)	(56,914)	(55,278)	(55,509)	(59,013)	**(332,849)**
Run Rate Funding / Billable Income	51,924	52,352	55,467	53,788	54,009	53,788	**321,328**
Estimated Elective Recovery Fund Income	500	500	1,371	1,258	1,341	4,856	**9,826**
Covid Income (outside envelope)	458	349	261	234	164	234	**1,700**
Total Reported Surplus / (Deficit)	**(13)**	**(38)**	**185**	**2**	**5**	**(135)**	**6**

Balance Sheet

Gloucestershire Hospitals NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2021 £000	GROUP Balance as at M5 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	7,934	(346)
Property, Plant and Equipment	276,161	282,966	6,805
Trade and Other Receivables	6,149	6,093	(56)
Total Non-Current Assets	**290,590**	**296,993**	**6,403**
Current Assets			
Inventories	8,934	8,945	11
Trade and Other Receivables	18,054	26,325	8,271
Cash and Cash Equivalents	77,216	77,580	364
Total Current Assets	**104,204**	**112,850**	**8,646**
Current Liabilities			
Trade and Other Payables	(87,606)	(99,809)	(12,203)
Other Liabilities	(11,585)	(12,915)	(1,330)
Borrowings	(3,404)	(3,401)	3
Provisions	(10,824)	(10,824)	0
Total Current Liabilities	**(113,419)**	**(126,949)**	**(13,530)**
Net Current Assets	**(9,215)**	**(14,099)**	**(4,884)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,289)	228
Borrowings	(37,438)	(37,321)	117
Provisions	(2,892)	(2,888)	4
Total Non-Current Liabilities	**(46,847)**	**(46,498)**	**349**
Total Assets Employed	**234,528**	**236,396**	**1,868**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	332,033	0
Reserves	27,975	27,975	0
Retained Earnings	(125,480)	(123,612)	1,868
Total Taxpayers' Equity	**234,528**	**236,396**	**1,868**

The table shows the M5 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 Board is asked to:

- Note the Trust is reporting a year to date surplus of £141k.

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – 14th OCTOBER 2021

Report Title
M5 Capital Programme and Long Term Capital Plan
Sponsor and Author(s)
Author: Craig Marshall, Project Accountant Sponsor: Karen Johnson, Director of Finance
Executive Summary

M5 Capital Programme

The Trust's forecast capital envelope is currently at £56.0m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£17.3m), IFRIC 12 (£0.9m) and Government Grant/Donations (£13.4m)

The system capital will need to be supported by emergency PDC totalling £8.0m. An application was submitted to the NHSI regional team on the 21st May and the Trust has answered a series of questions regarding the application with the National Team. The most recent line of questioning hinges around the Trust's forecast cash position of which the Trust are undertaking a detailed review to determine whether there is scope to fund the emergency capital from internal cash resources.

As at M5, the Trust had goods delivered, works done or services received to the value of £14.5m. This is £9.6m behind the YTD plan of £24.1m. This position doesn't appear to be improving and external scrutiny will now increase. There is a risk that if we cannot provide assurance to our regulators that we have a robust plan in place to spend the full allocation then it could be removed.

Given the year to date position and the necessity for the Trust to not overspend the capital programme, the Trust reported a Forecast outturn of £56.0m in the M5 NHSI return. This position was on the assumption that solutions can be found to fund the known pressures within the programme of £0.9m.

Long Term Capital Plan

Following a board development session earlier in the year and subsequent executive discussions that have taken place, a capital strategic prioritisation framework was developed and approved.

In summary, the capital programme will be split equally between medical equipment, estates and digital. (Noting existing pre-commitments impacting on the 22/23 split. The SRO's will be Simon Lanceley / Karen Johnson. The Programme leads for the three areas will be Medical Equipment - Mark Pietroni, Estates – Qadar Zada and Digital – Mark Hutchinson

The Executive Leads have worked with key personnel across the Trust to develop a balanced long term capital plan within the annual system capital allocation of £24m available to the Trust.

Each allocation has been able to work up their programmes to differing levels of detail as explained in this report and no doubt further explained by each of the Executive Leads at IDG. With only a finite amount of resource their remains a number of risks attached to those schemes that it is not possible to fund from each of the allocations. Some of the key risks and issues are noted within this report. There is likely going to need to be ongoing discussions within the Trust about how these risks are mitigated both prior and after the long term capital plan is submitted to the ICS and NHSIE from October.

Recommendations

The Trust Board are asked to:

- NOTE the M5 capital position
- RECOGNISE the importance of the project progress reporting process.
- NOTE the introduction of the capital strategic prioritisation framework
- RECOGNISE the enormous effort that has taken place with a complex prioritisation.
- APPROVE the long term capital plans within this paper for onward submission to ICS

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

M5 Capital Programme

21/22 Programme Overview

The Trust's forecast capital envelope is currently at £56.0m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£17.3m), IFRIC 12 (£0.9m) and Government Grant/Donations (£13.4m)

There has been no movement in the forecast envelope since the M4 position was submitted.

Table A – Programme by Allocation

	M4	M5	Change
Programme Allocation	**£000's**	**£000's**	**£000's**
System Capital*	24,404	24,404	0
National Programme	17,328	17,328	0
Donations and Government Grants	13,397	13,397	0
IFRIC 12	874	874	0
Total Programme	**56,003**	**56,003**	**0**

*£7,951k is subject to a successful emergency PDC application

The system capital will need to be supported by emergency PDC totalling £8.0m. An application was submitted to the NHSI regional team on the 21st May and the Trust has answered a series of questions regarding the application with the National Team. The most recent line of questioning hinges around the Trust's forecast cash position of which the Trust are undertaking a detailed review to determine whether there is scope to fund the emergency capital from internal cash resources.

Post Month End Note: the programme will be increased in M6 to £57.0m due to the original plan figure for the Salix money never being uplifted for the 20/21 slippage within the project.

The grant for Salix was £13.7m, with £1.6m originally intended to be completed in 20/21 and £12.1m in 21/22. Only £0.6m was completed in 20/21 but the 21/22 plan had never been increased to reflect the £1m that had slipped over into 21/22.

M5 Position

As at M5, the Trust had goods delivered, works done or services received to the value of £14.5m. This is £9.6m behind the YTD plan of £24.1m. The breakdown of this expenditure by programme allocation is shown in Table B.

Table B – M4 Expenditure position by Programme Allocation

Application of Funds	In Month			Year to Date			Forecast		
Programme Allocation	**Plan £000's**	**Actual £000's**	**Variance to Plan £000's**	**Plan £000's**	**Actual £000's**	**Variance to Plan £000's**	**Plan £000's**	**Actual £000's**	**Variance to Plan £000's**
System Capital	1,762	1,788	(26)	9,147	6,014	3,133	24,404	24,404	0
National Programme	1,417	413	1,004	5,919	2,282	3,637	19,602	17,328	2,274
Donations and Government Grants	1,670	800	870	8,695	5,817	2,878	12,659	13,397	(738)
IFRIC 12	73	73	0	364	364	0	874	874	0
Total Programme	**4,922**	**3,074**	**1,848**	**24,125**	**14,477**	**9,648**	**57,539**	**56,003**	**1,536**

The by project spend detail can be found in Appendix A. This shows forecasts as received by the project leads and is not the forecasts that were submitted as part of the M5 NHSI return. The NHSI return is showing the Trust forecast to plan until such time that the Trust has had the opportunity to conclude its review of the project lead forecasts.
The Forecast Outturn position remains at £0.2m, which was previously reduced from a commitment of over £0.9m.

This was generated largely by two schemes; a) Slippage from IGIS of c£0.5m, which would impact on the 22/23 programme. This is not feasible due to existing large pre-commitment and b) A reduction in the Trak-care implementation forecast of c£0.2m.

These were being reviewed by the respective project leads;

- IGIS is awaiting the detailed design to compute a more accurate spend profile.

- Digital are collating the Trakcare costs to forward to Finance to ensure that the forecast is correct and additionally work with Finance to review the expenditure to see if it all should/could be classified as revenue expenditure. An unexpected delay has meant that this has not been possible to conclude prior to the September IDG.

Other areas to review in September are;

- A current a list of schemes will be circulated following the September meeting for project leads to detail the impact of this scheme not proceeding. The Trust cannot continue to carry an over-commitment as well as being some way behind YTD plan as this puts not only 21/22 programme at risk.

- The slippage allocation was calculated at the beginning of the year based on the expected costs that did not materialise in 20/21 and therefore spend would be incurred in 21/22. During September, a detailed investigation will be undertaken to ascertain why some of these costs have not materialised.

Project Progress Reporting Process
As part of the improved project progress reporting timetable, project leads were sent a provisional expenditure position and were asked to review for any inaccuracies and notify finance of any inaccuracies that were found.

Once the position was closed, the project progress reports were circulated, asking for project leads to review the reported position for their projects and;

- Provide a Forecast Spend by Month
- Provide the Original intended completion date and the Month of the latest intended completion date.
- Update the narrative fields
    a) If the Overall Cost RAG is an Amber or Red, then give a summarised reason.
    b) Provide a summary update for the project.

It was decided that in Month 5 that the Schedule RAG would be introduced so that progress on completion dates could be monitored as well as the previously included Cost RAG.

Due to the shortened time available due to an earlier IDG than previous months, a full review and analysis of the responses has not been possible. Initial review suggests a level of questionability over the timely and accurate submission of the responses.

It was agreed at IDG that there would be deep-dives carried out into largest at risk/significant projects to improve the forecasts and accurate capturing of costs. The four areas that will be subjected to a deep-dive are;

- Estates Lifecycle,
- IGIS,
- SSD and
- Energy Efficiency (Salix)

The full project progress reports are included in appendix A.

Risks

Key risks to the 21/22 capital programme include:

- Whist we have received confirmation of the digital aspirant capital funding for 21/22 the funding as yet to have been received and is due for drawdown in March, albeit there is discussions taking place to bring this forward to January or February.

- The Trust's programme assumes that the Trust will receive Emergency Capital PDC. The financial risk of this has been mitigated by correlating the start dates of schemes that make up the application with the expected application outcome date. A couple of schemes have been started at risk and should the funds not be forthcoming then further slippage from the System Capital programme will be required to fund the costs that have been committed on these schemes.

- Timing of capital payments and drawdowns could impact on cash-flow. Work is being commenced with financial accounts team to ensure that there is drawdowns of cash are done in a timely fashion to best match the expenditure profile. This will need continually monitored throughout the year as the forecast expenditure profiles change.

- Spending revenue money on capital items and not following the IDG capital approval route. Enhancements to the level of reviews being undertaken are being made within the revenue accounts and any examples of this happening will be reported to IDG.

- There are pressures within the capital programme that if not addressed will put the programme at risk of overspending. The work that has been recommended to address this coupled with the YTD spend position being behind plan suggests the current risk is fairly low but one that needs to be resolved sooner rather than later.

- Without a clear plan as to how the Lifecycle allocation, the capital programme is at risk of over-committing.

- Incomplete and inaccurate project progress reports could lead to incorrect management action and failure to deliver the capital programme.

- The charity will be launching a fundraising appeal in September to fund the purchase of a gamma camera. The timing of the operational need may mean the Trust will need to commit funds at risk ahead of any fundraising

Recommendations
The Trust Board are asked to:

- NOTE the M5 capital position and
- RECOGNISE the importance of the project progress reporting process.

Long Term Capital Plan

Introduction
The Board Development session earlier this year affirmed that, even with the context of the recent pandemic, the Trust's strategic objectives remain valid in respect of ambition and timeline. The Board also noted that in endorsing the strategic priorities, the Board's investment decisions needed to be shaped by this more strategic context and less by the operational day to day drivers that have characterised previous approaches.

In order to balance these competing priorities it was proposed that we would give thought to how we aligned the (scarce) capital resource allocation to the priorities. With no weighting applied to the ten priorities it proposed that the available resource be split between the three main areas of capital investment i.e. medical equipment, buildings and digital. The benefit of this approach is that it not only aligns investment to priorities in a way that reflects the strategic intent but it also prevents the current scenario of operational colleagues (with inevitable bias) being asked to compare the merits of investment in a leaking roof and a ground breaking technology.

In support of the above, a strategic prioritisation framework was approved in August and is designed to help the Trust conduct a systematic and auditable prioritisation exercise and reduce the burden and complexity of the task in order to make evidenced based decisions across all areas.

The SRO's for the strategic capital framework will be Simon Lanceley / Karen Johnson.

Programme leads for the three areas will be Medical Equipment - Mark Pietroni,- Estates – Qadar Zada and Digital – Mark Hutchinson

The Process
The proposed process is outlined in Table A.

Table A- The Process

	CAPITAL STRATEGIC PRIORITISATION FRAMEWORK PROCESS
1	SET PROGRAMME AREAS ALLOCATIONS FOR THE COMING PERIOD
2	EVALUATION PRIORITISATION CRITERIA REVIEWED AND AGREED
3	INVESTMENT PROPOSALS SUBMITTED TO PROGRAMME LEADS FROM CORPORATE AND CLINICAL LEADS
4	EXECUTIVE LEADS OVERSEE EVALUATION PROCESS AND CONFIRM PROPOSED INVESTMENT PRIORITIES FOR THEIR AREA
5	CALIBRATION TO TEST
6	FURTHER PRIORITISATION BETWEEN PROGRAMME LEADS IF STEP 6 RAISES CONCERNS.
7	GOVERNANCE SIGN OFF
8	BUSINESS CASE PROCESS FOR APPROVED INVESTMENTS.

Step 1 – Set Programme Areas Allocations for the coming period

The Executive Leads via IDG, will review the Programme Areas and decide if the programme areas are the correct for the forthcoming financial year and whether the proportion needs to be changed.

Step 2 – Evaluation Prioritisation Criteria Reviewed and agreed

The Executive Leads will Review the Evaluation Prioritisation Criteria, which should align with the Strategic Objectives of the Trust, to ensure that it is still reflects the key criteria from which the proposals should be assessed.

Step 3 – Investment proposals submitted to relevant Executive Lead

The Departments within each Programme Area will be asked to submit their proposals to the Executive Lead (most likely in the form of a simple project proposal template)

Step 4 – Executive Leads oversee evaluation process and confirm proposed investment priorities for their area

The Executive Lead and their team will review the proposals and using the Evaluation Prioritisation Criteria will decide which proposals will be funded. Rationale should be documented should there be the need to override the outputs of the prioritisation scoring and will be ratified by IDG prior to reporting to Finance and Digital Committee.

Step 5 – Calibration to test, for example, a digital investment that is to proceed within the digital resource envelope isn't considered a higher strategic priority that something that could not be funded in another programme area.

After each Executive Lead has a prioritised list for utilising their allocation, all the Executive Leads will meet and cross check to ensure alignment with strategic priorities. They will also review those schemes that didn't get funded within each of the areas to ensure that as a Trust the overall prioritised list is justified. The final list will be reported through the normal governance process via IDG.

For example, a digital investment that is to proceed within the digital resource envelope isn't considered a higher strategic priority that something that could not be funded in another programme area.

Step 6 – Further prioritisation between Programme Leads if Step 5 raises concerns.

The Programme Area Executive leads will need to further prioritise their allocations in the event that the Executive review (Step 5) raises concerns. This step would need to be continually repeated until a balanced programme had been agreed by the Executive Team. This would be normally expected to conclude after no more than one review.

Step 7 – Governance Sign Off

Once an overall prioritised programme has been decided the programme will need to go through the requisite governance sign off's through IDG, Finance and Digital Committee and Trust Board.

Step 8 – Business Case Process

Once the prioritised programme has been signed off and before budget can be released, Business cases will need to be drafted and the requisite IDG approval process followed.

Emerging In Year Pressure

Should there be an emerging pressure arise in year then Steps 3 to 7 will need to be followed.

The department would need to send a proposal to the relevant Executive Lead. The Exec lead and their team would review the proposal using the prioritisation framework and alongside proposals that are already funded. If the Exec lead is able to reprioritise their existing allocation to deal with this emerging pressure then this would go straight to Exec Sign off and Business Case. In the event that the Executive Lead was unable to accommodate the emerging

pressure within their constituent allocation then a discussion with the other Executive leads should be held to see if the other allocations can be reprioritised.

In the event that the emerging pressure cannot be accommodated from any of the allocations then the Executive team will need to discuss what action is necessary (for example: carrying the increase risk or decommissioning of a service)

The Strategic Prioritisation Framework should be reviewed annually by the Executive Team, Finance and Digital Committee and Board.

Setting of the Allocations
Based on historical spend and coverage, it has been proposed that this begins as equal splits across the following programme areas; Estates, Digital and Operations. (See Table B)

Table B - The Programme Areas Allocations

PROGRAMME AREAS	ALLOCATION %
ESTATES	33.33%
DIGITAL	33.33%
MEDICAL EQUIPMENT	33.33%

The Executive Leads for the programme areas are;

- Medical Equipment - Mark Pietroni,
- Estates – Qadar Zada and
- Digital – Mark Hutchinson

Due to a significant element of the 22/23 programme having already been pre-committed this results in an unequal split in 22/23. Therefore the balance of the available funds have been equally applied to the Digital and Medical Equipment areas to bring those up to a consistent level, leaving the Estates area at a higher value, driven mainly by IGIS.

There is a small central contingency amount to be held by the Chairs of IDG.

For years 23/24 onwards, the equal split across the programme areas will be used across the entire programme as shown in Table C. This will be reviewed annually to ensure that the programme areas and allocations remain appropriate.

Table C - The Programme Areas Allocations

	2022/23			2023/24 and beyond
PROGRAMME AREAS	Precommitted £000's	Not Committed £000's	Total Allocation £000's	Total Allocation £000's
ESTATES	13,583	0	13,583	8,000
DIGITAL	3,300	1,909	5,209	8,000
MEDICAL EQUIPMENT	116	5,093	5,209	8,000
CENTRAL CONTINGENCY	0	404	404	404
SYSTEM CAPITAL (CDEL)	16,999	7,405	24,404	24,404

Evaluation Prioritisation Criteria
The Executive Team recently set the Evaluation Prioritisation Criteria for 22/23 as follows:

Table D - Evaluation Prioritisation Criteria

EVALUATION PRIORITISATION CRITERIA	WEIGHTING
PATIENT BENEFIT	20
MANDATORY / LEGAL / STATUTORY	20
FINANCIAL SUSTAINABILITY	20
DELIVERABILITY / LIKELIHOOD OF SUCCESS	10
IMPROVING CARE AND SERVICES THROUGH INTEGRATION & COLLABORATION	10
ENVIROMENTALLY SUSTAINABLE	10

Each proposal that is submitted will be given a score of 1 to 5 against each of the criteria above and then using the weighting adjustment to give a weighted score. The Executive Leads will review all the scores for the proposals within their programme area and will have an opportunity to override the outputs providing there is suitable rationale recorded.

Prioritisation of the Plan

Digital
The Digital prioritisation used the prioritisation criteria to inform the plan and then categorised into four main digital areas for investment.

- Clinical Enabling Technology
- Replacement Kit / Systems
- EPR / Digital Improvement
- Systems Integration

The prioritised plan is shown in Table E.

Table E – Digital Long Term Capital Plan Summary

	22/23	23/24	24/25	25/26
Scheme/Category	Allocation £000's	Allocation £000's	Allocation £000's	Allocation £000's
Total Clinical Enabling Tech	1,421	900	1,500	1,500
Total Replacement kit/systems	638	3,800	2,000	2,000
Total EPR / Digital Improvement	2,800	2,600	4,000	4,000
Total Systems Integration	350	700	500	500
DIGITAL	5,209	8,000	8,000	8,000
Aspirant Funding (Separate to System Capital)	3,300			
DIGITAL including Digital Aspirant Funding	8,509	8,000	8,000	8,000

Notes / Key Risks

If the Trust agrees that this is an acceptable level of digital funding that the following risks are noted and understood.

- There is a financial risk associated with the Digital Aspirant funding in that the Trust need to match fund the £3.3m. There is a concern that in 22/23 that the Digital allocation will have to fund business critical items rather than advancing and make digital progress. If

we are unable to prove that the £3.3m Aspirant funding has been spent on accelerating the HIMMS journey, funding could be pulled.

- The level of funding risks the Trusts progress on the HIMMs journey and our Aspirant status.

- A few schemes within the original plan need fully assessed to see if they are capital or revenue costs. The initial assessment indicates that they are running costs and should be charged revenue – therefore have been excluded from this capital plan.

Medical Equipment

The Medical Equipment prioritisation used the prioritisation criteria to inform the plan and then at the recent Equipment Contingency group divisional representatives reviewed the Divisional priorities and using the best information available at the time were able to produce a balanced programme across the four years.

The prioritised plan is shown in Table F.

Table F – Medical Equipment Long Term Capital Plan

	22/23	23/24	24/25	25/26
Scheme/Category	**Allocation £000's**	**Allocation £000's**	**Allocation £000's**	**Allocation £000's**
Pre-Commitments / Contingency				
Finance Lease Buyouts / Extensions	**116**	**261**	**274**	**10**
MEF Contingency	**1,139**	**1,208**	**2,825**	**2,825**
Total Pre-Commitments	**1,255**	**1,469**	**3,099**	**2,835**
Prioritised Schemes				
Corporate Medical Equipment (Mattresses, Beds)	**200**	**200**	**200**	**200**
Linac Replacements	**0**	**400**	**400**	**0**
Ultrasound replacement	**400**	**390**	**0**	**0**
Image intensifiers	**220**	**330**	**330**	**220**
IR room 8	**0**	**1,511**	**0**	**0**
CT replacements CTC	**0**	**0**	**1,400**	**0**
MRI replacement	**0**	**0**	**0**	**1,700**
Maternal Bed Replacement	**75**	**0**	**0**	**0**
NICU Incubator and Bassinet Replacement	**360**	**0**	**0**	**0**
3rd Cath Lab - Cardiology	**0**	**1,500**	**0**	**0**
Echos - Cardiology	**300**	**700**	**0**	**0**
Hybrid Vascular theatre (Theatre 3 GRH)	**1,200**	**0**	**0**	**0**
Various Theatre Equipment	**800**	**1,500**	**1,900**	**1,500**
Ophthalmology - TOP CON - replacement PASCAL LASER	**94**	**0**	**0**	**0**
Diabetic Screening	**55**	**0**	**0**	**0**
Cardiac ward Monitoring CGH - Cardiology	**250**	**0**	**0**	**0**
Cardiac MRI scanner + reporting system - Cardiology	**0**	**0**	**0**	**300**
Replacement of highest risk Endoscopy Kit	**0**	**0**	**600**	**1,174**
Birth Pool Replacement	**0**	**0**	**71**	**71**
Total Prioritised Schemes	**3,954**	**6,531**	**4,901**	**5,165**
MEDICAL EQUIPMENT	**5,209**	**8,000**	**8,000**	**8,000**

Notes / Key Risks

- Medicine and W&C not present in discussions

- Schemes including Cath Lab are needing business case approval

- The Fluoroscopy room does not feature in the long term priorities and is c10years old.

- Endoscopy Replacement is zero in 22/23 and 23/24, the total value is more than halved.

- A contingency allocation has been provided but should any large items fail then the plan will need to be revisited.

- Subject to final divisional reviews and sense checking of divisional priorities (i.e. Endoscopy below Cath Lab?)

- The plan will be continually reviewed to reflect the dynamic and predictable nature of equipment failures.

- There has been no provision specifically set aside for the Radiology/Cardiology Managed Equipment Service that is currently being considered.

Estates

The prioritisation of the future years' capital plan is intended to be informed by the recently completed '6 Facet Survey' which includes an assessment of the backlog liability of the Trust estate. This report is still being reviewed for assurance of the outputs. The alignment of the estates capital plan with the outputs from the '6 Facet Survey' is also an approach that is supported by the BDO external audit for addressing backlog maintenance.

The steps that need to be taken and estimated dates to utilise the outputs are:

1. Final meeting to confirm 6 Facet Survey contents for finalisation of report – end Sept 21

2. Overlay Trust Estates Strategy onto the outputs - Oct 21

3. Establish anticipated backlog funding allocation – Oct 21

4. Line by line review of headline items – Statutory Compliance, High and Significant Risk (initially) to identify key priorities by year Oct 21 – Dec 21

5. Complete 5 year capital plan based upon outputs above - Jan 21

Until this is complete any submissions we might make as regards detailed capital plans for next financial year and beyond will be entirely speculative. Additionally this will only address associated estates 'backlog maintenance' works that have been reviewed, risk profiled and graded in terms of urgency and H&S as a result of the '6 Facet Survey' and further external audits of the Trust's estates compliance with HTM recommendations. It is therefore proposed for the current planning submission that the Trust shows the remaining Estates allocation as one line under backlog maintenance (Table H)

We strongly believe that Estates Strategic development schemes also need funding, in particular the Electrical Strategy requires significant funding (c.£20m over 5 years) in order that the Trust has sufficient capacity to service the increasing load demand and the resilience to ensure that this is delivered in a safe manner in line with HTM recommendations.

These costs could be included but would certainly in 22/23 exceed the funding available.

Table G – Estates Long Term Capital Plan

	22/23	23/24	24/25	25/26
	Allocation £000's	Allocation £000's	Allocation £000's	Allocation £000's
Pre-Committed				
Gloucestershire Hospitals Strategic Site Development	2,500	2,500		
Fit for the Future (IGIS)	8,083			
Backlog Maintenance / Lifecycle	3,000			
Total Estates Pre-Commitment	**13,583**	**2,500**	**0**	**0**
Remainder to prioritise				
Backlog Maintenance / Lifecycle*	0	5,500	8,000	8,000
Total Prioritised Schemes	**0**	**5,500**	**8,000**	**8,000**
ESTATES	**13,583**	**8,000**	**8,000**	**8,000**

*Subject to further review following the assurance review from the 6 facet survey (further explained in the narrative of the September IDG paper

Next Steps
A calibration test of the capital prioritisation process took place on 20th September with no changes made to the draft long term plan contained within this paper.

The draft long term plan was supported by the Finance and Digital Committee on the 30th September and if supported by the Board then the prioritised plan will be submitted to the ICS Board in October.

Recommendations
The Trust Board are asked to:

- NOTE the introduction of the capital strategic prioritisation framework
- RECOGNISE the enormous effort that has taken place with a complex prioritisation.
- APPROVE the long term capital plans within this paper for onward submission to ICS

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – October 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 30th September 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	Detailed financial report covering the year to date results. Ytd surplus of £0.14 million compared to a break even position. Activity at 100% of 19/20 levels. Higher than planned agency costs and pressures from Mental Health Nurse requirement	What are the specifics in terms of required mental health nurse staffing levels? Can we conduct a deep dive into agency costs?	Comprehensive report provided continued assurance that the financial position is well understood and in control There are instances where a patient can need care from 3 high level mental health nurse on a 24/7 basis.	In depth review to be scheduled – requires co-ordinated approach with the People and Organisation Development Committee to avoid duplication of effort
Capital Programme Report	Update on capital spending - year to date £14.5 million, £9.6 million behind plan. Detailed project analysis described and presented	Can the supporting narrative addressing major variances be reinstated?	Committee assured by detailed reporting Yes, this is planned	Consideration being given to project owners attending committee to explain issues on projects that are significantly behind plan
Long Term	Update on the previously	What if the available	Agreement that the	Current plan submission is

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Capital Plan	provided long term plan based on annual expenditure of £24 million utilising a 3 way split - equipment, estates and digital	funds are not sufficient to provide a safe and efficient service?	approach was robust and appropriate. Extensive discussion around funding options and possible escalation of shortfall provided further assurance of grip but highlighted risks	draft and further iteration expected
Financial Sustainability	Update on the year to date, first half and preliminary second half positions. Year to date savings at £3.1 million exceed plan by £1.1 million but are weighted excessively to non-recurrent benefits.	Can the Committee see more detail of the benchmarking tool that has been developed?	The analysis is comprehensive and shows the expectation.	Further analysis expected and identification of gaps once national guidance finalised.
Update on H2 Planning	Briefing on the status of the second half financial and operational plans plan which have been prepared in the absence of national guidance at this stage.	Are the demand levels and consequent financial impacts congruent given the capacity shortfall indicated by the graphs?	This is work in progress and the next stage is to match the demand and financial assumptions The committee was assured by the thoroughness of the approach	
Costing	The Committee received an update on the status of the National Cost Collection submission which was required by NHSE/I by October 5th. The presentation also covered the current year's challenges in meeting the deadline and described opportunities for future improvements	Is there good liaison between the costing team and the benchmarking work in	He Committee was assured of the robustness of the process for 20/21 acknowledging that the pandemic had complicated the process and would lead to some limitations which NHSE/I accepted	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		the project management office	Yes close cooperation and a steering group is in place	
Gloucestershire Managed Services Dividend Plan	Presentation by the GMS Finance Director of the proposed revised approach to GMS dividend payments to obviate issues associated with year-end consolidation and audit	Are there any legal/statutory considerations associated with declaring a dividend ahead of final accounts? Why is it necessary to have interim and divided declarations given we are dealing with a wholly owned subsidiary?	No this is permissible and any variance would be below the materiality threshold Issue discussed and conclusion reached that a single declaration would be appropriate and simpler to administer	
Board Assurance Framework	Update on the principal risks as reviewed by Executives up to the end of August with no new risks or changes to scores of existing risks.	Is there a revenue risk arising from the digital industry move to subscription based services?	Discussion around the risk assessments provided assurance	Needs to be considered going forward
Cash Analysis	The Finance Director presented detailed cash flow projections to support the proposal to finance £7.9 million of in year capital expenditure rather than apply for NHSI funding and its associated costs and impact on the Trust's financial sustainability metrics .	Why is the Trust still recorded as distressed against some measures?	The Committee was assured of the robustness of the process and supported the proposal. The preparation work had highlighted an oversight at Regional level that had failed to correctly record the Trust's improved position – correction is being formally pursued by	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			the Finance Director	
Digital Programme Report	Project progress report presented following the standard format highlighting changes since the prior month and areas of focus. The principal effort has been the support of Pathology following the go live of the new laboratory system (TCLE)	Is the deployment of TCLE a more significant issue than current reporting indicates? Is there a capacity constraint with IT resource?	RAG rated progress reports provide assurance of individual project status levels	The TCLE task and finish group report will be presented to the next committee for assurance Requires further review once the second half cost position is refined
Integrated Care System	Committee advised that deployment of the Health Information and Management Systems Society (HIMMS) to assess the Continuity of Care Model was imminent		Committee assured that this system wide work was now planned	
EPR Benefits	An update on the work that has been undertaken to quantify the benefits of the Sunrise EPR system. This highlighted: - The release of hours to provide patient care, - reduction in length of stay - coding benefits - elimination of hard copy letters		Analysis continues to develop well but the work to provide full validation is extensive.	

Rob Graves
Chair of Finance and Digital Committee
8th October 2021

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – October 2021

From Audit and Assurance Committee Chair – Mike Napier (deputising for Claire Feehily), Non-Executive Director

This report describes the business conducted at the Estates and Facilities Committee held 28th September 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
Matters Arising	It was reported that this is still no new system, or plan, for a register for gifts and hospitality. It would be part of the ESR (Electronic Staff Records), but it is not currently considered a priority.	Do we have an effective system for registering gifts or other potential conflicts?	It was reported that some staff are probably not reporting everything they receive. It should be declared/raised during staff appraisals, but there is a risk things get missed.	An update will be provided at the next Committee meeting.
Risk Assurance Report	A new risk relating to TCLE implementation has been raised.	There don't appear to be any actions against this risk. What are the gaps in controls?	Committee were advised that the Risk Management Group process was robust and that new risks would not be accepted without associated actions.	
	A new risk relating to the implementation/use of cinapsis.	Is this a specialty or corporate risk? How is it being addressed/mitigated.	The original implementation of cinapsis was on a pilot basis but had been extended during the pandemic. The Medical Director advised that there was a piece of work ongoing centrally to bring the system under proper	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
			control and scrutiny. Progress would be reported through the Digital Care Board.	
Business Assurance Framework	The Committee considered the overall framework that covers all strategic objectives. It was agreed that reviews of this would be half-yearly in future (from quarterly).	The RAG scoring of Finance risk profile of RED seems overly pessimistic.	Director of Finance advised that this reflected the current high levels of uncertainty of the external funding regime/levels.	
External Audit	Report was received covering final situation and lessons learned. Trust audit is completed, while GMS and Charity audits would be signed off before the end of November. Verbal notification of an increase in costs due to the value for money review and the additional time that was needed to concluded the Trust's audit.	Are we at risk of missing any filing deadlines? Why was the Audit Certificate delayed?	No, we should not miss any deadlines. There was a confusion on dates. While it should have been issued by the end of August, it was actually mid-September.	
Internal Audit	Only one audit report was issued (Clinical Audit).	Are operational pressures impacting the audit programme?	While there have been some delays, there is nothing of significance and it was expected that reports would catch up for the next meeting.	
	Clinical Audit Final Report: report reviewed by	This was considered a good report, with some	The report has been reviewed by the Quality	Progress and completion of audit actions will be monitored

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Committee. Opinion was "Substantial" for Design and "Moderate" for Operational Effectiveness. There were two medium findings with actions agree.	good practices reported.	and Performance Committee.	by Q&P Committee.
GMS Update	External Audit will commence in October for completion in November. There are a number of internal audit actions delayed due to a software package (MiCad) not yet implemented.	Are there operational concerns? Will implementation go ahead according to the revised timeline?	There are no serious operational issues. The revised plan is robust and there are good relationships with Trust Digital time, so confident implementation will be according to plan (Jen/Feb 2022).	
Counter Fraud Update	Regular report on counter fraud activities, including ongoing investigations	How are staff managed during periods when they are under investigation?	There are formal conduct routes and whether staff continue to work or are suspended will depend on severity of the case.	Committee to receive further assurance on this process.
Cyber Assurance Report	Audit report from PwC covering DSPT (Data Security and Protection Toolkit), which had been commissioned in conjunction with NHS Digital. The audit reflected refreshed National Safety Guardian "10 steps to cyber security". The overall opinion was "unsatisfactory" with the greatest concern	How concerned should we be with this opinion? Will we achieve a situation of zero unsupported software?	Given the renewed standards, the outcome was not a surprise. A number of actions had already been completed to address findings, such as combining Cyber and IG in the Trust and strengthened controls against ransomware.	The audit report will be taken to Finance & Digital Committee for review and monitoring of actions.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	being unsupported software in the Trust.		Actions to address unsupported software/systems are being incorporated into the workplan and work was taking place to address the options to eliminate them.	
Patient Property Assurance Report	The Chief Nurse updated Committee on the Patient Property boxes. Counter to previous updates, he advised that the "purple boxes" proposal had not been funded and this project had not been progressed. He reassured Committee that a new box had been designed and would be rolled out shortly.	This is a highly emotive issue and one that patients		Committee will want to see confirmation of this roll-out, with the associated updated policy and procedures. It was also expected that there would be some form of follow-up audit to ensure that the new arrangements would be effective.

Mike Napier
Stand-in Chair of Audit and Assurance Committee
7th October 2021